

September 2020

**Improving Our  
Maternity Care Now**  
*Four Care Models  
Decisionmakers Must  
Implement for Healthier  
Moms and Babies*

Carol Sakala, Director for Maternal Health  
Sinsi Hernández-Cancio, Vice President for Health Justice  
Sarah Coombs, Director for Health System Transformation  
Ndome Essoka, Health Justice Legal Intern  
Erin Mackay, Managing Director for Health Justice







*The National Partnership for Women & Families dedicates this report to the millions of birthing people and their families who have been disrespected and mistreated by the U.S. health care system, the 700 women annually who have made the ultimate sacrifice birthing the next generation, and especially the families who have struggled this year to stay healthy and birth with dignity and safety during our dual national crises of the COVID-19 pandemic and racist injustice.*



The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

This report was authored by the following National Partnership for Women & Families staff:

- Carol Sakala, Director for Maternal Health
- Sinsi Hernández-Cancio, Vice President for Health Justice
- Sarah Coombs, Director for Health System Transformation
- Ndome Essoka, Health Justice Legal Intern
- Erin Mackay, Managing Director for Health Justice

The following National Partnership for Women & Families staff contributed to this report (in alphabetical order):

- Stephanie Green, Health Justice Policy Associate
- Llena Jackson-Leslie, Senior Communications Specialist
- Blasmeli León-Depass, Health Justice Policy Counsel
- Nikita Mhatre, Health Justice Policy Associate

We also acknowledge the following professionals who helped make this report a reality:

- Jorge Morales, Editor
- Nichole Edralin, Designer

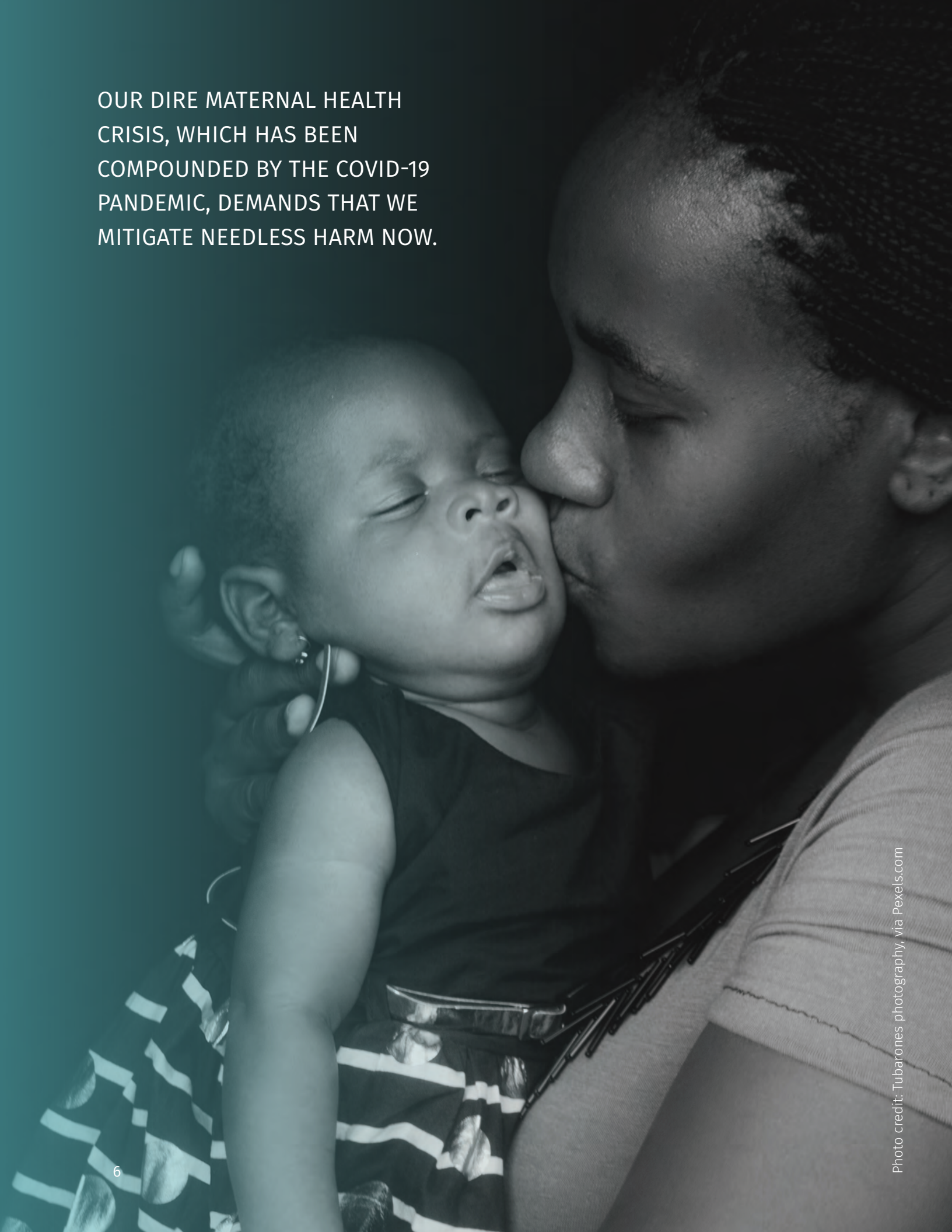
*This report was made possible thanks to the generous support of the Yellow Chair Foundation.*

# Improving Our Maternity Care Now: *Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*



<b>07</b>	Executive Summary	<b>51</b>	Promising, Emerging Hybrid Model: Community-led Perinatal Health Worker Groups
<b>13</b>	Introduction	<b>59</b>	Conclusion
<b>21</b>	High-Quality, Evidence-Based Maternity Care Models	<b>60</b>	Complete Recommendations
	22 Midwifery Care	<b>66</b>	Resource Directory
	32 Community Birth: Birth Centers and Home Birth	<b>70</b>	Endnotes
	43 Doula Support		

OUR DIRE MATERNAL HEALTH  
CRISIS, WHICH HAS BEEN  
COMPOUNDED BY THE COVID-19  
PANDEMIC, DEMANDS THAT WE  
MITIGATE NEEDLESS HARM NOW.



# Improving Our Maternity Care Now: *Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*

## Executive Summary

The U.S. maternity care system fails to provide many childbearing people\* and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income country.

Our health care system spectacularly fails communities struggling with the burden of structural inequities and other forms of disadvantage, including Black, Indigenous, and other communities of color; rural communities; and people with low incomes.

In the long term, we must transform the maternity care system through multiple avenues: delivery system and payment reform, performance measurement, consumer engagement, health professions education, and modifying the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models lead to demonstrably better care, experiences, and birth outcomes. We just have to take steps to make them readily and widely available. We have identified three reliably high-quality forms of maternal and newborn care, as well as one promising, emerging model.

Clear evidence shows **midwifery care**, **“community birth” settings** (birth center and home birth settings), and **doula support** (including the extended model of prenatal, childbirth, and postpartum support) provide excellent and appreciated woman- and family-centered experiences, leading to improved birth outcomes. In addition, **community-led and -based perinatal health worker groups** are a newer, hybrid model of care that explicitly centers meeting community needs and priorities – particularly in communities of color – by providing a wide range of services, including in many cases some combination of midwifery care, community birth settings, and doula support. This model has emerged

\* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this report uses both gendered terms such as “women” or “mothers” and gender-neutral terms such as “people,” “pregnant people,” and “birthing persons.”

*The terrible impacts of these inequities are unfair and unconscionable, considering that 60 percent of pregnancy-related deaths are preventable.*

as a very promising practice in maternal care that has not been extensively evaluated as a unit, even as specific elements of care clearly have strong evidence of success, as already described. Given the strong focus on community-led services and the prominent role Black, Indigenous, and other women leaders of color have played in its creation and growth, it is likely that this last model is highly effective in reducing intractable racial inequities that have plagued many communities.

These four models of care share characteristics that distinguish them from the typical maternal care currently available in the United States. They provide highly appropriate care, minimizing both overuse and underuse. Care team members tend to be highly mission-driven and committed to meet their clients where they are. They holistically help meet families' physical, emotional, and social needs, providing individualized, respectful, trusted, relationship-based care. They tend to incorporate the skills and understanding to expertly support physiologic childbearing for the growing proportion of people interested

in birthing in a less medicalized, more holistic way that avoids unneeded medical interventions. Their remarkable outcomes on key health indicators succeed for communities that are commonly left behind. Lastly, while demand for these services is great, too often women and families can't access and benefit from them.

This report describes each of these models, their current availability, and the evidence that supports their safety, effectiveness, and broader adoption to improve maternal and infant health. The report also provides recommendations for decisionmakers in the public and private sector to achieve this goal.

### **Models of Care Meriting Wide Adoption**

Evidence shows that the first three models – midwifery care, community birth settings for medically low-risk pregnancies, and doula support – are highly effective and improve maternal and infant health. These results are especially notable given that usual maternity care continues to fail many birthing people and their families. We continue to have rates of preterm



birth, low birth weight, and cesarean births that are too high; rates of vaginal birth after cesarean and initiation and duration of breastfeeding that are too low; and extreme and unacceptable racial and ethnic inequities. Clearly, many more childbearing people and families could and should benefit from these higher-quality options.

The newer model comprises perinatal health worker groups headed by local community leaders. These multifunction groups are explicitly designed to meet the individual needs of childbearing people, families, and communities. They offer a wide range of services, often including one or more of the three evidence-based models described above. Frequently, they combine clinical and support services. They are particularly known for their expertise in offering respectful, trusted, culturally congruent care to communities of color. Such care acknowledges that women's cultural identity is central to the clinical encounter, upholds racial justice, fosters agency and practices cultural humility. In many cases, the groups also offer training programs that include national competencies such as comfort measures for doula support, as well as trauma-informed care to address the distinctive needs of marginalized communities and mitigate the harms of racism.

While evaluations of the perinatal health worker groups model are limited, available data show impressive results. And to the extent that these groups offer proven

services such as midwifery care, community birth, and doula support, they are based on clear evidence. Given the urgency to mitigate the country's maternal health crisis, support for these groups should be prioritized along with evaluations of their impact.

*As we work to transform the maternity care system, midwifery care, community birth, doula support, and the services of community-led perinatal health groups must be central to quality, value, and equity.*

## RECOMMENDATIONS

The ongoing maternal health crisis, compounded by the current COVID pandemic, underscores the urgency of taking concrete action now to improve birth outcomes for women and their families.

### Congress and federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act, a bipartisan bill designed to increase the supply of midwives with nationally recognized credentials.
- Enact the Birth Access Benefiting Improved Essential Facility Services (BABIES) Act, a bipartisan bill to fund sustainable Medicaid demonstrations of birth centers for enrollees with low-risk pregnancies in underserved areas.
- Enact the Kira Johnson Act, which would improve Black maternal health by providing funding for community-based perinatal health worker organizations, especially those led by Black women; address racism and bias in all maternal health settings; and support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act, which aims to grow the maternal health workforce, to provide guidance to states for promoting diverse maternity care teams and centering culturally congruent care in improving outcomes, and to study the barriers to entry for low-income and minority women into maternity care professions.
- Ensure that Medicaid, CHIP (Child Health Insurance Program), TRICARE (military health care program), Veterans Health Administration (VHA), Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service (as appropriate) cover:
  - ◆ Certified midwives (CMs) and certified professional midwives (CPMs)
  - ◆ Licensed birth centers and midwife birth center providers with nationally-recognized credentials
  - ◆ Home birth attended by midwives with nationally-recognized credentials
  - ◆ Doula support
- Create programs to support and evaluate community-based multi-functional programs, such as through the Center for Medicare and Medicaid Innovation.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health (including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding).

### State decisionmakers should:

- Enact necessary licensure in remaining jurisdictions for CMs, CPMs, and birth centers.
- Ensure that midwives with nationally recognized credentials are paid at the same level as physicians for the same service.
- Ensure that state Medicaid and CHIP programs pay for
  - ◆ Services provided by CMs and CPMs
  - ◆ Facility fees of licensed birth centers and professional fees of midwives with nationally-recognized credentials practicing in licensed birth centers
  - ◆ Home births attended by midwives with nationally-recognized credentials
  - ◆ Doula support
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice “at the top of their license” according to their full competencies and education.
- Ensure that doula training is tailored to the specific needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Pursue partnerships with community-based perinatal health worker groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments.

### Private sector decisionmakers should:

- Educate employees and beneficiaries about the benefits of high-value forms of maternal health care, including midwifery care, birth centers, and doula support.
- Ensure that plan directories maintain up-to-date listings for available birth centers and midwives.
- Ensure that plans contract with birth centers and midwives with nationally recognized credentials in their service area and reimburse care in all settings provided by midwives with nationally-recognized credentials.
- Include extended model doula support as a covered benefit in health plans.
- Make the services of community-based perinatal health worker groups available to beneficiaries and evaluate the return on investment, including implications for quality of care, health outcomes, and women’s experiences.

WE ALREADY KNOW WHAT TO DO TO  
MAKE CONCRETE PROGRESS AND ACHIEVE  
HEALTHIER MOTHERS AND BABIES.



## **Conclusion**

Our nation's terrible birth outcomes and unconscionable racial and ethnic inequities are driven by many separate yet interrelated factors and will require a multifaceted strategy to solve permanently. Nevertheless, we already know what to do to make concrete progress and achieve healthier mothers and babies. We must not accept the status quo of inequitable and expensive care that perpetuates avoidable harm. Concrete progress is within reach if decisionmakers are willing to act.

## Introduction

The U.S. maternity care system fails to provide many childbearing people\* and newborns with equitable, respectful, safe, effective, and affordable care. More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income country.<sup>1</sup> It spectacularly fails communities struggling with the burden of structural inequities and other forms of disadvantage, including: Black, Indigenous, and other communities of color; rural communities; and people with low incomes.<sup>2</sup>

In the long term, we must transform the maternity care system through levers, including delivery system and payment reform, performance measurement, consumer engagement, health professions education, and modifying the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models make a demonstrable difference in better care, experiences, and birth outcomes. We must take steps to make these widely available. We have identified three reliably high-quality forms of maternal and newborn care, as well as one promising, emerging

model. Clear evidence shows that **midwifery care, “community birth” settings** (birth center and home birth), and **doula support** provide highly effective care and excellent experiences, leading to improved birth outcomes. A newer model of **community-led and community-based perinatal health worker groups** has shown promise, especially in reducing glaring racial inequities in maternal health outcomes. Often, one setting or service provides some combination of these four models together. These combinations likely offer synergistic effects.

These forms of care share attributes that distinguish them from typical maternal care currently provided in the United States:

- They tend to have competence and reliability in providing highly appropriate services, avoiding both the underuse of high-value services and the overuse of unneeded care.
- The care team members tend to be exceptionally mission-driven and are ready to meet diverse needs of childbearing people and families where they are.
- They recognize and respond to the considerable physical, emotional, and social challenges that many families

\* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gendered identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this report uses both gendered terms such as “women” or “mothers” and gender-neutral terms such as “people,” “pregnant people,” and “birthing persons.”

face (and their root causes), offering holistic services that build on the individual's and family's strengths to support better health, more confidence, and increased resilience.

- They tend to provide individualized, relationship-based care and support that are respectful, dignifying, trustworthy and trusted, and often culturally congruent. Culturally congruent care centers the needs of patients and families within their social, cultural, and linguistic needs and values. In the process, providers and clients collaboratively build a trusting, effective, high-quality care experience.<sup>3</sup>
- They tend to incorporate the skills and understanding to expertly support physiologic childbearing for the growing proportion of people interested in birthing in a less medicalized, more holistic way that de-emphasizes unneeded medical interventions. This type of care actively supports the innate capabilities of birthing people and their fetus or newborn for labor, birth, breastfeeding, and attachment, only employing medical interventions as needed to augment physiologic processes.
- The outcomes they achieve are remarkable, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.

- Surveys of childbearing women find that large proportions are interested in these forms of care. However, too often women and families cannot access and benefit from them.

### **The current maternal care crisis: Terrible outcomes and deep inequities**

The United States lags behind every other high-income country, with the highest rates of infant and maternal mortality. Between 1987 and 2016, pregnancy-related deaths more than doubled – from 7.2 to 16.9 deaths per 100,000 live births.<sup>4</sup> Between 2006 and 2015, severe maternal morbidity, often reflecting a “near miss of dying,” rose by 45 percent, from 101.3 per 10,000 hospitalizations for birth to 146.6.<sup>5</sup>

In communities of color, the crisis is far greater. Compared to white non-Hispanic women, Black women are more than three times as likely – and Native women are more than twice as likely – to experience pregnancy-related deaths. Black, Hispanic, and Asian and Pacific Islander women disproportionately experience births with severe maternal morbidity relative to white non-Hispanic women.<sup>6</sup> Additionally, there are geographic disparities: Rural residents have a 9 percent greater risk of severe maternal morbidity and mortality, compared with urban residents.<sup>7</sup>

Multiple factors contribute to maternal mortality and to racial, ethnic, and geographic disparities. These include: gaps in health coverage and access to care; unmet

social needs, like transportation and time off from paid work for medical visits, and safe and secure housing; poor quality of care, including implicit and explicit bias; and structural and institutional racism in health care and community settings.<sup>8</sup> The terrible impacts of these inequities are

unfair and unconscionable, considering that 60 percent of pregnancy-related deaths are preventable.<sup>9</sup> One strategy to prevent maternal mortality and severe morbidity is to increase access to high-quality, culturally and linguistically congruent, evidence-based maternity care.

## MATERNAL HEALTH INEQUITIES IN COMMUNITIES OF COLOR

The deep racial inequities in maternal and infant health outcomes in the United States must be understood in the context of our history of slavery and colonialism. In fact, the practice of gynecology and obstetrics in our country was built on abusive, inhumane experimentation on enslaved Black women, such as developing cesarean and other surgical procedures without anesthesia.<sup>10</sup>

Even after slavery ended, the Black female body continued to be inextricably linked to a complicated history of racism, discriminatory health practices, inhumane medical experimentation, eugenics, and forced sterilization. For example, Henrietta Lacks's cervical cancer cells were used by the medical establishment to help understand disease and develop treatments, without her or her family's knowledge, and certainly without recognition, until 2010.<sup>11</sup>

Key advocates for contraception, such as Margaret Sanger, the founder of what became Planned Parenthood, were motivated by racist, eugenic, population control principles.<sup>12</sup> Oral contraception – heralded as a tool for the liberation of middle-class white women – was tested on women in Puerto Rico, often without their knowledge or consent, even as many were also forced to undergo sterilization. In 1965, one in three married women in Puerto Rico between the ages of 20 and 49 were sterilized.<sup>13</sup>

*The United States lags behind every other high-income country, with the highest rates of infant and maternal mortality.*

In this country, access to maternity care depends on many factors, including availability of health insurance. However, for many communities across the country, particularly rural and low-income communities, having health insurance does not ensure access to care. There are many barriers to care even if you have insurance, including cost, lack of transportation, family caregiving responsibilities, inability to take time off from work, and cultural and linguistic factors.<sup>14</sup>

One of the most challenging barriers to accessing care is provider availability – either in your insurance network or at all. More than one-third of counties in the United States are “maternity care deserts,” with neither a hospital maternity unit nor any obstetrician-gynecologist or certified nurse-midwife.<sup>15</sup> This means that most rural women have to drive more than a half-hour to the nearest hospital with maternity services.<sup>16</sup> Maternity care deserts are not limited to rural locations. For example, recent closures of maternity wards in the District of Columbia exacerbated ongoing maternity care provider shortages, despite

the fact that D.C. has the second-lowest rate of people without insurance in the country. Unsurprisingly, D.C. also has one of the worst maternal mortality rates in the nation.<sup>17</sup>

Even when people have access to maternity care, it may not be the high-quality, culturally congruent care they need to promote healthy pregnancies, births, and babies. Quality care is often defined as the right care at the right time in the right setting for the individual.<sup>18</sup> Quality care aligns with the person’s values, preferences, and needs. Efforts to promote and measure care quality often focus on better health outcomes, improved care coordination, the person’s experience of care, and in some cases adherence to clinical treatment guidelines and best practices.<sup>19</sup>

Another foundational element of quality maternity care – and all care – is respect for people. In fact, half of the World Health Organization’s standards for quality maternal and newborn care underscore “respect, dignity, emotional support, and a systemic commitment to a patient-led, informed decision-making process.” Disrespectful maternal care can include withholding



or distorting information, coercion, and unfounded threats of harm to the baby to gain consent for unwanted and often unnecessary procedures. In some cases, there may even be physical or sexual abuse in the form of hitting, unnecessary restraints, and rough vaginal examinations.<sup>20</sup> Mistreatment is experienced more frequently by women of color, by those birthing in hospitals, and among those who experience social, economic, and health inequities in the United States. In addition, mistreatment can be exacerbated by unexpected obstetric interventions and by disagreements between birthing people and their providers.<sup>21</sup> Mistreatment during childbirth has a clear negative effect on the health and well-being of the birthing person, child, and family.<sup>22</sup>

The growing focus on the maternal health crisis in Black, Indigenous, and other communities of color, in the context of efforts to promote dignity in childbirth, has elevated the importance of culturally centered and culturally congruent care as a fundamental component of high-quality maternity care. The National Perinatal Task Force recently concluded that care “that does not also take into consideration the unique experiences of a woman/person, her/their community, and the specificities of her/their cultural background cannot produce the highest quality outcome.”<sup>23</sup>

Yet our maternity care system regularly fails to provide birthing people of diverse

backgrounds the culturally centered attention required to ensure high-quality care and promote healthy outcomes for mothers and babies. Even worse, this failure can cause additional harm to birthing people already shouldering experiences of ongoing racism, toxic stress, and trauma – from failing to mitigate the impact of Black women’s lack of trust in the health care system, to disregarding Native women’s traditional ways of caring for pregnant people.<sup>24</sup>

Fortunately, doulas, midwives, and community-based perinatal health worker organizations like Mamatoto Village in the nation’s capital; Commonsense Childbirth in central Florida; Breath of My Heart in Española, N.M.; and Mama Sana Vibrant Woman in Austin, Texas, are leading the way in providing accessible culturally centered prenatal, birth, and postpartum care and support.<sup>25</sup>

*Another foundational element of quality maternity care – and all care – is respect for people.*

## DISMANTLING RACISM AND MITIGATING HARM IN MATERNITY CARE

As our understanding of the terrible impact of racism on health has grown, there has been an increasing focus on not just preventing racist harm in health care, but also leveraging how care is provided to mitigate the harm caused by systemic racism and other forms of oppression. Providing culturally congruent care is especially important as a strategy to improve maternal and infant health in communities struggling with intractable racial and ethnic health inequities.

Over the last few decades, researchers, practitioners, and advocates have evolved the concept of “cultural competence,” which focused on how health care systems could improve care delivery to diverse patients by tailoring care to meet their social, cultural, and linguistic needs,<sup>26</sup> to a more expansive concept of “cultural congruence.” Culturally congruent care centers the needs of patients and families within their social, cultural, and linguistic needs and values. In the process, providers and clients collaboratively build a trusting, effective, high-quality care experience.<sup>27</sup>

Culturally congruent maternity care is foundational for improving quality and eliminating racial and ethnic inequities in maternal health outcomes, as well as those based on sexual orientation, gender identity, disability, and religious beliefs.<sup>28</sup> It is care delivery that takes into account a pregnant person’s values, beliefs, preferences, and linguistic needs.<sup>29</sup> Culturally congruent perinatal providers strive to understand the broader social, environmental, and historical context of the childbearing person’s family, community, and culture, and understand that these factors may influence the experience of pregnancy, birth, and parenting. Such care requires sensitivity, compassion, and deference to pregnant people’s expertise about their own bodies and lives. While a provider cannot immerse themselves in every person’s specific culture, they are responsible for having a basic understanding of their needs and communicating with them effectively, so people feel heard and respected, without judgment.

Culturally congruent care is indispensable in high-quality care because conscious or unconscious bias, stereotyping, and lack of cultural awareness and sensitivity can result in misdiagnosis, improper treatment, and mutual mistrust between providers and patients.<sup>30</sup> Pregnant people should have access to diverse providers and care that is rooted in equity and cultural congruency. Developing cultural congruency in the delivery of maternity care can improve trust between patients and providers, and has the potential to reduce maternal and infant health disparities, particularly among Black women and other women of color and their babies.<sup>31</sup>

*One persistent and widespread failure of our maternity care system is that many beneficial practices are underused and ineffective or unneeded and potentially harmful practices are overused.*

Clinical standards for quality maternity care are also based on the safety and effectiveness of specific practices, treatments, and interventions. One persistent and widespread failure of our maternity care system is that many beneficial practices are *underused* and ineffective or unneeded and potentially harmful practices are *overused*.<sup>32</sup>

Overuse happens when procedures that offer no clear benefit, and could potentially cause harm, are employed for no well-supported clinical reason – often in healthy women. For example, labor inductions happen with about four in 10 women.<sup>33</sup> Yet research supports few indications for inducing labor, which increases the risk of complications such as infection for both mother and baby, uterine rupture, and low fetal heart rate.<sup>34</sup> Another example of overuse is the steep increase in cesarean births, which today account for nearly a third of all births. This surge in cesarean rates has not been accompanied by any improved health outcome for women and babies. Instead, many have been needlessly exposed to the additional short- and long-term risks and complications of cesareans, including postpartum hemorrhage, blood clots, and infection.<sup>35</sup> This particular problem – providing more medical care than is needed or recommended, is also known as “over-medicalization.”<sup>36</sup>

On the other hand, underuse happens when safe, beneficial, health-enhancing practices are not routinely available or employed. Examples among the many underused beneficial maternity care practices are smoking cessation interventions for pregnant people, manual manipulation to turn breech fetuses to the headfirst position, and treatment for perinatal depression.<sup>37</sup>

One response to over-medicalization, as well as birthing people’s desire to retain more autonomy and control during pregnancy and childbirth, has been an increasing interest in physiologic childbirth. In the early 20th century, pregnancy and childbirth were reframed as medical – even pathological – conditions, rather than healthy physiologic life processes. Birthing moved from being attended by midwives of all backgrounds and traditions at home, to hospitals dominated by white men who saw childbirth as a medical problem to be solved with an array of drugs, treatments, and interventions.<sup>38</sup> Physiologic childbirth approaches birthing from a less medicalized, more holistic frame that avoids unneeded medical interventions. This type of care actively supports the innate capabilities of birthing people and their fetus or newborn for labor, birth, breastfeeding, and attachment. Medical interventions are used judiciously, as needed, and not as routine practices.<sup>39</sup>

Without detailed demographic data we cannot address the crisis and transform the maternity care system. This includes collection and public reporting of maternal and infant health data, broken down by race, ethnicity (including relevant subgroups), primary language, sexual orientation, gender identity, disability status, and socioeconomic status. Better demographic data collection and disaggregated reporting is critical to promoting understanding and advancing accountability for quality, equitable, and high-value maternity care.

Every birthing person should have access to evidence-based maternity care and be supported with high-quality information to make informed decisions about their care and birth experience. Unfortunately, this is not what usually happens.<sup>41</sup> In this report, we describe the four highlighted models of care, current access to these models, and summarize the evidence that supports their use as high-quality, high-value models. We include specific recommendations for decisionmakers to expand the reach and impact of these exceptional forms of care on childbearing families.

## **Selected Examples of Overused and Underused Maternity Practices<sup>40</sup>**

### **OVERUSED PRACTICES**

- **Labor induction**
- **Scheduled births**
- **Cesarean birth**
- **Repeat cesarean birth**
- **Continuous electronic fetal monitoring**
- **Healthier babies admitted to neonatal intensive care units (NICUs)**

### **UNDERUSED PRACTICES**

- **Planned labor after one or two cesareans**
- **Smoking cessation interventions for pregnant people**
- **Continuous support during labor**
- **Hand maneuvers to turn a fetus to a headfirst position at term**
- **Intermittent auscultation with handheld device for fetal monitoring**
- **Being upright and mobile during labor**
- **Screening for and treating perinatal depression**

## THREE HIGH-QUALITY, EVIDENCE-BASED MATERNITY CARE MODELS TO SPREAD AND SCALE NOW

Three evidence-based models exemplify the high-quality, high-value maternity care that is urgently needed to tackle our maternal and infant health crisis and reduce inequities. Models with strong evidence of success include **midwifery care**, **community birthing** in either birth centers or homes, and **doula support**, including the extended model of prenatal and postpartum support.

# MIDWIFERY CARE



**In nearly all nations, midwives provide first-line maternity care to childbearing people and newborns.** However, in the United States, the vast majority of births are attended by obstetricians, while midwives attend only about 10 percent of births.<sup>42</sup> In general, midwifery is a high-touch, low-tech approach

to maternity care. It is based on the core understanding that childbearing for most women is a healthy process that requires monitoring to identify when higher levels of care are needed. It centers the childbearing person and family. The midwifery model of care emphasizes a trusted relationship,

health-promoting practices, information that birthing people need to make their own informed care decisions, and personalized care tailored to individual needs and preferences. Many midwives have the skills and knowledge to support the physiologic model of childbearing, in contrast to the medicalized model that has become the norm in the United States. Although any type of maternity care provider can theoretically offer the midwifery model of care and can foster physiologic birth, midwives do so most consistently.<sup>43</sup> The midwifery model of care contrasts with medical approaches that are more pathology-focused and procedure-intensive for lower- as well as higher-risk women.

Hospital-based midwives have access to and use epidural analgesia and other technologies that are not available in birth centers and at home, according to women's needs and preferences. Influenced by hospital protocols and culture of practice, as well as the needs and preferences of women with hospital births, the overall style of practice of hospital-based midwives involves more interventions than midwives practicing in birth centers and at home.<sup>44</sup>

As in other countries, U.S. midwives holding nationally recognized credentials provide expert care for birthing people, and are trained to identify when higher levels of more specialized care are needed. Midwives may consult, share care, or transfer women to specialty care when higher risks and

complications emerge.<sup>45</sup> Given that most women in the United States give birth in hospitals, it is no surprise that most midwives attend births in hospitals. However, nearly all maternity care providers in birth center and home birth settings are midwives.<sup>46</sup>

The United States has three nationally recognized midwifery credentials with education programs recognized by the U.S. Department of Education. Certified nurse-midwives (CNMs) have completed a nursing degree in addition to their midwifery training. They provide care in all three birth settings (hospitals, birth centers, and homes) and are licensed to practice, and be Medicaid providers, in all jurisdictions. In the 1990s, two additional credentials were created: certified midwife (CM) and certified professional midwife (CPM).

The CM educational program content and certification exams are the same as for CNMs, except that CMs are not required to hold a nursing degree. They also practice in all three settings. The CPM credential requires knowledge and experience in community birth, that is, care in birth centers or homes.<sup>47</sup> At this time, seven states regulate CMs, and 34 states and the District of Columbia have a path to CPM licensure, with ongoing efforts for legal recognition in remaining states and U.S. territories. Medicaid reimburses CMs in just one state and CPMs in 15 states.<sup>48</sup> The following table summarizes the three national midwifery credentials.

## Midwives with Nationally Recognized Credentials: CNMs, CMs and CPMs<sup>49</sup>

Credential	Degree	Setting	Legal recognition	Medicaid coverage
<b>Certified nurse-midwife (CNM)</b>	RN + master's degree	Hospital, birth center, home	All states, DC, U.S. territories*	Yes, by federal statute
<b>Certified midwife (CM)</b>	Bachelor's + master's degree	Hospital, birth center, home	7 states: DE, HI, ME, NJ, NY, OK, RI	NY
<b>Certified professional midwife (CPM)</b>	High school diploma or equivalent; may earn certificate, associate's, bachelor's, or master's degree	Birth center, home	34 states + DC (all except CT, GA, IA, IL, KS, MA, MO, MS, ND, NE, NC, NY, NV, OH, PA, WV, and U.S. territories)	AK, AZ, CA, DC, FL, ID, MN (birth centers only), NH, NM, OR, SC, VA, VT, WA, and WI

### Midwifery care provides equal or better outcomes compared to usual care

Several systematic reviews\*\* have compared the care and outcomes of midwives and physicians. Compared to physician care, midwifery care resulted in:

- Less electronic fetal monitoring
- Less epidural or spinal analgesia
- Less use of pain medication overall
- Fewer episiotomies
- Increased spontaneous vaginal birth (with neither forceps nor vacuum)

\* The US territories include: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

\*\* A systematic review is a method of assessing the weight of the best available evidence about possible benefits and harms of interventions or exposures. An investigation by the Institute of Medicine found that this rigorous methodology is the best way of “knowing what works in health care.” Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation*. (Washington, DC: The National Academies Press, 2008), <https://doi.org/10.17226/12038>



- More vaginal births after a cesarean
- Improved initiation of breastfeeding
- Better psychological experience (e.g., sense of control or confidence, satisfaction)
- Lower costs

Physicians and midwives produced the same results with regard to:

- Use of IV fluids in labor
- Maternal hemorrhage (excess bleeding)
- Signs of fetal distress in labor
- Condition of newborn just after birth
- Admission to a neonatal intensive care unit (NICU)
- Fetal loss or newborn death

For some indicators, systematic reviews varied in their conclusions. Compared to physicians, midwives had equal or better results for:

- Hospitalization in pregnancy
- Preterm birth
- Low birth weight
- Labor induction
- Use of medicine to speed labor
- Cesarean birth<sup>50</sup>

Other researchers have found that states that have more fully integrated midwifery care tend to have better maternal and infant health outcomes. More integrated states (measured by indicators such as regulation of the profession, Medicaid payment for their services, and the degree to which regulations allow them to practice autonomously)

were more likely to report higher rates of physiologic childbearing, lower rates of cesarean and other obstetric interventions, lower risk of adverse newborn outcomes (preterm birth, low birth weight, and infant mortality), and increased breastfeeding both at birth and at six months postpartum.<sup>51</sup>

Similarly, the availability of midwifery care at the hospital level has been associated with less use of labor induction, medication to speed labor, and cesarean birth, and greater likelihood of vaginal birth, including vaginal birth after a cesarean, than hospitals with physician-only maternity services.<sup>52</sup> Higher percentages of midwife-attended births at hospitals have been associated with lower rates of cesarean birth and episiotomy.<sup>53</sup>

In light of the intractable maternal health crisis plaguing the country, investing more resources in training and supporting high-quality, high-value midwifery care is a powerful strategy for rapidly expanding access to effective maternity care services. Compared to the time and money it takes to train an obstetrician or family physician, midwives can be ready to serve pregnant people and their families more quickly and at a lower cost.<sup>54</sup> This is especially important given how racial and ethnic inequities in maternal and infant health mirror educational and economic inequities to a significant degree.

# Spotlight on Success

## MERCY BIRTHING CENTER

The Mercy Birthing Center illustrates the potential of a flourishing midwifery-led unit within a hospital. The center is a separate unit operated by CNMs within Mercy Hospital St. Louis. It was established in response to women's growing interests in receiving support for physiologic childbearing.<sup>55</sup> This approach mobilizes the capabilities of women's own bodies in tandem with the capabilities of their fetus or newborn.

The homelike center includes four birthing suites with tubs and showers, a central living room and kitchen, an area for classes, and rooms for prenatal and postpartum and newborn visits.<sup>56</sup> The center offers comfort measures as well as nitrous oxide ("laughing gas") to help women cope with labor. The midwives use handheld devices for monitoring the fetal heart status ("intermittent auscultation"). In contrast to many typical hospital settings, laboring women are free to eat, drink, and move about, according to their interest, and to give birth in their position of choice. If they need higher levels of care (for example, an epidural or continuous electronic fetal monitoring) or develop a complication or concern, their midwife can accompany them upstairs to the standard labor unit and continue to care for them there. Care by obstetricians and maternal-fetal medicine specialists is available if needed.<sup>57</sup>

The center's care and outcomes contrast sharply with standard hospital birthing care:

- Their **cesarean rate is 70 percent lower** than that national average (less than one out of 10 births, compared to one in three).
- Their **rate of vaginal births after a cesarean (VBAC) among women planning to have one is up to 40 percent higher** (84 percent compared to usual rates of 60 to 80 percent, depending on the study).<sup>58</sup>
- Their **episiotomy rate is only 0.4 percent**, compared to 6.9 percent among hospitals reporting in 2018 – more than 17 times higher.<sup>59</sup>
- Their **epidural rate was 6.4 percent**, versus 75 percent nationally in 2018.<sup>60</sup>
- Their **labor induction rate was 68 percent lower than national rates** reported on 2018 birth certificates (8.7 percent, ).<sup>61</sup> However, birth certificate are known to greatly undercount inductions. For example, women in California who gave birth in 2016 reported a rate of 40 percent.<sup>62</sup>

## Mercy Birthing Center Care (Compared to Standard Hospital Care rates)

70%  
fewer  
cesareans

Up to  
40%  
higher VBAC  
success

More than  
17x  
fewer  
episiotomies

Nearly  
12x  
fewer epidurals

68%  
fewer inductions

In addition to these excellent clinical outcomes, 100 percent of their clients reported they would recommend this care to friends.

Eligible lower-risk women with Medicaid or private insurance typically have coverage for prenatal, hospital birth, and postpartum and care with CNMs. Thus, when cost sharing is not onerous, financial barriers to access at the Mercy Birthing Center are minimal. However, very few hospitals offer comparable midwifery-led units.

## Women’s positive experiences with and strong interest in midwifery care

In recent years, concerns about disrespectful maternity care have come to the fore, and many childbearing people – including those with tragic outcomes – have reported being ignored, having their concerns dismissed, not having choices in care, and otherwise being mistreated.<sup>63</sup> Two systematic reviews found that people who received midwifery care were more likely to report feeling more control, confidence, and satisfaction than people who received physician-led care.<sup>64</sup>

Women’s interest in midwifery care far exceeds their current access and use. For example, in the population-based *Listening to Mothers in California* survey, six times as many participants with 2016 births indicated an interest in midwifery care should they give birth in the future, compared to people who actually received midwifery care. A total of 54 percent indicated some level of interest, with 17 percent stating they would definitely want midwifery care, and 37 percent stating they would consider this type of care provider. Interest was especially high among Black women (66 percent), and

*Midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.*

In addition, midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.<sup>65</sup> Increasing the diversity of the midwifery profession would enable more women of color to obtain high-quality care that mitigates the racism embedded in maternity and other types of health care.<sup>66</sup>

interest of women with Medi-Cal (California’s Medicaid program) was similar to that of women with private insurance.<sup>67</sup>

## Access to midwifery care is limited

Despite the clear value of midwifery care, especially as a pathway to help solve the nation’s maternal health crisis and obtain better outcomes for birthing people and infants, there are important limitations to the availability of midwifery care. One indicator of

limited access is the gap between the number of women who state an interest in midwifery care – the majority – and the number of those who actually use it, which is roughly one in 10. Another indicator of lack of access is that in 2016, 55 percent of U.S. counties did not have a practicing certified nurse-midwife. Moreover, roughly one in three U.S. counties in that year were considered maternity care deserts, meaning that the county had neither an obstetrician-gynecologist, nor a nurse-midwife, nor a hospital maternity unit.<sup>68</sup> The American College of Obstetricians and Gynecologists recommends increasing the number of midwives as an essential strategy to solve this access crisis.<sup>69</sup> The availability of midwifery care is influenced by the supply and distribution of midwives and birthing facilities. CMs are only licensed in a handful of states, and CPMs still are not licensed in 16 states and U.S. territories. A model legislation process undertaken by leading midwifery organizations points the way to robust, woman-centered midwifery legislation.<sup>70</sup>

A factor that limits the supply of midwives is the lack of consistent, systemic support for midwifery education and educators, including preceptors, parallel to Medicare's support for medical residencies. The burden on midwifery educators (as well as student tuitions) and on preceptors is thus great. This is also a limiting factor in the availability of midwives to share their distinctive knowledge and first-line approaches to maternal-newborn care with medical students and trainees, and nursing and other students.<sup>71</sup> The Further Consolidated Appropriations Act of 2020 included \$2.5 million for this purpose, and a bill filed in

the current Congress would greatly expand support for CNM, CM, and CPM education. Both initiatives have equity framing.

Adequate payment for a model of care that typically involves longer office visits and significantly more time waiting for labor to progress naturally, rather than accelerating it with medications and procedures, may also be a barrier to midwifery practice. Across states, Medicaid payment for CNMs ranges from 70 percent to 100 percent of physician payment for the equivalent service.<sup>72</sup> Medicaid payment levels vary widely and the average payment for CNMs is just 65 percent of the CNM Medicare fee schedule rate.<sup>73</sup>

Lastly, unnecessarily restrictive practice acts that, for example, require these independent professionals to have physician supervision, limit their prescriptive authority, or limit their reimbursement, are associated with reduced midwifery practice, and thus appear to limit women's access to midwifery care.<sup>74</sup>

# RECOMMENDATIONS

## INCREASE ACCESS TO MIDWIFERY CARE

Midwives have a distinctive, dignifying, person-centered, skilled model of care and an exemplary track record. They are an important part of the solution to the nation's shortage of maternity care providers. However, there are barriers to meeting this need and enabling more childbearing people and families to experience benefits of midwifery care.

### Federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3849 in the 116th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (CNMs, CMs, CPMs) by supporting students, preceptors, and schools and programs. It would give funding preference to supporting students who would diversify the profession and who intend to practice in underserved areas.
- Mandate payment for services of CMs and CPMs recognized in their jurisdiction by Medicaid, the Child Health Insurance Program (CHIP), TRICARE (the military health care program), the Veterans Health Administration (VHA), the Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service.
- Mandate that hospitals cannot deny privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State and territorial policymakers should:

- In jurisdictions that currently fail to recognize them, enact CM and CPM licensure. For CMs, these include all of the territories, the District of Columbia, and all states except Delaware, Hawaii, Maine, New Jersey, New York, Oklahoma, and Rhode Island. Jurisdictions that have yet to recognize CPMs through licensure are: Connecticut, Georgia, Iowa, Illinois, Kansas, Massachusetts, Missouri, Mississippi, North Dakota, Nebraska, North Carolina, New York, Nevada, Ohio, Pennsylvania, West Virginia, and all U.S. territories.
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice “at the top of their license” in line with their full competencies and education as independent

providers who collaborate with others according to the health needs of their clients.

- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for services of CMs and CPMs licensed in their jurisdiction, mandate payment at 100 percent of physician payment levels for the same services. Currently, Delaware, Hawaii, Maine, New Jersey, Oklahoma, and Rhode Island recognize CMs but do not pay for their services through Medicaid. States that regulate CPMs yet fail to pay for their services through Medicaid are: Alabama, Arkansas, Colorado, Delaware, Hawaii, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota (does not pay for home birth services), Montana, New Jersey, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, and Wyoming.

**Private sector decisionmakers, including purchasers and health plans, should:**

- Incorporate clear expectations into service contracts about access to and sustainable payment for midwifery services offered by providers that hold nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.

# COMMUNITY BIRTH: BIRTH CENTERS AND HOME BIRTH



**While the vast majority of births in the United States occur in hospitals, demand is growing for alternatives outside of hospitals and within communities – both in birth centers and at home.** Collectively known

as “community birth,” these two options safely serve people with medically low-risk pregnancies who wish to have a physiologic childbirth, avoid the overmedicalization that is common in hospitals, retain more autonomy and control, and receive more personalized care. It is important to note that these options are not appropriate for people with medically high-risk pregnancies who require specialized care, which are a smaller proportion of all births.

**Birth center** care differs in fundamental ways from care in hospitals. Birth centers are designed to provide homelike care, and many are in converted homes. Compared to typical maternity office visits, prenatal and postpartum visits in birth centers are generally much longer. In addition to the standard clinical checks, significant time is invested in building relationships and trust, providing support and education, and answering questions. During labor and birth, birth centers provide care options not typically available in hospitals, allowing birthing persons to experience more freedom and autonomy. Their companions of choice are welcome, which may include their



partner, family members, and doula. They are encouraged to eat and drink if they want, and to walk and change positions. The fetus is monitored with a handheld device to allow for freedom of movement and to prevent the elevated risks of electronic fetal monitoring (e.g., increased likelihood of cesareans). Non-pharmacologic tools for coping with the challenges of labor include using tubs and showers, hot or cold compresses, inflated exercise balls, and massage. After birth, skin-to-skin contact and early breastfeeding initiation are highly encouraged and supported. Discharge to home typically occurs several hours after birth, with midwife or nurse home visits likely one and three or so days after birth. If needed, birth center midwives manage first-line complications and consult or transport to hospital settings as appropriate.<sup>75</sup>

**Home birth** care also contrasts notably with hospital care, and it shares attributes with birth center care. While home births are a small fraction of births in the country, they are growing in popularity. About 85 percent of home births are planned. Most planned home births are attended by midwives, although some physicians attend home births. For most people, the values and

preferences that guide their choice to birth at home are similar to those that move people to choose birth centers. In fact, some birth centers provide home birth as an option for their prenatal care clients.

Birthing at home in familiar surroundings can provide the maximum freedom and autonomy to have a physiologic birth. Midwives who attend home births bring needed tools and supplies to provide care similar to that provided in birth centers. Some women obtain inflatable birth pools for use at home. More detailed discussion of practices and precautions in both birth center and home birth settings is available in the National Academies of Sciences, Engineering, and Medicine's *Birth Settings in America* report.<sup>76</sup>

Community birth can also offer more opportunities for people of color to receive the additional benefits of racially congruent care that acknowledges a person's cultural identity as central to the clinical encounter, upholds racial justice, fosters agency, and practices cultural humility.<sup>77</sup>

Community births are a very small – but rapidly growing – fraction of births in this country. In 2018, most people in the United

## Rates of Community Births Are Increasing (2004 to 2017)

**85%**  
Increase

**COMMUNITY BIRTHS**

**77%**  
Increase

**HOME BIRTHS**

More than  
**50%**  
Increase

**BIRTH CENTER BIRTHS**

States (98.4 percent) gave birth in hospitals, 1 percent gave birth at home, and 0.5 percent in a birth center.<sup>78</sup> Rates of community birth can vary greatly from state to state, ranging from 0.4 percent in Alabama to 7.9 percent in Alaska, while the national average is 1.6 percent.<sup>79</sup> However, the use of community birth is increasing. From 2004 to 2017, community births rose by 85 percent,<sup>80</sup> with home births growing by 77 percent and birth center births more than doubling. This likely reflects both increasing interest, as well as loss of hospital maternity units in rural areas. One 2018 study found that the loss of hospital maternity units in rural areas was associated with a rise in home births, either planned or unplanned.<sup>81</sup> More recently, there is much anecdotal evidence that the COVID-19 pandemic is spurring an interest in these settings,<sup>82</sup> as people become increasingly concerned about reducing opportunities for the virus's transmission and many hospitals have set hard limits on who birthing people can have with them during labor and birth.

### **Evidence supports equal or better outcomes with community birth**

The *Birth Settings in America* report concludes that the overall results reflect both the self-selection of women who want this type of care and the contributions of the “wellness-oriented, individualized, relationship-centered approach of midwifery care.”<sup>83</sup> In addition to being safe and promoting better health outcomes, community birth is also a good value. A review of the costs of birthing at home and in birth centers found that resource use was generally lower in community birth settings due to fewer interventions, shorter lengths of stay, or both.<sup>84</sup>

### **Evidence supporting birth center care**

An integrative review comparing births in birth centers and those in hospitals, as well as national averages, found that birth centers provided equal or better maternal health outcomes. The review found that, compared to hospital births, birth center births averaged:

- Higher rates of spontaneous vaginal birth
- Higher rates of intact perineum (without a tear or episiotomy)
- Lower rates of cesarean birth
- Lower rates of episiotomy
- Equal rates of serious perineal tears.<sup>85</sup>

The main reasons for transfers from birth centers to hospitals were non-emergency conditions, such as lack of progress in labor. Serious maternal outcomes were extremely rare, and the reviewed studies reported no incidents of maternal death.<sup>86</sup>

A systematic review of newborn outcomes of birth center care found only one widely reported outcome, neonatal mortality. No included study found higher neonatal mortality nor a trend toward higher neonatal mortality in birth center versus hospital birth.<sup>87</sup> The *Birth Settings in America* report found that birth center care is associated with higher rates of breastfeeding initiation and exclusive breastfeeding six to eight weeks postpartum than hospital care.<sup>88</sup>

### **Evidence supporting home births**

A systematic review comparing planned home and hospital birth found that, compared to women with hospital births,

women with home birth were less likely to experience:

- Epidural analgesia
- Medication to speed labor
- Episiotomy
- Birth with vacuum or forceps
- Cesarean birth
- Serious perineal tears
- Infection

Hemorrhage either was less likely at home or not different, and there were no reported maternal deaths.<sup>89</sup> *Birth Settings in America* found that home birth care is associated with higher rates of breastfeeding initiation and exclusive breastfeeding six to eight weeks postpartum than hospital care.<sup>90</sup>

A systematic review of studies in countries where home birth midwives are well integrated into the health system found that neither perinatal nor neonatal mortality differed across the home and hospital settings.<sup>91</sup> However, *Birth Settings in America* identified a small increased absolute risk in neonatal mortality in U.S. studies of home versus hospital birth.<sup>92</sup> In reviewing the international literature, researchers found that home and hospital are equally safe for newborns in integrated systems with seamless transfer, ongoing risk assessment and selection for eligibility, and well-qualified providers. By contrast, in the United States, care is less safe due to “lack of integration and coordination and unreliable collaboration across maternity care providers and settings.”<sup>93</sup> To facilitate such integration, a multidisciplinary team has developed “Best Practice Guidelines: Transfer from Planned

*A systematic review of studies in countries where home birth midwives are well integrated into the health system found that neither perinatal nor neonatal mortality differed across the home and hospital settings.*

Home Birth to Hospital” and accompanying model transfer forms.<sup>94</sup>

Given this evidence, the benefits of community birth for medically low-risk pregnant people are clear. First, compared to usual hospital care, community birth better aligns with optimal care. It limits unneeded medical interventions such as induced labor, continuous electronic fetal monitoring, and cesarean birth (curbing overuse), and more reliably provides beneficial care that is not widely used, such as encouraging birthing people to eat and drink and be upright and mobile during labor according to interest, and to choose their birthing position (curbing underuse). In addition, compared to the routinized care provided in hospitals, community birth is more likely to offer respectful, individualized, and person-centered care.<sup>95</sup>

# Spotlight on Success

## THE STRONG START FOR MOTHERS AND NEWBORNS INITIATIVE

The Strong Start for Mothers and Newborns Initiative was a federal five-year, multi-site project to test and evaluate enhanced prenatal care interventions for women enrolled in Medicaid or the Children's Health Insurance Program (CHIP) who were at risk for having a preterm birth. One of the first Center for Medicare and Medicaid Innovation initiatives, it launched in 2012 to test three models of enhanced prenatal care among Medicaid beneficiaries: birth centers, group prenatal care, and maternity care homes.<sup>96</sup> Midwifery-led care in birth centers generated stellar results, whereas results of the other two care models were underwhelming.<sup>97</sup>

An independent evaluation compared women and infants in the midwifery-led birth center group with matched and adjusted women receiving typical Medicaid care in the same counties. The differences in outcomes between these two groups were compelling:

- Birth center infants were 26 percent **less likely to be born preterm** (6.3 percent versus 8.5 percent).
- Birth center infants were 20 percent **less likely to have a low birth weight** (5.9 percent versus 7.4 percent).
- The average **cesarean rate** in birth centers was **40 percent lower** (17.5 percent versus 29.0 percent).
- **Rates of vaginal birth after a cesarean** at birth centers were **nearly twice as high** (94 percent more likely: 24.2 percent versus 12.5 percent).
- **Childbirth costs** at birth centers were **21 percent lower** (\$6,527 versus \$8,286).
- At birth centers, **total childbirth and post-birth costs** up to one year after birth were **16 percent lower** (\$10,562 versus \$12,572).

All of these are statistically significant advantages favoring birth center care.<sup>98</sup>

In addition, Strong Start results were exceptional in reducing racial inequities. There were no differences by race for rates of cesarean birth and breastfeeding, or for the experience of care. Notably, participants reported feeling heard, being able to understand communications with the care team, having time for questions, being involved in decision-making, and being treated with respect.<sup>99</sup>

## Midwifery-Led Birth Centers Compared with Typical Medicaid Care

20%

Less likely to have low birth weight

40%

Lower average cesarean rate

Nearly  
2x

As high, rates of vaginal birth after cearean section

26%

Less likely to be born preterm

21%

Lower childbirth costs



The midwifery-led birth centers succeeded in providing benefits to families, the health system, and taxpayers by improving a series of fundamental health outcomes relative to usual approaches to maternity care. Given that Medicaid covered 42 percent of the nation's births in 2018, including 65 percent of Black and 59 percent Hispanic births,<sup>100</sup> advancing this model for lower-medical-risk Medicaid enrollees could have an enormous impact on our nation's maternal and infant health crisis.

## **Women report better experiences with community birth**

An integrative review of maternal outcomes in birth centers found that, compared to women birthing in hospitals, women birthing in birth centers reported greater satisfaction, greater likelihood of feeling that prenatal care elevated their self-esteem, and a desire to use this care model again. Specifically, they were more satisfied with the personalization of their care, their care environment, the quality of their relationship with their maternity care provider, their confidence, their ability to cope with life challenges, and their ability to have a physiologic childbirth.<sup>101</sup>

With regard to home birth, while we found no systematic reviews comparing satisfaction with hospital birth, women birthing at home perceived three interrelated themes regarding the benefits of not birthing in a hospital setting. First, giving birth at home contrasted with their perceptions or experience of hospital birth, which included too many interventions, too many disruptions, common use of pain medications, disrespectful care, and unfamiliar personnel. Second, they felt that they would have more control, be more able to make decisions, and be empowered in general. Lastly, the home was valued as being a peaceful, restful, and comfortable setting.<sup>102</sup>

Both forms of community birth can also offer additional benefits to birthing people of color because they enhance their opportunity to receive racially and culturally

congruent care<sup>103</sup> and avoid the institutional racism of hospital care.

## **Access to community birth is limited**

The many barriers to access to midwifery care, noted above, currently limit access to midwifery-led community birth. And also noted above, CPMs are specifically educated for these settings, yet are not legally regulated in 16 states and U.S. territories. And while the number of birth centers has been growing in the United States, 10 states and the U.S. territories do not have birth center licensure. Thus this care option still does not exist in many communities.<sup>104</sup> Payment of CPM services by private insurance and Medicaid is uneven, as is payment of other midwives when practicing in community settings.<sup>105</sup>

This lack of legal recognition and insurance coverage for community birth providers creates insurmountable financial barriers for many people who would otherwise choose to give birth in these settings. In 2017, only 3.4 percent of hospital births were paid out of pocket, but about two in three (67.9 percent) planned home births and one in three (32.2 percent) birth center births were self-pay.<sup>106</sup> Another reason for this mismatch between supply and demand is that Medicaid coverage pays for 42 percent of births in this country.<sup>107</sup> Medicaid payments are so low that operating a birth center with a large proportion of Medicaid clients is not financially sustainable. To extend the exceptional benefits of birth center care to the many eligible childbearing people who currently lack access will require new payment models.<sup>108</sup> As a result of

COMMUNITY BIRTH OFFERS ADDITIONAL BENEFITS TO BIRTHING PEOPLE OF COLOR BECAUSE IT ALLOWS THEM OPPORTUNITY TO RECEIVE RACIALLY AND CULTURALLY CONGRUENT CARE AND AVOID THE INSTITUTIONAL RACISM OF HOSPITAL CARE.



financial barriers, those with greatest interest and who might disproportionately benefit from this model of care may be least able to choose it.

There is a clear mismatch between the level of interest in community birthing options and their actual use. For example, in 2016 in California, less than 1 percent of births were in birth centers, and 1 percent were at home. However, *Listening to Mothers in*

*California* survey participants who gave birth in hospitals that year reported much higher interest in birthing in these settings should they give birth in the future. A full 40 percent expressed interest in birth center births, including 11 percent who said they would definitely want a birth center birth. For home births, 21 percent expressed interest in this setting, with 6 percent stating they would definitely want to birth at home.<sup>109</sup>

# RECOMMENDATIONS

## INCREASE ACCESS TO COMMUNITY BIRTH

For many pregnant people, community birth options offer better care, more positive experiences, improved health outcomes, and potential cost benefits. The differences in care, experiences, outcomes, and costs are so striking that a leading international maternity care researcher has recently asked, “Is it time to ask whether facility-based birth is safe for low-risk women and their babies?”<sup>110</sup> Given this track record and the increasing use of, and unmet need for, these types of care, decisionmakers should act to make them more available to low-risk pregnant people who desire them.

### Federal policymakers should:

- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and the Commissioned Corps of the U.S. Public Health Service for care in licensed birth centers and midwife providers in birth centers who hold nationally recognized credentials and are recognized in their jurisdiction.
- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and Commissioned Corps of the U.S. Public Health Service for home births attended by midwives with nationally recognized credentials who are recognized in their jurisdiction.
- Enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 5189 in the 116th Congress). This bipartisan bill would fund demonstrations of birth center models for improved maternity care access and quality for Medicaid beneficiaries with low-risk pregnancies in underserved areas, and develop sustainable approaches to payment for birth center care.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State and territorial policymakers should:

- Enact birth center licensure in the 10 states that do not currently regulate birth centers: Alabama, Idaho, Louisiana, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, Wisconsin, and in the U.S. territories.
- Mandate payment by Medicaid and CHIP programs for care in licensed birth centers, for services provided by midwife birth center providers with nationally recognized credentials who are recognized in their jurisdiction, and for home birth with midwives with nationally recognized credentials who are recognized in their jurisdiction.



COMMUNITY BIRTH CAN ALSO OFFER MORE OPPORTUNITIES FOR PEOPLE OF COLOR TO RECEIVE THE ADDITIONAL BENEFITS OF RACIALLY CONGRUENT CARE THAT ACKNOWLEDGES A PERSON'S CULTURAL IDENTITY AS CENTRAL TO THE CLINICAL ENCOUNTER, UPHOLDS RACIAL JUSTICE, FOSTERS AGENCY, AND PRACTICES CULTURAL HUMILITY.



**Private sector decisionmakers, including health care purchasers and health plans, should:**

- Incorporate clear expectations into purchaser-payer contracts about access to and sustainable payment for community birth (birth center and home) settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of community birth settings and midwifery care.
- Mandate that plans contract with birth centers and midwives with nationally recognized credentials in their service area and pay for care in all settings provided by midwives recognized in the jurisdiction.
- Mandate that plan directories maintain up-to-date listings for available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of integrated maternity care with consultation, shared care, and seamless transfer from community birth settings as needed, and encourage adoption of “Best Practice Guidelines: Transfer from Planned Home Birth to Hospital,” and accompanying Model Transfer Forms.

# DOULA SUPPORT



Photo credit: birthbecomesher.com

**The longstanding, widespread tradition of women providing comfort, emotional support, and information to women during childbirth was largely lost in the first half of the 20th century.** At that time, childbirth was reframed as a medical condition – as opposed to a physiologic life process – and moved into the world of male-dominated hospitals. However, over the last half century,

women have increasingly sought to birth without unneeded interventions, to exert more control over their birth experience, and to have supportive companionship in unfamiliar medical settings. These interests, supported by research studies showing the benefits of continuous support during labor, helped establish doulas as “new” non-clinical maternal support personnel.\*

\* Other types of doulas – including abortion, miscarriage, and stillbirth doulas, prison doulas, and end-of-life doulas – are beyond the scope of this report.

The doula role has been defined in various ways. Researchers have distilled four key attributes of doulas and other labor companions:

- They provide information about childbirth, fostering communication between women and members of the care team, and offering guidance for drug-free comfort during labor.
- They play an advocacy role, helping women to achieve their desired experiences.
- They provide practical support, through comfort measures and verbal and hands-on support.
- They provide emotional support for confidence and a sense of control.<sup>111</sup>

An extended model of doula support that begins during pregnancy helps build a trusting relationship, understand a woman's preferences, and prepare for birth.<sup>112</sup> Continued support after birth can help with myriad postpartum challenges, including recovery, newborn care, and changing family dynamics.

Initially, doulas focused on supporting women around the time of birth and were only available to women who could pay for their services out of their own funds. The private-pay postpartum doula role was also created to support women with recovery from birth, breastfeeding, household chores, and other needs after birth. Many private-pay doulas are certified through various national organizations.

More recently, as a response to the spiraling maternal health crisis and recognition of the extreme impact of racism on health, a community-based approach to doula support has been developed to help meet the particular needs of birthing people and families from communities of color and other marginalized groups. This model tends to provide culturally congruent, trauma-informed support that extends from pregnancy through birth and into the postpartum period. Myriad community-based organizations offer doula training that, in addition to covering the practical skills and knowledge needed to provide physical, emotional, and informational support, also focus on birth justice and mitigating the harmful effects of racism and systemic oppression. Financial support for this model varies, but rarely includes either public or private insurance. Some doulas offer their services on a sliding scale based on ability to pay. Services might also be paid by grants, donations, and other fundraising efforts of doula agencies. Some services are provided by volunteer staff, including by doula trainees who require experience with a fixed number of clients or births to attain certification. Bills have been filed in many states to provide more reliable financing, especially through Medicaid.<sup>113</sup> Bills filed in Congress include provisions to investigate Medicaid coverage of doula services and to cover doulas for TRICARE beneficiaries.<sup>114</sup>

## Evidence supports the value of doulas

A systematic review<sup>115</sup> has rigorously evaluated the effects of continuous support *during labor* as given by three categories of people: those functioning in doula roles, hospital staff, and members of a woman's social network. The benefits of continuous support, compared to usual care, include

- Greater likelihood of vaginal birth with neither vacuum nor forceps
- Higher rates of satisfaction with the childbirth experience
- Reduced likelihood of using pain medications
- Lower rates of cesarean birth.

This longstanding, periodically updated review has never identified a downside of doula support.<sup>116</sup>

Of the three types of people offering continuous support, the doula model appears to offer the greatest benefit. Support from members of the hospital staff had

fewer and weaker effects, and support from a member of the woman's social network was associated with increased satisfaction, but had no clinical benefits.<sup>117</sup> The well-documented outcomes of reducing use of pain medications and cesarean birth, with increased satisfaction, clarify why doulas are an important resource for people seeking physiologic childbearing experiences.

Individual studies have evaluated the "extended model" of doula support, which may begin in pregnancy and continue into the postpartum period. In addition to reduced likelihood of cesarean birth, the extended model has also been associated with reduced likelihood of preterm birth and increased likelihood of breastfeeding initiation and duration.<sup>118</sup>

Finally, evidence shows that doula support is a high-value service. A series of cost analyses have concluded that Medicaid coverage of doula services would likely yield a favorable return on investment.<sup>119</sup>

*Midwives who provide racially centered or congruent care offer childbearing people of color valued support through their focus on racial justice and commitment to combating inequity, care that is likely to be experienced as physically and emotionally safe.*

# Spotlight on Success

## OPEN ARMS PERINATAL SERVICES

Open Arms Perinatal Services is an excellent example of how community-based doulas that provide an extended range of prenatal to postpartum care can dramatically improve the health of mothers and babies. This program has served women with low incomes in the Puget Sound region of Washington state since 1997. Open Arms hires doulas directly from the communities it serves. They provide about 300 pregnant women annually with doula services and, when possible, match women with culturally and linguistically concordant doulas. Open Arms has offered services in 17 languages.

A less intense Birth Doula program supports women from the third trimester through birth and the first three postpartum months. The Community-Based Outreach Doula program provides home visits by the second trimester of pregnancy and through two years postpartum, in addition to continuous support at the time of birth.

Open Arms trains doulas, with an emphasis on equity and helping clients advocate for their needs. Open Arms works to provide doulas with a living wage and, as desired, a pathway to other health and social services jobs.<sup>120</sup>

An independent evaluation of all Latina and Somali mothers and babies enrolled in the Community-Based Outreach Doula program between 2008 and 2016 documented a broad range of benefits, including:

- Clients experienced high rates of **screening for depression and intimate partner violence** (more than 85 percent).
- Both Latina and Somali clients had **lower rates of preterm birth** than a comparable sample in King County, Wash.
- Somali clients had a **lower rate of cesarean birth** (25 percent) than the Black population in King County (35 percent).
- **99 percent of clients initiated breastfeeding**, exceeding the King County rate, and 94 percent were still breastfeeding at 6 months, by far exceeding the rate of state Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs (35.3 percent).
- Clients had **low rates of child developmental concerns**.

## Open Arms Results



Clients experienced high rates of screening for depression and intimate partner violence (more than 85 percent).



99% of clients initiated breastfeeding. 94% were still breastfeeding at six months.

This evaluation concluded that rates of low birth weight, preterm birth, cesarean birth, and breastfeeding compare favorably to a broad range of possible comparators.<sup>121</sup>

*Women value doulas' assistance during labor both as sources of information and in offering myriad nonpharmacologic approaches to comfort and coping. By explaining care options, doulas help women participate in their care.*

### **Women's positive experience of doula support**

Doulas help communicate women's preferences and needs to clinicians and in turn translate medical information to women, helping women feel heard and empowered. A qualitative synthesis found that women value doulas' assistance during labor both as sources of information and in offering myriad nonpharmacologic approaches to comfort and coping. By explaining care options, doulas help women participate in their care. They help women understand what is happening as labor progresses. They also help women feel confident in their ability to give birth and help them feel in control during labor. Continuous presence and support contribute to women's trust, sense of security, and a calm environment, and are buffers against the coming and going of clinical personnel. The support contributes to a positive birth experience and feelings of safety, strength, confidence, and security. Community-based doulas can be advocates for immigrant, refugee, and foreign-born women and help them feel confident and have a positive experience. Some women appreciate doulas'

spiritual support during labor. By contrast, women without a labor companion may feel alone, vulnerable, stressed, afraid, and isolated. Women without a companion may be more vulnerable to mistreatment, neglect, and poor communication.<sup>122</sup>

Independent follow-up of participants in a community-based doula program found that 96 percent of clients would recommend the program or encourage other women to participate. Ninety-four percent felt well matched with their doula.<sup>123</sup> A study of teen moms who had experienced an extended model of community-based doula support identified their appreciation for a respectful relationship that imparted coping skills, confidence, and knowledge and skills for parenting.<sup>124</sup> A study of women from marginalized communities who received community-based doula services found that 91 percent felt that their labor and birth experience had been improved, and 87 percent would use a doula again. Large proportions rated many specific physical and psychosocial support strategies during labor as helpful and appreciated. The respondents appreciated a broad range of support strategies, including massage, hot



and cold compresses, eye contact, answering questions, verbal encouragement, and continuous presence.<sup>125</sup>

Doulas of color are well positioned and highly motivated to support women from their own racial, ethnic, and cultural communities, bringing cultural knowledge and enhancing women's experiences at this crucial time of transition. Some consider this work to be a calling.<sup>126</sup> Doulas of color recognize the biases incorporated into the health care system and can provide culturally congruent support that helps mitigate the impact of racism. They can also connect women with the social and community services they need.<sup>127</sup> In addition to helping women navigate maternity services, doulas who support marginalized women may help improve life circumstances, services that are not reliably available to women with usual care.<sup>128</sup>

### **Interest in doula support is greater than its limited access**

Childbearing women appear to desire doula support out of proportion to their actual use. While recent national data on use and demand are not available, the third national Listening to Mothers survey found that 6 percent of women who gave birth in 2011 and 2012 reported having had a birth doula, and one in four women would have liked to receive doula support.<sup>129</sup> Additionally, an estimated 9 percent of respondents to the *Listening to Mothers in California* survey reported having had a doula in 2016. However, most respondents, 57 percent, indicated interest in doula support. Almost one in five (18 percent) stated they would

definitely want a doula should they give birth in the future. Two-thirds of Black women expressed interest in doulas, with more than one in four (27 percent) reporting they definitely would want one.<sup>130</sup>

A major reason for this large unmet need is the failure of public and private insurers to reliably pay for doula services. Moreover, there are not enough doulas for a policy of a doula for every woman who wants one, and the demographic makeup of the doula population does not reflect the diversity of the nation's childbearing population.

# RECOMMENDATIONS

## INCREASE ACCESS TO DOULA SUPPORT

There is a strong evidence base to support the wider availability of doula services, particularly for women of color. Yet doula services are often out of reach for many pregnant people because insurance coverage for these services is rare. Given the ongoing maternal health crisis, especially in communities of color, doula care must be financially supported as a public policy.

### Federal policymakers should:

- Mandate that all federally funded health insurance programs cover payment for doula support, including the extended model with prenatal and postpartum support, and for support for specific segments (e.g., birth doula) as desired by women, including Medicaid, CHIP, TRICARE, and IHS.
- Support research to more fully understand variations on this model, including effect of community-based and -led doula training and support programs for low-income, marginalized communities of color.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State policymakers should:

- Mandate payment for extended model doula support, and for support for specific segments (e.g., birth doula) as desired by women, in Medicaid and CHIP.
- Ensure that doula training is tailored to the specific needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Provide payment for extended doula support at a level that sustainably provides them with a living wage, and can help attract and retain these critically important birth workers.

### Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about sustainable plan payment for extended model doula services.
- Educate employees and beneficiaries about the benefits of doula support.
- Include doula support, including extended model with prenatal and postpartum support, as a covered benefit in health plans, ensure reimbursement levels that are able to sustain and expand the doula workforce, and promote this benefit among eligible beneficiaries.
- Ensure that plan directories maintain up-to-date listings for available doulas or doula agencies.

## **PERINATAL HEALTH WORKER GROUPS**

Community-led and -based perinatal health worker groups are a newer, hybrid model of care that explicitly centers meeting community needs and priorities – particularly in communities of color – by providing a wide range of services, including in many cases some combination of midwifery care, community birth settings, and doula support. This model has emerged as a very promising practice in maternal care that has not been extensively evaluated as a unit.

# A PROMISING, EMERGING HYBRID MODEL: COMMUNITY-LED PERINATAL HEALTH WORKER GROUPS



**Standard approaches to maternity services are failing to deliver care that communities of color and other marginalized groups in the country reliably experience as safe, respectful, and trustworthy.** Recognition of longstanding systemic inequities and unmet needs in their communities has motivated people to step forward and come together to build new tailored multifunction programs that center and support marginalized families affected by systemic racism and other forms of oppression.<sup>131</sup> A growing number of community-led and -based groups are filling this gap with services that directly address specific community needs.<sup>132</sup>

In general, women of color head these community-led perinatal health worker

groups. Frequently, the groups combine clinical services, such as midwives offering birth center and/or home birth services, with a wide range of non-clinical support services. The latter may include doula support that often extends from pregnancy through the postpartum period, lactation support, mental health support, and health and social care navigation. Some of these community-led groups informally or formally poll community members, identify unmet community needs, and develop and implement programs to address them. For example, they may institute programs for young families that need long-term parenting support.<sup>133</sup>

Many of these groups develop and operate training programs for work within and

beyond the organization. Unlike much national training program content, the community-based programs typically are tailored to meet the specific needs of the communities they serve, including topics such as birth and broader social justice, the effects of systemic racism, and how to provide trauma-informed services.<sup>134</sup> Many community-based perinatal care leaders become active in state or other jurisdiction policy development and community advocacy. This might include advocating for CPM and/or birth center licensure legislation, for additional resources for the organization, and for social services needed by clients and communities. Less established groups may aspire to build capacity and add components such as clinical services, training programs, and policy advocacy down the line.<sup>135</sup>

Because of their multifaceted work, these groups play a major role in community development. They provide new services, educational opportunities, and employment; improve maternal and infant health; strengthen families, improve health literacy, and clients' sense of agency; and mitigate harmful effects of racism and other forms of oppression.<sup>136</sup>

### **Community-based perinatal health worker groups are a promising model**

Of the four models featured in this report, community-led and -based perinatal health worker groups are the newest, and have not yet been evaluated to the extent needed to generate a solid evidence base. There is an urgent need to assess this model, which in theory is an ideal design from multiple

perspectives. The community-based settings are geographically accessible, as they are located within the neighborhoods they serve. They strive to be financially accessible as well, and often provide care to people regardless of their ability to pay, insurance, and immigration status. Moreover, these programs are tailored to their local community and offer a range of services designed to center their diverse needs and build trust, including by offering cultural congruence and language accessibility. Additionally, their explicit focus on dignity and respect and on countering racism and discrimination enables them to recognize and support their clients' intersectional identities (such as race, ethnicity, gender identity, sexual orientation, and disability), so they can buffer the trauma that many of their clients experience, both in engaging with the health care system and in their daily lives.

To the extent that these groups offer proven services such as midwifery care, birth center care, and doula support, they are clearly providing evidence-based care. While the cumulative effect of combining these practices under a community-led, culturally congruent umbrella hasn't been fully evaluated, evidence about how a birth center versus a hospital allows the midwifery model to flourish to the benefit of childbearing people and families suggests a synergistic effect. To the extent that they offer more than one of these high-quality, high-value services, the synergistic effects may have an even greater positive impact on birthing people's health and well-being, and that of their families. Measuring effects of these models is an urgent research priority.

# Spotlight on Success

## COMMONSENSE CHILDBIRTH

Commonsense Childbirth is a midwifery-led practice in Orlando, Fla., that provides a range of clinical and support services to any pregnant person seeking care. Most clients come into the practice at risk for adverse outcomes in usual care settings, yet end up with much better health results than would be expected, thanks to an innovative community-led approach that combines respectful, dignifying, individualized services focusing on health promotion and building on assets of clients and families.

Jennie Joseph, a British-trained midwife, founded Commonsense Childbirth in 1998 in response to the maternal and infant health crisis she observed in central Florida. She is committed to providing a model of care that successfully supports healthy births for everyone. The model, known as the JJ Way®, is based on four pillars:

- Immediate unrestricted **access** to quality care and support, regardless of ability to pay;
- **Connections** among woman, care provider, baby, family, community, resources, and support systems;
- **Knowledge** of skillful, evidence-based care and support; leading to
- **Empowerment** of women, care providers and systems, agencies, and organizations.<sup>137</sup>

The program strives to serve low-income people who are un- or under-insured, come from marginalized communities, and are at risk of poor birth outcomes due to their life circumstances and unmet social needs – reflecting structural discrimination.<sup>138</sup> The services they provide include midwifery care, birth center care, childbirth education, birth doula support when available, lactation support, and social service navigation. Services are available in English, Spanish, and Portuguese.<sup>139</sup>

To advance birth equity, Joseph has pioneered the creation of “easy access clinics” and “perinatal safe spots” that offer safe harbor and respectful support to childbearing people who are often disrespected and poorly supported in “materno-toxic areas” within their broader communities and usual maternity care services.<sup>140</sup>

An independent evaluation of 256 Commonsense Childbirth clients found that this approach to care greatly reduced, and even eliminated, inequities that pervade our standard approach to maternity care.<sup>141</sup> Commonsense Childbirth outcomes for births between 2016 and 2017 were compared with

those for Orange County (where they are located) and the state of Florida in the same period. The results were remarkable:

- The preterm birth rate for Black clients in this program matched the white preterm birth rates for both Orange County and the state of Florida (9 percent in every case) and **eliminated the 4-percentage-point gap** at county and state levels: 13 percent Black versus 9 percent white in both cases.
- The low birth weight rate for Black clients in this program (9 percent) largely erased the broader community Black-white gap for this indicator: for both the county and state, **Black women had 13 percent low birth weight rates versus 7 percent for white women.**
- The **breastfeeding rate among Black women exceeded overall state and national rates of any breastfeeding.**
- Latina clients had a **preterm birth rate much lower** than their counterparts at the county and state levels. Whereas only 4 percent of Latina clients had preterm births, more than twice as many Latinas did at the county (9 percent) and state (9 percent) levels.
- **Only 1 percent of Latina clients had low birth weight babies,** compared to 8 percent at the county, and 7 percent at the state levels.
- Non-Hispanic white clients' **outcomes improved for preterm births** (5 percent compared to 9 percent at the county and state levels) and low birth weight (3 percent compared to 7 percent at both levels).<sup>142</sup>

In addition, the cesarean rate in this practice is 8 percent, in comparison with rates of about 30 percent to 50 percent in local hospitals.<sup>143</sup> These results are not even adjusted for risk; given that Commonsense Childbirth disproportionately serves clients from marginalized communities, these outcomes are even more impressive.

These results have major implications for the well-being of families. Considerable reduction in rates of preterm and cesarean birth have favorable cost implications for purchasers and payers.

Commonsense Childbirth also operates the Commonsense Childbirth School of Midwifery, with a three-year program to prepare midwives for the CPM exam and a four-month program to prepare foreign-trained midwives and some other U.S. midwives to obtain a Florida midwifery license. They also offer preparation for community-based childbirth education, doula, and lactation support.<sup>144</sup>

## **Women's experience of community-based perinatal health worker groups**

At this time, understanding of women's experiences of receiving care and support from community-led, multifunctional perinatal groups appears to be limited to anecdotal sources. Research comparing women's experiences in these settings to similar women who lack access to such services is a research priority.

## **Access to community-based perinatal health worker groups is limited**

There is no inventory of the number and location of community-based perinatal health worker groups across the United States. Many are located in urban areas, and some are available in remote areas. However, this is a relatively new service model, with no clear, reliable sources of financial support. If reimbursable clinical services are provided, payments for clinical services may be spread to also provide modest support to non-clinical services. But, given the high-touch, resource-intensive support they provide families, there are practical limits to how many families these groups can serve. At present, just a fraction of the childbearing families that might benefit from this model of care have access to it.<sup>145</sup>

*Tailored to their local community, these programs offer a range of services that center clients' diverse needs and build trust, including providing culturally congruent and language accessible care.*



# RECOMMENDATIONS

## INCREASE SUPPORT FOR COMMUNITY-LED AND -BASED PERINATAL HEALTH WORKER GROUPS AND FOR EVALUATIONS OF THIS MODEL

Given the extremely promising early evidence, community-led perinatal health worker groups have great potential for reducing racial and ethnic health inequities. Their frequent use of proven maternal care and support models is a strong asset. Decisionmakers should target support for and ongoing evaluation of these innovative, community-centered and -led groups.

### Federal policymakers should:

- Create programs to support and evaluate new and existing community-led and -based multifunctional programs, including quality of services, health outcomes, women's experiences, and impact on equity, in comparison with similar women without access to such programs. One mechanism would be through a major program at the Centers for Medicare and Medicaid Services Center for Medicare and Medicaid Innovation.
- Enact the Kira Johnson Act (H.R. 6144 and S. 3424 Title II in the 116th Congress) to provide funding for community-based perinatal health worker organizations, especially those led by Black women, to improve Black maternal health; to address racism and bias in all maternal health settings; and to support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act (H.R. 6164 and S. 3424 Title IV in the 116th Congress) to provide guidance to states for promoting diverse maternity care teams and the role of culturally congruent care in improving outcomes, especially for minority women; establish and scale programs to grow the maternal health workforce (including doulas, community health workers, and peer supporters); and study barriers to entry for low-income and minority women into maternity care professions.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State policymakers should:

- Pursue partnerships with community-based perinatal health groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments, to support partnership efforts.
- Work to identify and establish inventories of community-based perinatal health groups, and support efforts to evaluate them.

**Private sector decisionmakers, including health care purchasers and health plans, should:**

- Incorporate clear expectations into purchaser-payer contracts about access to, and sustainable payment for, community-led perinatal health worker groups offering services of midwives with nationally recognized credentials, community birth, and/or doula services.
- Educate employees and beneficiaries about the benefits of midwifery care, community birth, and doula services.
- Make services of community-led perinatal health workers incorporating midwifery care, community birth, and/or doula services available to beneficiaries, and evaluate the overall multifunction model and return on investment, including implications of quality of care, health outcomes, and women's experiences, and possible synergistic effects.
- Mandate that plan directories maintain up-to-date listings for available community-led perinatal health worker groups whose services are paid for by plans.

## Conclusion

The U.S. maternal and infant health crisis requires urgent action. The models of care featured in this report are examples of proven solutions to many of the failings of usual maternity care. Inequitable, disrespectful, inaccessible, costly approaches are not delivering on quality, experiences, and outcomes. Especially as the twin pandemics of COVID-19 and structural and interpersonal racism make birthing in this country even more risky for many people, we must invest in what we know works and quickly scale these models.

The evidence is clear: Moms and babies will be healthier if more families are able to access these types of care. We will have fewer premature and underweight babies. We will have fewer cesarean births, including for women with a history of cesareans. More babies and mothers will enjoy the emotional and health benefits of breastfeeding. We will see concrete progress toward eliminating our country's intractable racial and ethnic maternal and infant health inequities.

Less tangible, but no less important, is the models' potential to instill confidence, agency, and empowerment at this crucial time of transformation in women's lives. They are more likely to provide respectful, attentive, dignifying, relationship-based, culturally congruent care and invest heavily in health-promoting prenatal and postpartum care and support.

As we work to transform the maternity care system, midwifery care, community birth, doula support, and the services of community-based perinatal health groups must be central to solving for quality, value, and equity. Most importantly, they help us achieve healthier families.

We can't afford to wait. It is past time for federal and state policymakers, and private sector health care decisionmakers to take action.

*The outcomes these models achieve are remarkable, succeeding where standard care comes up short on such crucial indicators as rates of preterm birth, cesarean birth, and breastfeeding.*

# COMPLETE RECOMMENDATIONS

## INCREASE ACCESS TO MIDWIFERY CARE

Midwives have a distinctive, dignifying, person-centered, skilled model of care and an exemplary track record. They are an important part of the solution to the nation's shortage of maternity care providers. However, there are barriers to meeting this need and enabling more childbearing people and families to experience benefits of midwifery care.

### Congress and federal policymakers should:

- Enact the Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act (H.R. 3849 in the 116th Congress). This bipartisan bill would increase the supply of midwives with nationally recognized credentials (CNMs, CMs, CPMs) by supporting students, preceptors, and schools and programs. It would give funding preference to supporting students who would diversify the profession and who intend to practice in underserved areas.
- Mandate payment for services of CMs and CPMs recognized in their jurisdiction by Medicaid, the Child Health Insurance Program (CHIP), TRICARE (the military health care program), the Veterans Health Administration (VHA), the Indian Health Service (IHS), and Commissioned Corps of the U.S. Public Health Service.
- Mandate that hospitals cannot deny privileges to midwives as a class.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State and territorial policymakers should:

- In jurisdictions that currently fail to recognize them, enact CM and CPM licensure. For CMs, these include all of the territories, the District of Columbia, and all states except Delaware, Hawaii, Maine, New Jersey, New York, Oklahoma, and Rhode Island. Jurisdictions that have yet to recognize CPMs through licensure are: Connecticut, Georgia, Iowa, Illinois, Kansas, Massachusetts, Missouri, Mississippi, North Dakota, Nebraska, North Carolina, New York, Nevada, Ohio, Pennsylvania, West Virginia, and all U.S. territories.
- Amend unnecessarily restrictive midwifery practice acts to enable midwives to practice “at the top of their license” in line with their full competencies and education as independent providers who collaborate with others according to the health needs of their clients.

- Mandate reimbursement of midwives with nationally recognized credentials at 100 percent of physician payment levels for the same service in states without payment parity.
- In states where Medicaid agencies do not currently pay for services of CMs and CPMs licensed in their jurisdiction, mandate payment at 100 percent of physician payment levels for the same services. Currently, Delaware, Hawaii, Maine, New Jersey, Oklahoma, and Rhode Island recognize CMs but do not pay for their services through Medicaid. States that regulate CPMs yet fail to pay for their services through Medicaid are: Alabama, Arkansas, Colorado, Delaware, Hawaii, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota (does not pay for home birth services), Montana, New Jersey, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, and Wyoming.

#### **Private sector decisionmakers, including purchasers and health plans, should:**

- Incorporate clear expectations into service contracts about access to and sustainable payment for midwifery services offered by providers that hold nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of midwives with nationally recognized credentials.
- Mandate that plan directories maintain up-to-date listings for available midwives.

## **INCREASE ACCESS TO COMMUNITY BIRTH**

For many pregnant people, community birth options offer better care, more positive experiences, improved health outcomes, and potential cost benefits. The differences in care, experiences, outcomes, and costs are so striking that a leading international maternity care researcher has recently asked, “Is it time to ask whether facility-based birth is safe for low-risk women and their babies?”<sup>146</sup> Given this track record and the increasing use of, and unmet need for, these types of care, decisionmakers should act to make them more available to low-risk pregnant people who desire them.

#### **Federal policymakers should:**

- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and the Commissioned Corps of the U.S. Public Health Service for care in licensed birth centers and midwife providers in birth centers who hold nationally recognized credentials and are recognized in their jurisdiction.
- Mandate payment by Medicaid, CHIP, TRICARE, VHA, IHS, and Commissioned Corps of the U.S. Public Health Service for home births attended by midwives with nationally recognized credentials who are recognized in their jurisdiction.
- Enact the Birth Access Benefitting Improved Essential Facility Services (BABIES) Act (H.R. 5189

in the 116th Congress). This bipartisan bill would fund demonstrations of birth center models for improved maternity care access and quality for Medicaid beneficiaries with low-risk pregnancies in underserved areas, and develop sustainable approaches to payment for birth center care.

- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

#### **State and territorial policymakers should:**

- Enact birth center licensure in the 10 states that do not currently regulate birth centers: Alabama, Idaho, Louisiana, Maine, Michigan, North Carolina, North Dakota, Vermont, Virginia, Wisconsin, and in the U.S. territories.
- Mandate payment by Medicaid and CHIP programs for care in licensed birth centers, for services provided by midwife birth center providers with nationally recognized credentials who are recognized in their jurisdiction, and for home birth with midwives with nationally recognized credentials who are recognized in their jurisdiction.

#### **Private sector decisionmakers, including health care purchasers and health plans, should:**

- Incorporate clear expectations into purchaser-payer contracts about access to and sustainable payment for community birth (birth center and home) settings and for services of midwives with nationally recognized credentials.
- Educate employees and beneficiaries about the benefits of community birth settings and midwifery care.
- Mandate that plans contract with birth centers and midwives with nationally recognized credentials in their service area and pay for care in all settings provided by midwives recognized in the jurisdiction.
- Mandate that plan directories maintain up-to-date listings for available birth centers and midwives.
- Educate maternity care providers and hospitals about the safety of integrated maternity care with consultation, shared care, and seamless transfer from community birth settings as needed, and encourage adoption of “Best Practice Guidelines: Transfer from Planned Home Birth to Hospital,” and accompanying Model Transfer Forms.

## INCREASE ACCESS TO DOULA SUPPORT

There is a strong evidence base to support the wider availability of doula services, particularly for women of color. Yet doula services are often out of reach for many pregnant people because insurance coverage for these services is rare. Given the ongoing maternal health crisis, especially in communities of color, doula care must be financially supported as a public policy.

### Federal policymakers should:

- Mandate that all federally funded health insurance programs cover payment for doula support, including the extended model with prenatal and postpartum support, and for support for specific segments (e.g., birth doula) as desired by women, including Medicaid, CHIP, TRICARE, and IHS.
- Support research to more fully understand variations on this model, including effect of community-based and -led doula training and support programs for low-income, marginalized communities of color.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.

### State policymakers should:

- Mandate payment for extended model doula support, and for support for specific segments (e.g., birth doula) as desired by women, in Medicaid and CHIP.
- Ensure that doula training is tailored to the specific needs of the Medicaid population (including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism).
- Promote racial, ethnic, and language diversity in the doula workforce that better aligns with the childbearing population covered by Medicaid and CHIP.
- Provide payment for extended doula support at a level that sustainably provides them with a living wage, and can help attract and retain these critically important birth workers.

### Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about sustainable plan payment for extended model doula services.
- Educate employees and beneficiaries about the benefits of doula support.

- Include doula support, including extended model with prenatal and postpartum support, as a covered benefit in health plans, ensure reimbursement levels that are able to sustain and expand the doula workforce, and promote this benefit among eligible beneficiaries.
- Ensure that plan directories maintain up-to-date listings for available doulas or doula agencies.

## **INCREASE SUPPORT FOR COMMUNITY-LED AND -BASED PERINATAL HEALTH WORKER GROUPS AND FOR EVALUATIONS OF THIS MODEL**

Given the extremely promising early evidence, community-led perinatal health worker groups have great potential for reducing racial and ethnic health inequities. Their frequent use of proven maternal care and support models is a strong asset. Decisionmakers should target support for and ongoing evaluation of these innovative, community-centered and -led groups.

### **Federal policymakers should:**

- Create programs to support and evaluate new and existing community-led and -based multifunctional programs, including quality of services, health outcomes, women's experiences, and impact on equity, in comparison with similar women without access to such programs. One mechanism would be through a major program at the Centers for Medicare and Medicaid Services Center for Medicare and Medicaid Innovation.
- Enact the Kira Johnson Act (H.R. 6144 and S. 3424 Title II in the 116th Congress) to provide funding for community-based perinatal health worker organizations, especially those led by Black women, to improve Black maternal health; to address racism and bias in all maternal health settings; and to support hospital Respectful Maternity Care Compliance Offices.
- Enact the Perinatal Workforce Act (H.R. 6164 and S. 3424 Title IV in the 116th Congress) to provide guidance to states for promoting diverse maternity care teams and the role of culturally congruent care in improving outcomes, especially for minority women; establish and scale programs to grow the maternal health workforce (including doulas, community health workers, and peer supporters); and study barriers to entry for low-income and minority women into maternity care professions.
- Require the collection and public reporting of data related to health inequities, such as racial, ethnic, socioeconomic, sex, gender, language, and disability disparities in critical indicators of maternal and infant health, including, but not limited to, maternal mortality, severe maternal morbidity, preterm birth, low birth weight, cesarean birth, and breastfeeding.



### State policymakers should:

- Pursue partnerships with community-based perinatal health groups, using Medicaid levers such as value-based contracts, managed care organization regulations, and state plan amendments, to support partnership efforts.
- Work to identify and establish inventories of community-based perinatal health groups, and support efforts to evaluate them.

### Private sector decisionmakers, including health care purchasers and health plans, should:

- Incorporate clear expectations into purchaser-payer contracts about access to, and sustainable payment for, community-led perinatal health worker groups offering services of midwives with nationally recognized credentials, community birth, and/or doula services.
- Educate employees and beneficiaries about the benefits of midwifery care, community birth, and doula services.
- Make services of community-led perinatal health workers incorporating midwifery care, community birth, and/or doula services available to beneficiaries, and evaluate the overall multifunction model and return on investment, including implications of quality of care, health outcomes, and women's experiences, and possible synergistic effects.
- Mandate that plan directories maintain up-to-date listings for available community-led perinatal health worker groups whose services are paid for by plans.

## Resource Directory

This curated list of key publications and other resource provides additional information for decision makers, advocates, and community leaders

### Reproductive and Birth Justice

- *Reproductive Justice*  
SisterSong Women of Color Reproductive Justice Collective, <https://www.sistersong.net/reproductive-justice>
- *Black Women Birthing Justice*, <https://www.blackwomenbirthingjustice.org/what-is-birth-justice>
- *Birth Justice Bill of Rights*  
Southern Birth Justice Network, <https://southernbirthjustice.org/birth-justice>
- *The Birth Equity Agenda: A Blueprint for Reproductive Health and Wellbeing*  
Joia Crear-Perry. National Birth Equity Collaborative, June 16, 2020, <https://birthequity.org/birth-equity-agenda/>
- *Building a Movement to Birth a More Just and Loving World*  
Haile Eshe Cole, Paula X. Rojas, and Jennie Joseph. National Perinatal Task Force, March 2018, <https://perinataltaskforce.com/heads-up-maternal-justice-npt-2018-report-out-now/>
- *2019 Birth Justice Fund Docket*  
Groundswell Fund. 2019, <https://groundswellfund.org/birth-justice-fund/>
- *A Black Mama's Guide to Living and Thriving*  
Mamatoto Village. 2020, <https://www.mamatotovillage.org/viewguide.html>

### Physiologic Childbearing

- *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*  
American College of Nurse-Midwives, Midwives Alliance of North America, and National Association of Certified Professional Midwives. The Journal of Perinatal Education, Winter 2013, <https://doi.org/10.1891/1058-1243.22.1.14>
- *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care*  
National Partnership for Women & Families, 2015, <http://www.nationalpartnership.org/physiology>

- *Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*  
Melissa D. Avery, Amy D. Bell, Debra Bingham, Maureen P. Corry, Suzanne F. Delbanco, Susan Leavitt Gullo, Catherine H. Ivory, *et al.* National Partnership for Women & Families, June 2018, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/blueprint-for-advancing-high-value-maternity-care.pdf>

## Midwifery

- *Midwifery*  
The Lancet. June 23, 2014, <https://www.thelancet.com/series/midwifery>
- *More Midwife-Led Care Could Generate Cost Savings and Health Improvements*  
Katy B. Kozhimannil, Laura Attanasio, and Fernando Alarid-Escudero. University of Minnesota School of Public Health, November 2019, <https://www.sph.umn.edu/sph-2018/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf>
- *Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes*  
Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, *et al.* Plos One, February 21, 2018, <https://doi.org/10.1371/journal.pone.0192523>
- *Midwifery = High Value Maternity Care*  
Every Mother Counts. May 2018, [https://everymothercounts.org/wp-content/uploads/2018/10/Midwifery\\_High\\_Value\\_Maternity\\_Care\\_5\\_3\\_18\\_2-sided\\_Final.pdf](https://everymothercounts.org/wp-content/uploads/2018/10/Midwifery_High_Value_Maternity_Care_5_3_18_2-sided_Final.pdf)
- *PBGH Midwifery Initiatives*  
Pacific Business Group on Health. <https://www.pbgh.org/midwifery>
- *Maximizing Midwifery to Achieve High-Value Maternity Care in New York*  
Nan Strauss. Choices in Childbirth, 2018, [https://everymothercounts.org/wp-content/uploads/2018/10/MaxiMiNY\\_Final\\_5\\_3\\_18.pdf](https://everymothercounts.org/wp-content/uploads/2018/10/MaxiMiNY_Final_5_3_18.pdf)
- *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid: A Resource for State Medicaid Agencies and Medicaid Managed Care Organizations*  
Jennifer E. Moore, Karen E. George, Chloe Bakst, and Karen Shea. Institute for Medicaid Innovation, 2020, [https://www.medicaidinnovation.org/images/content/2020-IMI-Improving\\_Maternal\\_Health\\_Access\\_Coverage\\_and\\_Outcomes-Report.pdf](https://www.medicaidinnovation.org/images/content/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf)

## Doula Care

- *Doula Medicaid Project*  
National Health Law Program, 2020, <https://healthlaw.org/doulamedicaidproject/>

- *Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid*  
Chloe Bakst, Jennifer E. Moore, Karen E. George, and Karen Shea, Institute for Medicaid Innovation, May 2020, [https://www.medicaidinnovation.org/images/content/2020-IMI-Community\\_Based\\_Maternal\\_Support\\_Services-Report.pdf](https://www.medicaidinnovation.org/images/content/2020-IMI-Community_Based_Maternal_Support_Services-Report.pdf)
- *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities*  
Asteir Bey, Aimee Brill, Chanel Porchia-Albert, Melissa Gradilla, and Nan Strauss. Ancient Song Doula Services, Village Birth International, and Every Mother Counts, March 25, 2019, <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>
- *Routes to Success for Medicaid Coverage of Doula Care*  
Amy Chen. National Health Law Program, December 14, 2018, <https://healthlaw.org/resource/routes-to-success-for-medicaid-coverage-of-doula-care/>
- *Building a Successful Program for Medi-Cal Coverage for Doula Care: Findings from a Survey of Doulas in California*  
Amy Chen and Alexis Robles-Fradet. National Health Law Program, May 21, 2020, <https://healthlaw.org/resource/doulareport/>
- *The Perinatal Revolution*  
HealthConnect One. 2014, <https://www.healthconnectone.org/wp-content/uploads/2020/03/The-Perinatal-Revolution-CBD-Study.pdf>
- *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*  
National Partnership for Women & Families and Choices in Childbirth, January 2016, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicaid-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf>

## Community-Led Birthing Solutions

- *Supporting Midwife-Led Independent Birth Centers Makes Sense*  
American Association of Birth Centers. 2016, [https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/Insurers-Employers/Impact\\_Statement\\_-\\_rv8.16.pdf](https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/Insurers-Employers/Impact_Statement_-_rv8.16.pdf)
- *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*  
Nora Ellman. Center for American Progress, April 14, 2020, <https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/>

- *Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches*  
National Partnership for Women & Families. 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

## Data Deep Dives

- *Continuous Support for Women During Childbirth*  
M.A. Bohren, G.J. Hofmeyr, C. Sakala, R.K. Fukuzawa, and A. Cuthbert. Cochrane Database of Systematic Reviews, July 6, 2017, <https://doi.org/10.1002/14651858.CD003766.pub6>
- *What Matters to Women: A Systematic Scoping Review to Identify the Processes and Outcomes of Antenatal Care Provision That Are Important to Healthy Pregnant Women*  
S. Downe, K. Finlayson, Ö. Tunçalp, and A. Metin Gülmezoglu. BJOG: An International Journal of Obstetrics and Gynaecology, December 24, 2015, <https://doi.org/10.1111/1471-0528.13819>
- *What Matters to Women During Childbirth: A Systematic Qualitative Review*  
S. Downe, K. Finlayson, O.T. Oladapo, M. Bonet, and A.M. Gülmezoglu. Plos One, April 17, 2018, <https://doi.org/10.1371/journal.pone.0194906>
- *What Matters to Women in the Postnatal Period: A Meta-Synthesis of Qualitative Studies*  
K. Finlayson, N. Crossland, M. Bonet, and S. Downe. Plos One, April 22, 2020, <https://doi.org/10.1371/journal.pone.0231415>
- *Perceptions and Experiences of Labour Companionship: A Qualitative Evidence Synthesis*  
Meghan A. Bohren, Blair O. Berger, Heather Munthe-Kaas, and Özge Tunçalp. Cochrane Database of Systematic Reviews, March 2019, <https://doi.org/10.1002/14651858.CD012449.pub2>
- *Assessing Health Outcomes by Birth Settings*  
National Academies of Sciences, Engineering, and Medicine. <https://www.nationalacademies.org/our-work/assessing-health-outcomes-by-birth-settings>
- *Strong Start for Mothers and Newborns Evaluation: Year 5 Project Synthesis (Volume 1: Cross-Cutting Findings)*  
Ian Hill, project director. Urban Institute, October 2018, <https://downloads.cms.gov/files/cmml/strongstart-prenatal-finalevalrpt-v1.pdf>

## Endnotes

<sup>1</sup> Julia Belluz. “We Finally Have a New U.S. Maternal Mortality Estimate. It’s Still Terrible,” *Vox*, January 30, 2020, <https://www.vox.com/2020/1/30/21113782/pregnancy-deaths-us-maternal-mortality-rate>

<sup>2</sup> National Partnership for Women & Families. “Maternity Care in the United States: We Can – and Must – Do Better,” February 2020, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf>

<sup>3</sup> Stephanie Myers Schim, and Ardith Z. Doorenbos. “A Three-dimensional Model of Cultural Congruence: Framework for Intervention,” *Journal of Social Work in End-of-Life & Palliative Care*, July 2010, <https://doi.org/10.1080/15524256.2010.529023>

<sup>4</sup> Melissa D. Avery, Amy D. Bell, Debra Bingham, Maureen P. Corry, Suzanne F. Delbanco, Susan Leavitt Gullo, Catherine H. Ivory, et al. “Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing,” National Partnership for Women & Families, June 2018, <http://www.nationalpartnership.org/blueprint>

<sup>5</sup> Kathryn R. Fingar, Megan M. Hambrick, Kevin C. Heslin, and Jennifer E. Moore. “Trends and Disparities in Delivery Hospitalizations Involving Severe Maternal Morbidity, 2006–2015,” *Healthcare Cost and Utilization Project*, September, 2018, <https://hcup-us.ahrq.gov/reports/statbriefs/sb243-Severe-Maternal-Morbidity-Delivery-Trends-Disparities.jsp>

<sup>6</sup> National Partnership for Women & Families. “Maternity Care in the United States: We Can – and Must – Do Better,” February 2020, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf>; Howell, Elizabeth A. “Reducing Disparities in Severe Maternal Morbidity and Mortality,” *Clinical Obstetrics and Gynecology*, July 29, 2020, <https://doi.org/10.1097/GRF.0000000000000349>

<sup>7</sup> Katy Backes Kozhimannil, Julia D. Interrante, Carrie Henning-Smith, and Lindsay K. Admon. “Rural-Urban Differences in Severe Maternal Morbidity and Mortality

in the U.S., 2007–15,” *Health Affairs*, December 2019, <https://doi.org/10.1377/hlthaff.2019.00805>

<sup>8</sup> E.E. Petersen, N.L. Davis, D. Goodman, et al. “Racial/Ethnic Disparities in Pregnancy-Related Deaths: United States, 2007–2016,” *Morbidity and Mortality Weekly Report*, September 6, 2019, [https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s\\_cid=mm6835a3\\_w](https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w)

<sup>9</sup> Wanda Barfield, William M. Callaghan, Shanna Cox, Nicole L. Davis, David Goodman, Emily Johnston, Nikki Mayes, et al. “Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017,” *MMWR*, May 10, 2019, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6542194/>

<sup>10</sup> Durrenda Ojanuga. “The Medical Ethics of the ‘Father of Gynaecology,’ Dr. J. Marion Sims,” *Journal of Medical Ethics*, March 1, 1993, <https://jme.bmj.com/content/medethics/19/1/28.full.pdf>

<sup>11</sup> Maninder Ahluwalia. “Genetic privacy: We must learn from the story of Henrietta Lacks,” *New Scientist*, August 1, 2020, <https://www.newscientist.com/article/2250449-genetic-privacy-we-must-learn-from-the-story-of-henrietta-lacks/s>

<sup>12</sup> Margaret Sanger. *Woman and the New Race* (New York: Brentano’s, 1920)

<sup>13</sup> H.B. Presser. “The Role of Sterilization in Controlling Puerto Rican Fertility,” *Population Studies*, November 1969, <https://doi.org/10.1080/00324728.1969.10405290>

<sup>14</sup> Carolyn Rodehau, Robyn Russell, and Patricia Quinn. “Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, D.C.,” District of Columbia Primary Care Association, September 2018, <http://www.dcpca.org/includes/storage/brio/files/204/The%20D.C.%20Womens%20Health%20Improvement%20Project.%2009.12.18.pdf>

<sup>15</sup> March of Dimes. “Nowhere to Go: Maternity Care Deserts Across the U.S.,” 2018, [https://www.marchofdimes.org/materials/Nowhere\\_to\\_Go\\_Final.pdf](https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf)

<sup>16</sup> American College of Obstetricians and Gynecologists. “Committee Opinion No. 586: Health Disparities in Rural Women,” *Obstetrics & Gynecology*, February 2014,

<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women>

<sup>17</sup> Carolyn Rodehau, Robyn Russell, and Patricia Quinn. “Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, D.C.,” District of Columbia Primary Care Association, September 2018, <http://www.dcpca.org/includes/storage/brio/files/204/The%20D.C.%20Womens%20Health%20Improvement%20Project.%209.12.18.pdf>

<sup>18</sup> Institute of Medicine. “Crossing the Quality Chasm: A New Health System for the 21st Century” March 2001, <https://doi.org/10.17226/10027>

<sup>19</sup> —. Measuring the Quality of Health Care: A Statement by “The National Roundtable on Health Care Quality,” 1999, <https://doi.org/10.17226/6418>

<sup>20</sup> Christine H. Morton and Penny Simkin. “Can Respectful Maternity Care Save and Improve Lives?” *Birth Issues in Perinatal Care*, September 2019, <https://doi.org/10.1111/birt.12444>

<sup>21</sup> Saraswathi Vedam, Kathrin Stoll, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney, Nan Strauss, Monica McLemore, et al. “The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States,” *Reproductive Health*, June 11, 2019, <https://doi.org/10.1186/s12978-019-0729-2>

<sup>22</sup> *Ibid.*

<sup>23</sup> Haile Eshe Cole, Paula X. Rojas, and Jennie Joseph. “Building a Movement to Birth a More Just and Loving World,” National Perinatal Task Force, March 2018, <http://perinataltaskforce.com/heads-up-maternal-justice-npt-2018-report-out-now/>

<sup>24</sup> Bernice Roberts Kennedy, Christopher Clomus Mathis, and Angela K. Woods. “African Americans and Their Distrust of the Health Care System: Healthcare for Diverse Populations,” *Journal of Cultural Diversity*, Summer 2007, <https://www.ncbi.nlm.nih.gov/pubmed/19175244>; Changing Woman Initiative. “Native American Prenatal Care Trends in NM,” January 2019, <http://www.changingwomaninitiative.com/reports.html>

<sup>25</sup> National Partnership for Women & Families. “Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches,” 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

<sup>26</sup> Joseph Betancourt. “Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches,” The Commonwealth Fund, October 1, 2002, <https://www.commonwealthfund.org/publications/fund-reports/2002/oct/cultural-competence-health-care-emerging-frameworks-and>

<sup>27</sup> S.M. Schim and A.Z. Doorenbos. “A Three-Dimensional Model of Cultural Congruence: Framework for Intervention,” *Journal of Social Work in End-of-Life & Palliative Care*, 2010, <https://doi.org/10.1080/15524256.2010.529023>

<sup>28</sup> Elizabeth A. Howell and Zainab N. Ahmed. “Eight Steps for Narrowing the Maternal Health Disparity Gap: Step-by-Step Plan to Reduce Racial and Ethnic Disparities in Care,” *Contemporary OB/GYN*, January 16, 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6822100/>

<sup>29</sup> Somnath Saha, Mary Catherine Beach, and Lisa A. Cooper. “Patient Centeredness, Cultural Competence and Healthcare Quality,” *Journal of the National Medical Association*, February 18, 2010, [https://doi.org/10.1016/s0027-9684\(15\)31505-4](https://doi.org/10.1016/s0027-9684(15)31505-4)

<sup>30</sup> Ramona Benkert, Rosalind M. Peters, Rodney Clark, and Kathryn Keves-Foster. “Effects of Perceived Racism, Cultural Mistrust and Trust in Providers on Satisfaction with Care,” *Journal of the National Medical Association*, September 2006, <https://pubmed.ncbi.nlm.nih.gov/17019925/>

<sup>31</sup> Cindy Brach and Irene Fraserirector. “Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model,” *Medical Care Research and Review*, November 2, 2016, <https://doi.org/10.1177/1077558700057001S09>

<sup>32</sup> Carol Sakala and Maureen P. Corry. “Evidence-Based Maternity Care: What It Is and What It Can Achieve,” Childbirth Connection, the Reforming States Group, and the Milbank Memorial Fund, 2008, <https://www.milbank.org/wp-content/files/documents/0809MaternityCare/0809MaternityCare.html>

<sup>33</sup> American College of Obstetricians and Gynecologists. “ACOG Committee Opinion No. 736: Optimizing postpartum care,” *Obstetrics & Gynecology*, May 2018, <https://doi.org/10.1097/AOG.0000000000002849>; Eugene R. Declercq, Carol Sakala, Maureen P. Corry, Sandra Applebaum, and Ariel Herrlich. “Listening to Mothers III: New Mothers Speak Out,” National Partnership for Women & Families, June 2013, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-new-mothers-speak-out-2013.pdf>

<sup>34</sup> Divya Patel, Christina Davidson, Meliha Salahuddin, and David Lakey. “Factors Associated with Induction of Labor Among Primiparous Women Delivering at Term in the LTM III Study,” *Obstetrics & Gynecology*, May 2017, <https://doi.org/10.1097/01.AOG.0000514623.13999.38>; E. Mozurkewich, J. Chilimigras, E. Koepke, K. Keeton, and V.J. King. “Indications for Induction of Labour: A Best-Evidence Review,” *BJOG*, March 2009, <https://doi.org/10.1111/j.1471-0528.2008.02065.x>; Eva F. Zwertbroek, Maureen T.M. Franssen, Kim Broekhuijsen, Josje Langenveld, Henk Bremer, Wessel Ganzevoort, Aren J. van Loon, et al. “Neonatal Developmental and Behavioral Outcomes of Immediate Delivery Versus Expectant Monitoring in Mild Hypertensive Disorders of Pregnancy: 2-Year Outcomes of the HYPITAT-II Trial,” *American Journal of Obstetrics & Gynecology*, August 2019, <https://doi.org/10.1016/j.ajog.2019.03.024>

<sup>35</sup> American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. “Safe Prevention of the Primary Cesarean Delivery.” *American Journal of Obstetrics & Gynecology*, March 2014 (reaffirmed 2016), <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery>

<sup>36</sup> Emilia Kaczmarek. “How to Distinguish Medicalization from Over-Medicalization?” *Medicine, Health Care, and Philosophy*, March 2019, <https://doi.org/10.1007/s11019-018-9850-1>

<sup>37</sup> National Partnership for Women & Families. “Maternity Care in the United States: We Can – and Must – Do Better,” February 2020, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf>

<sup>38</sup> Annalisa Merelli. “The Reason Childbirth Is Over-Medicalized in America Has Its Roots in Racial Segregation,” *Quartz*, November 27, 2017, <https://qz.com/1119699/how-racial-segregation-led-childbirth-in-america-to-be-over-medicalized/>.

<sup>39</sup> National Partnership for Women & Families. “Hormonal Physiology of Childbearing,” January 2015, [www.nationalpartnership.org/physiology](http://www.nationalpartnership.org/physiology).

<sup>40</sup> National Partnership for Women & Families. “Maternity Care in the United States: We Can – and Must – Do Better,” February 2020, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf>

<sup>41</sup> Eugene R. Declercq, Erika R. Cheng, and Carol Sakala. “Does Maternity Care Decision-Making Conform to Shared Decision-Making Standards for Repeat Cesarean and Labor Induction after Suspected Macrosomia?” *Birth*, September 2018, <https://doi.org/10.1111/birt.12365>

<sup>42</sup> *National Vital Statistics Reports*. “Births: Final Data for 2018,” November 27, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_13\\_tables-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf)

<sup>43</sup> Midwives Alliance of North America. “The Midwives Model of Care,” accessed August 24, 2020, <https://mana.org/about-midwives/midwifery-model>

<sup>44</sup> Eugene R. Declercq, Candice Belanoff, and Carol Sakala. “Intrapartum Care and Experiences of Women with Midwives Versus Obstetricians in the Listening to Mothers in California Survey,” *Journal of Midwifery and Women’s Health*, January 2020, <https://doi.org/10.1111/jmwh.13027>; P.A. Janssen, L. Saxell, L.A. Page, M.C. Klein, R.M. Liston, and S.K. Lee. “Outcomes of Planned Home



Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician,” *CMAJ*, October 27, 2009, <https://doi.org/10.1503/cmaj.081869>

<sup>45</sup> Melissa D. Avery and Phillip N. Rauk. “Midwife and Ob-Gyn Role Clarity for Team-Based Practice,” accessed August 24, 2020, <https://acnm-acog-ipe.org/wp-content/uploads/2019/07/Role-Clarification-Module-rev-5-14-2018.pdf>

<sup>46</sup> *National Vital Statistics Reports*. “Births: Final Data for 2018,” November 27, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_13\\_tables-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf)

<sup>47</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>48</sup> CM regulation and reimbursement information: Karen Jefferson, personal communication, August 2020. CPM regulation and reimbursement information: Mary Lawlor, personal communication, August 2020.

<sup>49</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>; CM regulation and reimbursement information: Karen Jefferson, personal communication, August 2020; CPM regulation and reimbursement information: Mary Lawlor, personal communication, August 2020.

<sup>50</sup> Meg Johantgen, Lily Fountain, George Zangaro, Robin Newhouse, Julie Stanik-Hutt, and Kathleen White. “Comparison of Labor and Delivery Care provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008,” *Women’s Health Issues*, 2012, <https://doi.org/10.1016/j.whi.2011.06.005>; J. Sandall, H. Soltani, S. Gates, A. Shennan, and D. Devane. “Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women,” *Cochrane Database of Systematic Reviews*, 2016, <https://doi.org/10.1002/14651858.CD004667.pub5>; Katy Sutcliffe, Jenny Caird, Josephine Kavanagh, Rebecca Rees, Kathryn Oliver, Kelly Dickson, Jenny Woodman, et al. “Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews,” *Journal of*

*Advanced Nursing*, 2012, <https://doi.org/10.1111/j.1365-2648.2012.05998.x>

<sup>51</sup> Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, et al. “Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes,” *Plos One*, February 21, 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6509022/>

<sup>52</sup> Jeremy L. Neal, Nicole S. Carlson, Julia C. Phillippi, Ellen L. Tilden, Denise C. Smith, Rachel B. Breman, Mary S. Dietrich, et al. “Midwifery Presence in United States Medical Centers and Labor Care and Birth Outcomes Among Low-Risk Nulliparous Women: A Consortium on Safe Labor Study,” *Birth*, 2019, <https://doi.org/10.1111/birt.12407>; Carlson N.S., J.L. Neal, E.L. Tilden, et al. “Influence of Midwifery Presence in United States Centers on Labor Care and Outcomes of Low-Risk Parous Women: A Consortium on Safe Labor Study,” *Birth*, 2019, <https://doi.org/10.1111/birt.12405>; Lisbet S. Lundsberg, Elliott K. Main, Henry C. Lee, Haiqun Lin, Jessica L. Illuzzi, and Xiao Xu. “Low-Interventional Approaches to Intrapartum Care: Hospital Variation in Practice and Associated Factors,” *Journal of Midwifery and Women’s Health*, 2020, <https://doi.org/10.1111/jmwh.13017>

<sup>53</sup> Laura Attanasio and Katy B. Kozhimannil. “Relationship Between Hospital-Level Percentage of Midwife-Attended Births and Obstetric Procedure Utilization,” *Journal of Midwifery & Women’s Health*, November 16, 2017, <https://doi.org/10.1111/jmwh.12702>

<sup>54</sup> Jesse S. Bushman. “The Role of Certified Nurse-Midwives and Certified Midwives in Ensuring Women’s Access to Skilled Maternity Care,” *American College of Nurse-Midwives*, November 2015, [https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKewi\\_1P-ck6vrAhXl3IEHYjWBJUQFjABegQIARAC&url=http%3A%2F%2Fwww.midwife.org%2Facnm%2Ffiles%2FclibraryFiles%2Ffilename%2F000000005794%2FMaternityCareWorkforce-11-18-15.pptx&usg=AOvVaw2eGIDudt-voBqk65Yy\\_C\\_V](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKewi_1P-ck6vrAhXl3IEHYjWBJUQFjABegQIARAC&url=http%3A%2F%2Fwww.midwife.org%2Facnm%2Ffiles%2FclibraryFiles%2Ffilename%2F000000005794%2FMaternityCareWorkforce-11-18-15.pptx&usg=AOvVaw2eGIDudt-voBqk65Yy_C_V)

<sup>55</sup> Mercy Birthing Center Midwifery Care, accessed August 24, 2020, <https://www.mercy.net/practice/mercy-birthing-center-midwifery-care-st-louis/#>

<sup>56</sup> *Ibid.*

<sup>57</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>58</sup> American College of Obstetricians and Gynecologists. "Practice Bulletin No. 184 Summary: Vaginal Birth After Cesarean Delivery," *Obstetrics & Gynecology*, November 2017, <https://doi.org/10.1097/AOG.0000000000002392>

<sup>59</sup> "Report on Results of the 2018 Leapfrog Hospital Survey," Leapfrog Group, 2019, [https://www.leapfroggroup.org/sites/default/files/Files/MaternityCare\\_Report\\_PDF\\_0.pdf](https://www.leapfroggroup.org/sites/default/files/Files/MaternityCare_Report_PDF_0.pdf)

<sup>60</sup> *National Vital Statistics Reports*. "Births: Final Data for 2018," November 27, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_13\\_tables-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf)

<sup>61</sup> *Ibid.*

<sup>62</sup> Carol Sakala, Eugene R. Declercq, Jessica M. Turon, and Maureen P. Corry. "Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences," National Partnership for Women & Families, 2018, <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>

<sup>63</sup> Rose L. Molina, Suha J. Patel, Jennifer Scott, Julianna Schantz-Dunn, and Nawal M. Nour. "Striving for Respectful Maternity Care Everywhere," *Maternal Child Health Journal*, September 2016, [doi.org/10.1007/s10995-016-2004-2](https://doi.org/10.1007/s10995-016-2004-2)

<sup>64</sup> J. Sandall, H. Soltani, S. Gates, A. Shennan, and D. Devane. "Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women," *Cochrane Database of Systematic Reviews*, 2016, <https://doi.org/10.1002/14651858.CD004667.pub5>; Katy Sutcliffe, Jenny Caird, Josephine Kavanaugh, Rebecca Rees, Kathryn Oliver, Kelly Dickson, Jenny Woodman, et al. "Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews," *Journal of Advanced Nursing*, 2012, <https://doi.org/10.1111/j.1365-2648.2012.05998.x>

<sup>65</sup> J. Almanza, J. Karbeah, K.B. Kozhimannil, and R. Hardeman. "The Experience and Motivations of Midwives of Color in Minnesota: Nothing for Us without Us," *Journal of Midwifery & Women's Health*, 2019, <https://doi.org/10.1111/jmwh.13021>; L. Guerra-Reyes and L.J. Hamilton. "Racial Disparities in Birth Care: Exploring the Perceived Role of African-American Women Providing Midwifery Care and Birth Support in the United States," *Women and Birth*, 2017, <https://doi.org/10.1016/j.wombi.2016.06.004>

<sup>66</sup> Jyeshtha Wren Serbin and Elizabeth Donnelly. "The Impact of Racism and Midwifery's Lack of Racial Diversity: A Literature Review," *Journal of Midwifery & Women's Health*, December 7, 2016, <https://doi.org/10.1111/jmwh.12572>

<sup>67</sup> Carol Sakala, Eugene R. Declercq, Jessica M. Turon, and Maureen P. Corry. "Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences," National Partnership for Women & Families, 2018, <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>

<sup>68</sup> March of Dimes. "Nowhere to Go: Maternity Care Deserts Across the U.S.," 2018, [https://www.marchofdimes.org/materials/Nowhere\\_to\\_Go\\_Final.pdf](https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf)

<sup>69</sup> William F. Rayburn, *The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications* (Washington, D.C.: American Congress of Obstetricians and Gynecologists, 2017), [https://books.google.com/books/about/The\\_Obstetrician\\_gynecologist\\_Workforce.html?id=cEMdtAEACAAJ](https://books.google.com/books/about/The_Obstetrician_gynecologist_Workforce.html?id=cEMdtAEACAAJ)

<sup>70</sup> H.P. Kennedy, J.A. Myers-Ciecko, K.C. Carr, et al. "United States Model Midwifery Legislation and Regulation: Development of a Consensus Document," *Journal of Midwifery & Women's Health*, 2018, <https://doi.org/10.1111/jmwh.12727>

<sup>71</sup> American College of Nurse-Midwives. "Midwifery and Addressing the Shortage of Maternal Care Providers," accessed August 25, 2020, <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005444/MidwiferyAndShortages2.pdf>

<sup>72</sup> —. “Medicaid Fee-for-Service Reimbursement Rates for CNMs and CMs as of September 2013,” 2012, <https://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000003389/091713%20ACNM%20Compilation%20Medicaid%20Fee%20for%20Service%20Rates.pdf>

<sup>73</sup> —. “Variations in 2015 Medicaid CNM/CM Reimbursement for Normal Vaginal Delivery (CPT 59400): How Attractive Is Your State to These High Value Providers?” accessed August 25, 2020, <https://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005129/MedicaidPayment-CPT59400.pdf>

<sup>74</sup> Y. Tony Yang and Katy B. Kozhimannil. “Making a Case to Reduce Legal Impediments to Midwifery Practice in the United States,” *Women’s Health Issues*, 2015, <https://doi.org/10.1016/j.whi.2015.03.006>; Y. Tony Yang, Laura B. Attanasio, and Katy B. Kozhimannil. “State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes,” *Women’s Health Issues*, 2016, <https://doi.org/10.1016/j.whi.2016.02.003>

<sup>75</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>.

<sup>76</sup> *Ibid.*

<sup>77</sup> J. Karbeah, R. Hardeman, J. Almanza, and K.B. Kozhimannil. “Identifying the Key Elements of Racially Concordant Care in a Freestanding Birth Center,” *Journal of Midwifery & Women’s Health*, 2019, <https://doi.org/10.1111/jmwh.13018>

<sup>78</sup> *National Vital Statistics Reports*. “Births: Final Data for 2018,” November 27, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_13\\_tables-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf)

<sup>79</sup> M.F. MacDorman and E. Declercq. “Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017,” *Birth*, 2019, <https://doi.org/10.1111/birt.12411>

<sup>80</sup> *Ibid.*

<sup>81</sup> K.B. Kozhimannil, P. Hung, C. Henning-Smith, M.M. Casey, and S. Prasad. “Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States,” *JAMA*, 2018, <https://doi.org/10.1001/jama.2018.1830>

<sup>82</sup> Robbie Davis-Floyd, Kim Gutschow, and David A Schwartz “Pregnancy, Birth and the COVID-19 Pandemic in the United States,” *Medical Anthropology*, May 14, 2020, <https://doi.org/10.1080/01459740.2020.1761804>

<sup>83</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>.

<sup>84</sup> J. Henderson and S. Petrou. “Economic Implications of Home Births and Birth Centers: A Structured Review,” *Birth*, 2008, <https://doi.org/10.1111/j.1523-536X.2008.00227.x>

<sup>85</sup> Jill Alliman and Julia C. Phillippi. “Maternal Outcomes in Birth Centers: An Integrative Review of the Literature,” *Journal of Midwifery & Women’s Health*, January/February 2016, <https://doi.org/10.1111/jmwh.12356>

<sup>86</sup> *Ibid.*

<sup>87</sup> Julia C. Phillippi, Kathleen Danhausen, Jill Alliman, and R. David Phillippi. “Neonatal Outcomes in the Birth Center Setting: A Systematic Review,” *Journal of Midwifery & Women’s Health*, February 8, 2018, <https://doi.org/10.1111/jmwh.12701>

<sup>88</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>89</sup> A. Reitsma, J. Simioni, G. Brunton K. Kaufman, and E.K. Hutton. “Maternal Outcomes and Birth Interventions among Women Who Begin Labour Intending 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,” *EclinicalMedicine*, 2020, <https://doi.org/10.1016/j.eclinm.2020.100319>

<sup>90</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>91</sup> E.K. Hutton, A. Reitsma, J. Simioni, G. Brunton, and K. Kaufman. "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," *EClinicalMedicine*, 2019, <https://doi.org/10.1016/j.eclinm.2019.07.005>

<sup>92</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, DC: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>93</sup> *Ibid.*

<sup>94</sup> Home Birth Summit. "Best Practice Guidelines: Transfer from Planned Home Birth to Hospital," accessed August 25, 2020, <https://www.homebirthsummit.org/best-practice-transfer-guidelines/>

<sup>95</sup> Dorothy Shaw, Jeanne-Marie Guise, Neel Shah, Kristina Gemzell-Danielsson, K.S. Joseph, Barbara Levy, Fontayne Wong, *et al.* "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centered Care?" *The Lancet*, November 5, 2016, [https://doi.org/10.1016/S0140-6736\(16\)31527-6](https://doi.org/10.1016/S0140-6736(16)31527-6)

<sup>96</sup> Centers for Medicare & Medicaid Services. "Strong Start for Mothers and Newborns Initiative: General Information," accessed August 25, 2020, <https://innovation.cms.gov/innovation-models/strong-start>

<sup>97</sup> Lisa Dubay, Ian Hill, Bowen Garrett, Frederic Blavin, Emily Johnston, Embry Howell, Justin Morgan, *et al.* "Improving Birth Outcomes and Lowering Costs for Women on Medicaid: Impacts of 'Strong Start for Mothers and Newborns,'" *Health Affairs*, 2020, <https://doi.org/10.1377/hlthaff.2019.01042>

<sup>98</sup> Angela Reitsma, Julia Simioni, Ginny Brunton, Karyn Kaufman, and Eileen K. Hutton. "Maternal Outcomes and Birth Interventions among women who begin

labour intending 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," *EClinicalMedicine*, April 5, 2020, <https://doi.org/10.1016/j.eclinm.2020.100319>

<sup>99</sup> Susan Stapleton, Jennifer Wright, and Diana R. Jolles. "Improving the Experience of Care: Results of the American Association of Birth Centers Strong Start Client Experience of Care Registry Pilot Program, 2015-2016," *The Journal of Perinatal & Neonatal Nursing*, January/March 2020, <https://doi.org/10.1097/JPN.0000000000000454>

<sup>100</sup> Joyce A. Martin, Brady E. Hamilton, Michelle J.K. Osterman, and Anne K. Driscoll. "Births: Final Data for 2018," *National Vital Statistics Reports*, November 27, 2019, [https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_13-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf)

<sup>101</sup> Jill Alliman and Julia C. Phillippi. "Maternal Outcomes in Birth Centers: An Integrative Review of the Literature," *Journal of Midwifery & Women's Health*, 2016, <https://doi.org/10.1111/jmwh.12356>

<sup>102</sup> Kelly Ackerson, Lisa Kane Low, and Ruth Zielinski. "Planned Home Birth: Benefits, Risks, and Opportunities," *International Journal of Women's Health*, April 8, 2015, <https://doi.org/10.2147/IJWH.S55561>

<sup>103</sup> J. Karbeah, R. Hardeman, J. Almanza, and K.B. Kozhimannil. "Identifying the Key Elements of Racially Concordant Care in a Freestanding Birth Center," *Journal of Midwifery & Women's Health*, 2019, <https://pubmed.ncbi.nlm.nih.gov/31373434/>

<sup>104</sup> National Academies of Sciences, Engineering, and Medicine. *Birth Settings in America: Outcomes, Quality, Access, and Choice*. (Washington, D.C.: The National Academies Press, 2020), <https://doi.org/10.17226/25636>

<sup>105</sup> *Ibid.*

<sup>106</sup> *Ibid.*

<sup>107</sup> Women's Health Policy. "Medicaid's Role for Women," March 28, 2019, <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>

<sup>108</sup> Jill Alliman and Kate Bauer. “Next Steps for Transforming Maternity Care: What Strong Start Birth Center Outcomes Tell Us,” *Journal of Midwifery & Women’s Health*, April 11, 2020, <https://doi.org/10.1111/jmwh.13084>

<sup>109</sup> Carol Sakala, Eugene R. Declercq, Jessica M. Turon, and Maureen P. Corry. “Listening to Mothers in California: A Population-Based Survey of Women’s Childbearing Experiences,” National Partnership for Women & Families, 2018, <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>

<sup>110</sup> Hannah G. Dahlen. “Is it Time to Ask Whether Facility Based Birth Is Safe for Low Risk Women and Their Babies?” *EClinicalMedicine*, September 1, 2019, <https://doi.org/10.1016/j.eclinm.2019.08.003>.

<sup>111</sup> M.A. Bohren, B.O. Berger, H. Munthe-Kaas, and Ö. Tunçalp. “Perceptions and Experiences of Labour Companionship: A Qualitative Evidence Synthesis. *Cochrane Database of Systematic Reviews*, 2019, <https://doi.org/10.1002/14651858.CD012449.pub2>

<sup>112</sup> *Ibid.*

<sup>113</sup> National Health Law Program. “Doula Medicaid Project,” accessed August 31, 2020, <https://healthlaw.org/doulamedicaidproject/>

<sup>114</sup> National Partnership for Women & Families. “Federal Legislation to Improve Maternal Health,” July 16, 2020, <https://www.nationalpartnership.org/our-work/health/federal-legislation-to-improve-maternal-health.html>

<sup>115</sup> M.A. Bohren, G.J. Hofmeyr, C. Sakala, R.K. Fukuzawa, and A. Cuthbert. “Continuous Support for Women During Childbirth. *Cochrane Database of Systematic Reviews*, 2017, <https://doi.org/10.1002/14651858.CD003766.pub6>

<sup>116</sup> *Ibid.*

<sup>117</sup> *Ibid.*

<sup>118</sup> Katy B. Kozhimannil, Laura B. Attanasio, Rachel R. Hardeman, and Michelle O’Brien. “Doula Care Supports Near-Universal Breastfeeding Initiation Among Diverse, Low-Income Women,” *Journal of Midwifery & Women’s*

*Health*, July–August 2013, <https://doi.org/10.1111/jmwh.12065>; Katy B. Kozhimannil, Rachel R. Hardeman, Fernando Alarid-Escudero, Carrie A. Vogelsang, Cori Blauer-Peterson, and Elizabeth A. Howell. “Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery,” *Birth*, March 2016, <https://doi.org/10.1111/birt.12218>; Renee C. Edwards, Matthew J. Thullen, Jon Korfmacher, John D. Lantos, Linda G. Henson, and Sydney L. Hans. “Breastfeeding and Complementary Food: Randomized Trial of Community Doula Home Visiting,” *Pediatrics*, November 2013, <https://doi.org/10.1542/peds.2013-1021P>

<sup>119</sup> Katy B. Kozhimannil, Rachel R. Hardeman, Fernando Alarid-Escudero, Carrie A. Vogelsang, Cori Blauer-Peterson, and Elizabeth A. Howell. “Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery,” *Birth*, March 2016, <https://doi.org/10.1111/birt.12218>; Katy Backes Kozhimannil, Rachel R. Hardeman, Laura B. Attanasio, Cori Blauer-Peterson, and Michelle O’Brien. “Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries,” *American Journal of Public Health*, April 2013, <https://doi.org/10.2105/AJPH.2012.301201>; Will Chapple, Amy Gilliland, Dongmei Li, Emily Shier, and Emily Wright. “An Economic Model of the Benefits of Professional Doula Labor Support in Wisconsin Births,” *WMJ*, April 2013, <https://wmjonline.org/wp-content/uploads/2013/112/2/58.pdf>; Karen S. Greiner, Alyssa R. Hersh, Sally R. Hersh, Jesse M. Remer, Alexandra C. Gallagher, Aaron B. Caughey, and Ellen L. Tilden. “The Cost-Effectiveness of Professional Doula Care for a Woman’s First Two Births: A Decision Analysis Model,” *Journal of Midwifery & Women’s Health*, July 2019, <https://doi.org/10.1111/jmwh.12972>.

<sup>120</sup> Open Arms Perinatal Services. “About Us,” accessed August 25, 2020, <https://www.openarmsps.org/about-us/>

<sup>121</sup> —. “Community-Based Outreach Doula Program,” June 2017, <https://www.openarmsps.org/wp-content/uploads/2017/09/Open-Arms-Outcome-Evaluation-June-2017.pdf>

<sup>122</sup> Meghan A. Bohren, Blair O. Berger, Heather Munthe-Kaas, Özge Tunçalp, and Cochrane Effective Practice and Organisation of Care Group. “Perceptions and Experiences of Labour Companionship: A Qualitative Evidence Synthesis,” *Cochrane Database of Systematic Reviews*, March 2019, <https://doi.org/10.1002/14651858.CD012449.pub2>

<sup>123</sup> Mary-Powel Thomas, Gabriela Ammann, Ellen Brazier, Philip Noyes, and Aletha Maybank. “Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population,” *Maternal and Child Health Journal*, December 2, 2017, <https://doi.org/10.1007/s10995-017-2402-0>

<sup>124</sup> Ginger Breedlove. “Perceptions of Social Support from Pregnant and Parenting Teens Using Community-Based Doulas,” *The Journal of Perinatal Education*, Summer 2005, <https://doi.org/10.1624/105812405X44691>.

<sup>125</sup> Lynn Deitrick and Patrick Draves. “Attitudes towards Doula Support during Pregnancy by Clients, Doulas, and Labor-and-Delivery Nurses: A Case Study from Tampa, Florida,” *Human Organization*, Winter 2008, <https://www.jstor.org/stable/44127804>

<sup>126</sup> Rachel R. Hardeman and Katy B. Kozhimannil. “Motivations for Entering the Doula Profession: Perspectives from Women of Color,” *Journal of Midwifery & Women’s Health*, November 14, 2016, <https://doi.org/10.1111/jmwh.12497>; Sarah Ireland, Ruth Montgomery-Andersen, and Sadie Geraghty. “Indigenous Doulas: A Literature Review Exploring Their Role and Practice in Western Maternity Care,” *Midwifery*, August 2019, <https://doi.org/10.1016/j.midw.2019.04.005>

<sup>127</sup> Kristina Wint, Thistle I. Elias, Gabriella Mendez, Dara D. Mendez, and Tiffany L. Gary-Webb. “Experiences of Community Doulas Working with Low-Income, African American Mothers,” *Health Equity*, April 8, 2019, <https://doi.org/10.1089/heq.2018.0045>

<sup>128</sup> Katy B. Kozhimannil, Carrie A. Vogelsang, Rachel R. Hardeman, and Shailendra Prasad. “Disrupting the Pathways of Social Determinants of Health: Doula Support during Pregnancy and Childbirth,” *Journal of the American Board of Family Medicine*, May-June 2016, <https://www.jabfm.org/content/jabfp/29/3/308.full.pdf>

<sup>129</sup> E.R. Declercq, C. Sakala, M.P. Corry, S. Applebaum, and A. Herrlich. *Listening to Mothers III: Pregnancy and Birth*, (New York: Childbirth Connection, 2013), <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-major-findings.pdf>

<sup>130</sup> Carol Sakala, Eugene R. Declercq, Jessica M. Turon, and Maureen P. Corry. “Listening to Mothers in California: A Population-Based Survey of Women’s Childbearing Experiences,” National Partnership for Women & Families, 2018, <https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf>

<sup>131</sup> Lisa Speckhard Pasque. “Latina Health Cooperative Offers Maternal Health Care and More to Madison Spanish-Speakers,” *The Capital Times*, July 10, 2019, [https://madison.com/ct/news/local/neighborhoods/latina-health-cooperative-offers-maternal-health-care-and-more-to-madison-spanish-speakers/article\\_94d0aaf7-4ec3-5e19-ab80-1ccbc96d7469.html](https://madison.com/ct/news/local/neighborhoods/latina-health-cooperative-offers-maternal-health-care-and-more-to-madison-spanish-speakers/article_94d0aaf7-4ec3-5e19-ab80-1ccbc96d7469.html); Xander Negozio. “Missouri’s First Black Midwife Advocates for Accessible Maternal Care,” *The St. Louis American*, October 15, 2019, [http://www.stlamerican.com/your-health-matters/health-news/missouri-s-first-black-midwife-advocates-for-accessible-maternal-care/article\\_bc78e6a6-ef7b-11e9-9995-570a33891796.html](http://www.stlamerican.com/your-health-matters/health-news/missouri-s-first-black-midwife-advocates-for-accessible-maternal-care/article_bc78e6a6-ef7b-11e9-9995-570a33891796.html)

<sup>132</sup> Groundswell Fund. “Birth Justice Fund Docket 2019,” <https://groundswellfund.org/birth-justice-fund/>

<sup>133</sup> National Partnership for Women & Families. “Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches,” 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

<sup>134</sup> *Ibid.*

<sup>135</sup> *Ibid.*

<sup>136</sup> *Ibid.*

<sup>137</sup> Commonsense Childbirth Institute. “The Commonsense Childbirth Institute Utilizes The JJ Way® Model, Designed by Jennie Joseph, Throughout Its Entire Curriculum,” accessed August 25, 2020, <https://savinglives.biz/the-jj-way/>

<sup>138</sup> Visionary Vanguard Group. “The JJ Way®: Community-Based Maternity Center,” 2017, <https://secureservercdn.net/198.71.233.109/f3b.e30.myftpupload.com/wp-content/uploads/2019/07/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf>

<sup>139</sup> National Partnership for Women & Families. “Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches,” 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

<sup>140</sup> Commonsense Childbirth Institute. “The Perinatal Task Force,” accessed August 25, 2020, <https://perinataltaskforce.com/>

<sup>141</sup> Visionary Vanguard Group. “The JJ Way®: Community-Based Maternity Center,” 2017, <https://secureservercdn.net/198.71.233.109/f3b.e30.myftpupload.com/wp-content/uploads/2019/07/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf>

<sup>142</sup> *Ibid.*

<sup>143</sup> National Partnership for Women & Families. “Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches,” 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

<sup>144</sup> Commonsense Childbirth. “Commonsense Childbirth School of Midwifery,” accessed August 25, 2020, <https://commonsensemidsifery.org/>; Commonsense Childbirth. “Certified Childbirth Consultant (CCC),” accessed August 25, 2020, <https://savinglives.biz/certified-childbirth-consultant-ccc/>

<sup>145</sup> National Partnership for Women & Families. “Tackling Maternal Health Disparities: A Look at Four Local Organizations with Innovative Approaches,” 2019, <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/tackling-maternal-health-disparities-a-look-at-four-local-organizations-with-innovative-approaches.pdf>

<sup>146</sup> Hannah G. Dahlen. “Is it Time to Ask Whether Facility Based Birth Is Safe for Low Risk Women and Their Babies?” *EclinicalMedicine*, September 1, 2019, <https://doi.org/10.1016/j.eclinm.2019.08.003>







THE EVIDENCE IS CLEAR:  
MOMS AND BABIES WILL  
BE HEALTHIER IF MORE  
FAMILIES CAN HAVE ACCESS  
TO MIDWIVES, DOULAS,  
COMMUNITY-LED PERINATAL  
HEALTH GROUPS, AND BIRTH  
IN COMMUNITY SETTINGS.







1875 Connecticut Ave. NW, Suite 650  
Washington, DC 20009  
[nationalpartnership.org](http://nationalpartnership.org)