



# Community-Based Doulas and Midwives

Key to Addressing the U.S. Maternal Health Crisis

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By Nora Ellmann    April 2020

Center for American Progress



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# Contents

- 1 Introduction and summary**
- 5 Methodology**
- 7 The role of community-based doulas and midwives in improving maternal health outcomes**
- 9 The recentering of community and humanity in pregnancy-related care**
- 15 Integration in the health care system and the role of government**
- 21 Policy recommendations**
- 27 Conclusion**
- 28 About the author and acknowledgements**
- 29 Endnotes**

# Introduction and summary

The United States is facing a maternal and infant health crisis fueled by structural racism that drives significant racial disparities in maternal and infant morbidity and mortality. Particularly affected are Black and Indigenous birthing people:<sup>1</sup> Black women and American Indian/Alaska Native women are three to four times more likely than non-Hispanic white women to die from pregnancy-related causes—during pregnancy, birth, and up to one year postpartum.<sup>2</sup> What’s more, Black women are twice as likely as non-Hispanic white women to experience severe maternal morbidity, or life-threatening pregnancy-related complications, which affect 50,000 women in the United States each year.<sup>3</sup> While the data are mixed around maternal health outcomes for Hispanic women, studies show that particular subgroups of Hispanic women, including Puerto Rican women, experience higher rates of maternal mortality compared with non-Hispanic white women.<sup>4</sup> Studies also show higher rates of severe maternal morbidity for Hispanic women compared with non-Hispanic white women.<sup>5</sup>

Racism is the driving force of disparities in maternal mortality. Income and education level are not protective factors when it comes to these disparities in maternal health outcomes, further reinforcing the central role of racism in these trends.<sup>6</sup> And while there is a severe lack of data around the experiences and outcomes of LGBTQ birthing people, particularly for transgender individuals, the discrimination faced by these communities in accessing pregnancy-related care, and health care more broadly, is well documented.<sup>7</sup>

Now, the coronavirus pandemic has thrown the shortcomings of the U.S. health care system into stark reality. The compounding public health crises of the coronavirus and racial disparities in maternal mortality only exacerbate the strain on the health care system and the risks for those most vulnerable, particularly women of color. Pregnancy and birth do not stop during a pandemic, and neither does the maternal health crisis. Solutions put forth to reduce disparities in maternal health outcomes and improve experiences of birthing people from the communities disproportionately affected by the maternal health crisis include, but are not limited to, increasing access to doulas and midwives. Doulas and midwives are also key to supporting pregnant people and relieving the strain on the medical system during this pandemic.

## What are doulas and midwives?

**Doulas** are nonclinical birth workers who are trained to provide physical, emotional, and informational support to pregnant people in the prenatal, birth, and postpartum periods.<sup>8</sup> For example, doulas may help create birth plans, advocate for pregnant people during prenatal appointments, and provide support such as breath work and massage during labor.

**Midwives** are trained birth workers who provide care during the prenatal, birth, and postpartum periods.<sup>9</sup> Midwives may be trained to practice in birthing centers or home births without the presence of physicians, or in hospitals alongside physicians.<sup>10</sup> The care that midwives provide includes prenatal care, support throughout labor, delivery of the infant, and postpartum care for birthing people and infants—similar to the care that a physician would provide for a normal, low-risk pregnancy and birth.

Measures to protect individual and public health during the coronavirus pandemic must not come at the cost of maternal health, particularly for Black and Indigenous women, who are most at risk for maternal mortality and morbidity. In fact, the COVID-19 crisis further elucidates the need for a range of accessible, affordable options for pregnancy and birth support—and the fundamental problems with a system of pregnancy-related care that defaults to birth in places designed to treat illness.<sup>11</sup> Many pregnant people are considering changing their birth plans to give birth at home with a midwife and avoid hospitals.<sup>12</sup> This trend is not unique to the current crisis: During prior public health crises, including the SARS and H1N1, or swine flu, outbreaks, as well as in the aftermath of Hurricane Katrina, demand for home births and midwifery rose, making the value of such care all the more clear.<sup>13</sup>

The spread of COVID-19 emphasizes the need for this option, keeping pregnant people safe and reducing the burden on overwhelmed hospital systems. Yet restrictions on home births and midwives' ability to legally practice with autonomy, as well as a lack of sufficient insurance reimbursement and Medicaid coverage, put midwifery care out of reach for many birthing people, particularly low-income people and people of color, who are most at risk for poor maternal health outcomes. In addition, a lack of integration of midwifery into the health care system creates challenges for collaboration with hospitals to identify good candidates for midwifery care and facilitate smooth transfers if medical intervention is needed.

The support of a midwife or doula is seen by some as a luxury reserved for wealthier white women, and it is often true that their services are inaccessible for low-income people and people of color. Yet doulas and midwives of color and those who are LGBTQ,

as well as many from low-income communities, are leading the work to provide access to culturally competent prenatal, birth, and postpartum care and support for their communities. Expanding access to midwives and doulas, especially those who are part of the communities they support, can significantly improve the health and birthing outcomes and experiences of people of color and LGBTQ people. The spread of COVID-19 only amplifies the importance of their support and care.

Both midwives and doulas are associated with improved maternal health outcomes and lower rates of medical intervention in birth.<sup>14</sup> Doulas provide critical advocacy and support, especially for those at risk of bias and discrimination—including people of color and LGBTQ people. Hospitals and policymakers must balance the need to limit the spread of COVID-19 with the vital role doulas play in birthing people’s physical and mental health.<sup>15</sup>

As policymakers bring increased focus on the role of doulas and midwives in improving maternal health outcomes, this report seeks to share the experience and views of the people doing the work. This report is informed by interviews with doulas and midwives who are predominantly Black, Latinx, Indigenous, and LGBTQ and who serve the communities they represent. These interviews shine a light on the roles these doulas and midwives play in their communities; the challenges they and the birthing people they work with face; what they want, if anything, in terms of regulation and integration in the health care system; and their visions for pregnancy, birth, and postpartum care for their communities and for the country at large. These interviews do not represent the opinions of all community-based doulas and midwives, but the report aims to offer policy recommendations informed by the people who are leading the work in this field and who are directly affected.

This report presents key perspectives and lessons learned along with policy recommendations for state- and federal-level actions that center the work of doulas and midwives in addressing the nation’s maternal health crisis. These lessons and recommendations are particularly crucial now to support birthing people amid the ongoing coronavirus pandemic.

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## Key findings

Community-based doulas and midwives, while not the lone solution to the maternal health crisis, have crucial roles to play in improving outcomes and experiences for communities most affected by discrimination and disparities in health outcomes. The information and perspectives shared by the doulas and midwives interviewed for this report

fall under three main areas: the role and importance of community-based birth workers and the recentering of community and humanity in pregnancy-related care; guidelines for health care system integration and the role of government; and the creation of a progressive vision for pregnancy-related care in the United States. Under each issue area, those interviewed outlined the following principles as being critical to their role and to addressing the maternal health crisis more broadly:

1. The recentering of community and humanity in pregnancy-related care
  - Interrupt the harm to birthing people, particularly those from vulnerable communities, from exploitation, exclusion, discrimination, and a loss of autonomy in the medical system.
  - Build power and autonomy through relationships of trust and restoring community birthing knowledge.
  - Center the whole person in pregnancy-related care through wraparound support during the prenatal and postpartum periods.
  
2. Guidelines to successfully integrate doulas and midwives into the health care system and the role of government
  - Ensure provider education that includes a focus on racism and bias along with collaboration and respect for the work of doulas and midwives.
  - Reframe birth as not an inherently medical procedure.
  - Establish policies that support existing community-based organizations and birth workers already doing the work; include birth workers of color; value traditional birth knowledge; and preserve the autonomy of midwives and doulas.
  
3. Policy recommendations to achieve a progressive vision for pregnancy-related care
  - Provide patient- and community-centered care with access to a range of birth options, including midwifery and doula care, that are affordable and ensure a living wage for doulas and midwives.
  - Protect the autonomy and self-determination of both pregnant people and birth workers.

# Methodology

The interviews included in this report were conducted in February and March 2020 via phone, email, video conference, and in person. The interviewees are midwives and doulas who provide community-based care for the communities most affected by the maternal health crisis and discrimination in the health care system, particularly the Black, Indigenous, Latinx, and LGBTQ communities.

The midwives and doulas interviewed include: Alexis Hall, doula and birth companion at Mama Sana Vibrant Woman; Amy Ard, doula and executive director at Motherhood Beyond Bars; Ashley Hill Hamilton, doula at the Birthmark Doula Collective; Brittany “Tru” Kellman, certified professional midwife (CPM), doula, founder, and executive director at Jamaa Birth Village; Chanel Porchia-Albert, doula, founder, and executive director at Ancient Song Doula Services; Corinne Westing, certified nurse midwife, home birth midwife, and member of the Queer and Transgender Midwives Association; Elena Colón, birth companion (doula) and student-midwife at Mama Sana Vibrant Woman, and director at the Queer and Transgender Midwives Association; Jennie Joseph, midwife, founder, and executive director at Commonsense Childbirth Inc.; Jeretha McKinley, interim executive director at Health Connect One; Kortney Lapeyrolerie, co-founder at the Queer Doula Network; Lina Garcia, midwife at the Luna Tierra Casa de Partos; Ray Rachlin, CPM and member of the Queer and Transgender Midwives Association; and Steph McCreary, Yiya Vi Kagingdi doula project coordinator at Tewa Women United.

The interviews and quotes throughout this report have been edited for clarity.

## Background: Racism in the U.S. maternal health care system

Historically, structural racism has abounded in the foundation of the gynecological profession, which was built on nonconsensual experimentation on enslaved Black women<sup>16</sup> and sterilization campaigns and medical experimentation on Black, Native, and Latina women.<sup>17</sup> For centuries, pregnancy-related care in the United States was the purview of midwives, particularly Black midwives and Indigenous birth workers.<sup>18</sup> And before the term “doula” became widely used, family and community members commonly provided the physical and emotional support that today’s doulas offer during pregnancy and birth.<sup>19</sup> However, in the early- to mid-20th century, physicians used racist and misogynist attacks to paint Black “granny midwives” as unclean and uneducated and to scapegoat them as responsible for maternal and infant death.<sup>20</sup> These campaigns were used to shift control of birth from community-based and traditionally trained women of color into the power of the white-male-dominated medical profession.<sup>21</sup> They accompanied legislation, including the 1921 Sheppard-Towner Act, that targeted Black midwives and created regulatory barriers for education and licensure that effectively pushed

out out-of-hospital midwives and those without institutionalized training.<sup>22</sup> By 1975, less than 1 percent of births took place with a midwife outside of a hospital.<sup>23</sup>

Discrimination is deeply rooted in the health care system, and particularly in the medicalized birth system—the prevailing system of pregnancy-related care in the United States in which medical intervention in pregnancy and birth is the norm, and birth is seen as a medical procedure that takes place in clinical and hospital settings controlled by physicians.<sup>24</sup> People of color, particularly Black and Indigenous birthing people, experience bias and mistreatment in maternity care;<sup>25</sup> have their pain and autonomy ignored;<sup>26</sup> and are stripped of their traditional communal birthing knowledge.<sup>27</sup> LGBTQ people, especially transgender people, are misgendered, mistreated, and denied health care outright.<sup>28</sup> Structural racism, as well as homophobia and transphobia, embedded in systems such as housing, employment, and education, act as social determinants of health: conditions that affect people’s health and quality of life in a given environment.<sup>29</sup>

# The role of community-based doulas and midwives in improving maternal health outcomes

Doulas and midwives have gained particular attention for their role in improving maternal and infant health outcomes, as well as the experiences of pregnancy, birth, and postpartum, and in challenging what some see as the overmedicalization of birth in the United States. Many community members, policymakers, midwives, doulas, and other people focused on addressing the maternal health crisis are calling for expanded training of and access to community-based doulas and midwives—birth workers who are trusted members of the communities they serve and provide care responsive to the specific needs of their community, often at low or no cost.<sup>30</sup> Community-based birth workers have the unique capacity to challenge bias in the medicalized birth system and undo the exclusion of traditional, community-centered practices around pregnancy and birth.

These views are supported by a growing body of evidence that clearly demonstrates that both midwifery and doula support improve maternal and infant health outcomes. Multiple studies have found better outcomes for birthing people who have doula support, including lower rates of maternal and infant health complications; lower rates of preterm birth and low birth weight infants; lower rates of cesarean sections (C-sections), which are associated with higher rates of maternal mortality and severe maternal morbidity,<sup>31</sup> and other medical interventions; and higher rates of breastfeeding.<sup>32</sup> In addition to improved physical health outcomes, doula support is linked to reduced rates of postpartum depression and anxiety as well as increased positive feelings about the birth experience and ability to influence one's own pregnancy outcomes.<sup>33</sup> Research also backs doula support as a cost-saving measure in maternity care. In one study, doula support in the United States was associated with Medicaid expenditure savings averaging around \$1,000 per birth.<sup>34</sup> Such cost savings can be particularly important given that birth is more expensive in the United States than anywhere else in the world: The average out-of-pocket cost for birth is \$4,500 for those with insurance and \$30,000 for those without insurance.<sup>35</sup> In other countries, such as the Netherlands and Finland, childbirth costs are much lower, and insurance typically covers most if not all of the cost, creating a reduced financial burden for families.<sup>36</sup>

A study mapping midwifery integration into the health care system across the United States found that increased access to midwives and a higher density of midwives in a state were associated with improved maternal and infant health outcomes.<sup>37</sup> These include higher rates of vaginal delivery and vaginal delivery after C-section; higher rates of breastfeeding; lower rates of C-sections; low rates of preterm births, low birth weight infants, and neonatal deaths; and fewer obstetric interventions.<sup>38</sup> The study also found that states with the least integration of midwives and least access to midwives and community birth saw the highest rates of neonatal mortality.<sup>39</sup> These states also had the highest rates of Black births, meaning that Black families overall have less access to the benefits of midwifery.<sup>40</sup> Additional studies confirm that midwifery care is associated with decreased rates of C-sections and medical interventions in low-risk pregnancies.<sup>41</sup>

Despite this evidence-based support for increased access to community-based birth workers, doulas and midwives face significant barriers to practice, and birthing people, particularly those who are low income and people of color, face barriers in accessing their services. Among those barriers, which the author will explore further later in the report, are a lack of knowledge about midwives' and doulas' services; lack of support and integration in the health care system; barriers to insurance coverage and reimbursement at a living wage; and a patchwork of regulations creating a varied and often extremely restrictive environment in which to practice. For example, midwives who practice independently and outside of hospitals have no path to licensure in 17 states.<sup>42</sup> Doula and midwives of color face particular barriers as their historical exclusion from the birthing profession has had lasting impacts: Only 5 percent of midwives in the United States are women of color, and one nationally representative survey found that in 2003, 84 percent of doulas in the United States were white.<sup>43</sup>

The following sections are informed by the author's interviews with community-based midwives and doulas to further understand their role and their visions for pregnancy-related care in their communities.

# The recentering of community and humanity in pregnancy-related care

*I see pregnancy, birth, breastfeeding, and parenting as its own thing, separate from the medical system. And that's why being community focused is so important—because if it is needed, it brings the medical system alongside it, but that's not the focus.*<sup>44</sup> – Jeretha McKinley

In discussing the importance of the role of community-based doulas and midwives in providing support and care before, during, and after birth, the doulas and midwives interviewed emphasized that they see their work as part of larger effort to recenter the community and the birthing person in pregnancy-related care. For these doulas and midwives, patient- and community-centered care is key to improving both outcomes and experiences for all birthing people, especially those at the center of the maternal health crisis. For people of color, especially Black and Indigenous people as well as LGBTQ people, many of whom have experienced discrimination and disenfranchisement in their birthing and broader health care experiences, the support of a community-based birth worker helps them to reclaim control over their pregnancy and birth experiences. This reclaimed agency encompasses their physical bodies and knowledge of traditional community birth practices, along with the power to advocate for the birth experience that they want and need.

*From a place of respect, from a place of support, from a place of ensuring the centering of that woman, that patient, that person. The centering therefore allows for all the care plans, all the decisions, all of the policies, procedures, protocols, to be safely delivered and supported for the patient herself and her autonomy; her agency is respected.*<sup>45</sup>  
– Jennie Joseph

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## Interrupting harm

Community-based doulas and midwives have a particularly important role to play in combating exploitation, exclusion, discrimination, and loss of autonomy that their communities routinely experience in the medicalized birth system. The doulas and

midwives interviewed shared nearly universal experiences of harm and trauma from the health care system, particularly for birthing people of color and LGBTQ people—including having their pain ignored, coercive medical practices, lack of bodily autonomy, and experiences of racism, homophobia, and transphobia.

*Ignoring us ... not hearing us ... ignoring our cry out for care ... it devalues us ... constantly tries to remind us that we mean nothing. And so the little bit of care that we get, that's all we get, and we deserve to die, we deserve whatever comes to us.*<sup>46</sup>  
– Brittany “Tru” Kellman

*Every time a trans person is exposed to a new person or provider, there's an opportunity for discrimination.*<sup>47</sup> – Ray Rachlin

When community-based birth workers help pregnant people know and advocate for their rights, they push back against those devaluing experiences and hold medical providers accountable. The choice to have birth outside of a hospital setting is also often a response to these experiences of harm from the medical system. Particularly for LGBTQ families, having control over who is present for birth, knowing who the provider will be and that they will provide culturally competent care, helps to mitigate the potential for harm.

*Having somebody there to hold you through it can make a world of difference.*<sup>48</sup>  
– Elena Colón

*They [community-based birth workers] were doing it [providing care] in a way where it exemplified the humanity in one another. ... People were transformed by that level of care.*<sup>49</sup> – Chanel Porchia-Albert

Having pregnancy support that comes from within people's own communities and building relationships of trust are central for many of the doulas and midwives interviewed. Many observed that when the birthing person does not have to explain their identity—because the doula or midwife is part of their community—it creates a foundation of trust and eases anxieties.

*Having to explain yourself all day long, all the time, is like this layer, this heaviness that you carry around with you.*<sup>50</sup> – Elena Colón

*We always kind of see this deep exhale and this dropping of the shoulders ... really just deep gratitude of holding space and seeing and hearing them [the birthing person] while simultaneously providing them highly skilled quality care.*<sup>51</sup> – Brittany “Tru” Kellman

For the midwives interviewed who identify as queer and nonbinary or queer and gender-queer, this shared experience is particularly impactful within a health care system that has consistently misgendered and excluded them.

*Having this shared history and culture ... where things can go unsaid, where you don't have to explain your family ... or figure out how you fit in with language that doesn't apply to you.*<sup>52</sup> – Ray Rachlin

*When ... you know that your practice is set up to be queer- and trans-affirming, that can make a huge difference. ... Knowing that your midwife has some sense of a broad range of things that you might experience in the world as a queer person and not having to explain that, having a midwife that can know and respect your pronouns without needing to be educated extra about it by you as the client.*<sup>53</sup> – Corinne Westing

The shared understanding of birth support from within the community provides birthing people with confidence that their experiences will be truly seen and honored.

*What that person [the community-based birth worker] carries is relevant to the client's life, and they [the client] see it, and it resonates, and they know that they can trust that their experience is held in a nonjudgmental way.*<sup>54</sup> – Steph McCreary

Such support helps to counter the negative experiences that birthing people of color and LGBTQ people have had when interacting with health care system, such as having their voices and needs discounted. Community-based doulas and midwives can provide a layer of protection and resilience.

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## Building power

Forming a strong foundation of trust and shared understanding allows community-based doulas and midwives to give birthing people the tools they need to reclaim their power and advocate for themselves.

*They [the birthing person] have found their voice when they finish with us.*<sup>55</sup>  
– Brittany “Tru” Kellman

*Our community-based approach really is about community defining itself. ... You're just walking alongside them [the community].*<sup>56</sup> – Jeretha McKinley

This empowerment and advocacy can fundamentally shift the birth experience from one devoid of choice and potentially coercive, to one where the birthing person's autonomy is respected and valued.

*You don't feel like birth is something that's happening to you.*<sup>57</sup> – Alexis Hall

*The importance of having it [birth support] come from within the community is ... for people to really be able to approach their health care as partners with their providers.*<sup>58</sup> – Ashley Hill Hamilton

The process of empowerment has wide-reaching effects on people's pregnancy outcomes and beyond. Many of the doulas and midwives interviewed noted that the advocacy skills that their clients gain extended past their pregnancy and birth and strengthened people's voices, aiding them in more effectively advocating for better conditions in their communities.

*Physiological empowerment, not only in your mind, in your spirit, but also in your body.*<sup>59</sup> – Jennie Joseph

*The level of, just love ... genuine love, and how people are able to center themselves and their families, understanding that the care that you give someone has a ripple effect. ... It has implications that can last generations.*<sup>60</sup> – Chanel Porchia-Albert

Also key to the role of community-based midwives and doulas is helping communities reclaim their generational and traditional birthing knowledge. This aspect is particularly important for the doulas and midwives working with Black and Indigenous communities. Such education includes learning about community birth practices that precede the dominance of hospital-based birth, as well as reintegrating spiritual and herbal practices. These practices help communities restore knowledge and power over their birth experiences.

*Training doulas within the community ... it builds back knowledge around birth and ways of knowing that have been lost.*<sup>61</sup> – Steph McCreary

*Ancestral medicine ... learning Indigenous healing modalities and learning some of the herbs of the grand midwives ... helps to tie back in and bring back around the community midwife in our tradition.*<sup>62</sup> – Brittany "Tru" Kellman

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## Centering the whole person

The doulas and midwives interviewed also spoke of the need to consider the whole person, beyond the experiences of pregnancy and birth, in pregnancy-related care. This approach includes considering the factors that influence people’s ability to make decisions about their pregnancies and health without being judgmental and helping them to navigate systems based on their particular needs. Jennie Joseph refers to this process as “gap management”: helping people to access resources and fulfill their needs in order to have healthy pregnancies and lives.<sup>63</sup>

*What it really means is meeting people where they are, not where you expect them to be.*<sup>64</sup> – Chanel Porchia-Albert

Key to this type of support is not just recognizing the social determinants of health that affect people’s well-being and decision-making, but also providing wraparound support, such as connecting them to resources and social supports that allow them to get the most out of pregnancy and postpartum care.

This whole-person approach includes addressing factors that influence maternal health and outcomes, including mental health, food and housing security, immigration status, and more. It also means addressing the effect of systemic racism throughout people’s lives and the impact it has on pregnancy in particular. Providing a nonjudgmental space to hold those experiences and to provide the care that each individual needs is a key role of community-based doulas and midwives.

*No matter your socioeconomic status, no matter your education, due to racism, there’s an allostatic load that we carry, stressors that we carry, because of the way that we have to navigate life.*<sup>65</sup> – Alexis Hall

Ashley Hill Hamilton and Brittany “Tru” Kellman describe a “family model of care” that focuses on the needs of parents and families during the prenatal and postpartum periods.<sup>66</sup> Particularly important to many of the doulas and midwives interviewed was care that centered trauma-informed mental health support for birthing people, as well as care that does not stop immediately following birth. The postpartum period is incredibly stressful for all new parents, particularly those facing additional stresses such as financial instability; housing and food security; access to clean water; immigration status concerns; and the physical and mental stresses of racism.<sup>67</sup>

Without social supports to address these ongoing issues, new parents may be unable to access the care they need for themselves and their infants and as a result may face additional physical and mental health consequences.<sup>68</sup> Continuing to connect new parents to wraparound social supports is key to supporting families and improving health outcomes, especially considering that one-third of maternal deaths occur between one week and one year after delivery.<sup>69</sup>

Interrupting the harm of systemic racism and bias; recentering community and individual knowledge and power; building relationships based on trust; and improving the experience of pregnancy, birth, and postpartum care for communities of color and LGBTQ families are important and valuable goals in and of themselves. These interventions and supports provided by community-based midwives and doulas also lead to better health outcomes.<sup>70</sup>

# Integration in the health care system and the role of government

The doulas and midwives interviewed explored tensions and provided guidelines around the integration of doulas and midwives in the health care system and the role of government in regulating their licensure, scope of practice, and reimbursement.

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## Integrating doulas and midwives in the health care system

It is imperative that community-based midwives and doulas, along with physicians and other hospital-based providers, maintain respectful, collaborative relationships to achieve what should be the ultimate goal for pregnancy-related care and support: a positive and healthy pregnancy, birth, and postpartum experience. As COVID-19 puts huge strains on hospitals, this collaboration is especially key to ensuring quality care for birthing people. Yet for the doulas and midwives interviewed, any integration in the health care system must balance collaboration with maintaining autonomy and a focus on patient-centered care.

Integration of doulas and midwives in the health care system includes addressing issues such as availability in a range of birth settings, scope of practice, and insurance coverage, as well as acceptance and collaboration with other health care providers.<sup>71</sup> Among the doulas interviewed, many believed that doulas should not be integrated as part of the medical system, but rather should be able to practice independently while supporting pregnant people in their interactions with the health care system.

*We don't work for the health care system; we work for parents.<sup>72</sup>*  
– Ashley Hill Hamilton

While maintaining their role as part of the parent team, doulas can be most effective in providing care and support for the birthing person when their role is valued and when they can work collaboratively with physicians, nurses, and other hospital staff.

Other interviewees, however, do want to be integrated in the health care system but prioritize maintaining their autonomy. For many of the midwives interviewed, particularly those who work in out-of-hospital settings, successful integration with the health care system features collaboration between midwives and physicians; open communication; and smooth transfers from homes and birthing centers to hospitals if pregnant people require medical intervention.

*It's tremendously harmful for home birth to be a fringe thing in this country. ... I think we need to have real conversations that can bring the best of what we do in home birth to a wider variety of birth settings. ... If we're actually better integrated into the system and we could work together for patients, I think we could very easily eliminate a wide variety of reasons that people experience trauma during pregnancy and childbirth.<sup>73</sup>*  
– Corinne Westing

Yet in order to achieve this collaboration, interviewees emphasized the need for educating hospital staff on the role and value of doulas and midwives, including providing them with evidence of their effectiveness in improving maternal health outcomes. In addition, medical providers must take it upon themselves to receive racism and bias training as well as training on how to provide patient-centered, trauma-informed care that follows a cultural humility model.<sup>74</sup> Such training will affect not only the experiences and outcomes of patients who are most affected by bias and discrimination in health care, but also the relationship with and respect for midwives and doulas from those same communities—many of whom have also experienced medical-system-induced trauma, as shared by many interviewees.

*I would like to see a revamp in education of providers that is an anti-racist medical model of care, that understands that it's not just about practicing anti-racist medicine, it's about having anti-racist institutions.<sup>75</sup>* – Chanel Porchia-Albert

Midwives and doulas also point to a broader need for the health care system to reframe how it approaches pregnancy and birth—not viewing it as a medical procedure but as a humanity-driven experience.

*[A model that] approaches birth from a place of profound respect as opposed to a place of profound fear that can be found on a lot of units that are run primarily or almost exclusively by physicians.<sup>76</sup>* – Corinne Westing

This humanity-driven approach also requires centering the individual needs of each birthing person, rather than a systematized process that automatically turns to medicalized care.

*The medical establishment sees gestation, birth, and postpartum as a series of processes that are supposed to operate one way.*<sup>77</sup> – Kortney Lapeyrolerie

*The medical industrial complex ... is not set up in a way to care for patients—it's to treat them medically.*<sup>78</sup> – Alexis Hall

For many of the doulas and midwives interviewed, this lack of humanity-driven care is rooted in a health care system that is driven by profit.

*It's money over lives.*<sup>79</sup> – Brittany “Tru” Kellman

In a patient-centered model of care, medical intervention comes into play only if necessary and chosen by the birthing person—as Tewa Women United refers to it, with “free, prior, and informed consent,” free of coercion.<sup>80</sup> Centering pregnancy-related care around the humanity of the birthing person also means returning to a model of looking at the whole person and providing supports before pregnancy and birth to reduce the need for medical intervention.

*Health issues based on structural racism, and social determinants of health, and historical trauma, intergenerational trauma ... can ... sort of divert a family's experience. ... It's easier to medicalize birth when people show signs of not being at the healthy standard. I think that ... there's things to do preventively to help with women's health and reproductive health care.*<sup>81</sup> – Steph McCreary

Many of the midwives interviewed framed this shift as integrating the midwifery model of care in all forms of pregnancy-related care, whether provided by a midwife or not. The midwifery model of care is patient centered, considers the whole person, and prioritizes autonomy, consent, and collaboration.

Shifting the approach of pregnancy-related care to center birthing people is not as simple as integrating doulas and midwives in the medical system. A truly patient-centered system requires access to midwifery and doula care in a variety of birth settings as well as real systemic work to root out racism and bias from the maternity care system. Birth workers and maternity care providers in all settings must be willing to put in that work.

*It can seem easier to just add something to a system than to try to change the whole system.*<sup>82</sup> – Elena Colón

*We are really hobbled by systems and institutions that have embedded . . . racist ways of being, racist policies, procedures. . . . We recognize where things are unjust, and yet we are not really willing to dismantle, to decolonize, to take apart and rebuild something that is so clearly not safe, not fair, not just.*<sup>83</sup> – Jennie Joseph

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## The role of government in licensure, scope of practice, and reimbursement

When it comes to regulating midwifery and doula practice, the current U.S. policy landscape varies widely by state. Such regulation may include licensing and training requirements, scope-of-practice requirements, and public insurance coverage requirements for midwives and doulas.

### Current state policy landscape regulating doulas and midwives

Existing state policies around doulas are focused on Medicaid reimbursement. Oregon and Minnesota currently provide Medicaid reimbursement for doula services; Indiana has passed legislation to allow for Medicaid reimbursement, but the bill does not include any funding for such a program; and New York has a pilot program to cover doula services for Medicaid beneficiaries, although it has received critiques from community-based doulas for providing unsustainably low reimbursement rates.<sup>84</sup>

A number of other states have proposed legislation around Medicaid coverage for doulas, along with several federal bills.<sup>85</sup> The central contentions around these bills are low reimbursement rates as well as credentialing, training, and registration requirements for doulas that some community-based doulas believe should not be the government's purview and may exclude doulas of color and low-income doulas.<sup>86</sup>

Many more state policies affect the legality and scope of midwives' practice. Certified nurse midwives (CNMs) who practice in hospital settings can legally practice in all 50 states and receive Medicaid coverage.<sup>87</sup> CPMs and other so-called direct-entry midwives, who practice primarily outside of the hospital setting, including home births and birth centers, face a much more complicated regulatory landscape. Only 33 states have a path to licensure and thus legal practice of CPMs.<sup>88</sup> The states that have legal recognition of CPMs vary in how they regulate midwives' scope of practice, including by requiring supervision or collaborative agreements with physicians; limiting the types of births for which midwives can provide independent care; and setting certification requirements and regulatory authority for obtaining licensure.<sup>89</sup> Only 13 states cover CPM services for Medicaid beneficiaries.<sup>90</sup>

When asked about the correct method, if any, for government to regulate the practice of midwifery and doula care—including policies around licensure, scope of practice, and reimbursement—the midwives and doulas interviewed had no single answer. There were key tensions centered around issues such as increased funding for services; for example, Medicaid coverage for midwifery and doula care can increase pregnant people’s access to services. However, such coverage could come with trade-offs, including concerns over a loss of autonomy and the exclusion, through licensure and scope-of-practice requirements, of birth workers who are low income, people of color, and trained in traditional practices.

### Licensure and scope of practice

Among the doulas, many believed that there was no role for the state in regulating their practice through licensure, training, or scope-of-practice requirements, since doulas are not medical providers. Many doulas shared concerns that licensure and scope-of-practice regulations often push out low-income people and people of color who have a wealth of knowledge around birth work but may not have access to formal training or licensure.

*The more regulation you have, the less equitable it is.*<sup>91</sup> – Jeretha McKinley

In place of a system of licensure, Chanel Porchia-Albert recommended a doula registry that would make doula services more accessible.<sup>92</sup> She and others also stressed that standards for doula practice be determined within the community of doulas and the birthing people who they support and not by state governments.

Among the midwives interviewed, opinions on regulation also varied significantly, but they all voiced a shared concern for preserving the autonomy of midwifery care. While some believed that having no regulation, and operating outside of the medical and state system, was preferable, many others believed that working on the outside was not helpful to their ability to practice effectively. They argued that operating outside the health system was an obstacle to educating both the community and providers on the benefits of midwifery care and hampered efforts to form collaborative relationships with other providers, particularly in situations where medical intervention is necessary.

The midwives agreed that states need to allow for the legal practice of midwives both within and outside of hospital settings. However, many emphasized that rather than the state or physicians controlling midwives’ scope of practice, the standards and governing boards for midwifery should be controlled by midwives themselves.

*The midwife can be licensed, they can bill Medicaid, they can have birth centers, and also the board that governs the midwives are midwives.*<sup>93</sup> – Brittany “Tru” Kellman

Similar to the doulas interviewed, many of the midwives expressed concerns over policies that exclude or create barriers to practice for midwives of color and those trained in traditional care methods. Another main concern centered on regulation that would limit the scope of practice and the autonomy of midwives—particularly guidelines that placed control in the hands of physicians.

### Reimbursement

Another key concern for the doulas and midwives interviewed was ensuring that any insurance coverage of their services be reimbursed at a living wage. Steph McCreary added that the only role for the state in doula care should be through Medicaid, emphasizing that if doulas choose not to seek state funding through Medicaid, they should not be regulated by the state.

*They have their own training, they have their own code of ethics, they have their own certifying body to answer to, and that should be allowed to continue as is if they are not asking for state funding to do their work.<sup>94</sup> – Steph McCreary*

The most widely shared recommendation from the midwives and doulas interviewed was to provide government funding support for community-based organizations already doing pregnancy support work within communities. These organizations are embedded within communities and understand their unique needs; have proven to improve outcomes; already provide sources of accountability for patients and birth workers; and ensure that doulas and midwives are compensated at a living wage.

# Policy recommendations

The United States does not have consistent policies around the practice of doulas and midwives. Policies related to doula support and services are largely focused on certification and Medicaid coverage, as well as integrating doulas into hospitals and birthing facilities and including them on advisory boards such as state maternal mortality review committees.<sup>95</sup> Likewise, policies regulating midwifery are inconsistent and vary widely, mainly addressing the legal practice of midwifery both inside and out of hospital settings; the scope of practice of midwives; requirements for midwives to have physician supervision or collaborative agreements; and insurance coverage of midwifery.<sup>96</sup>

The policy recommendations presented in this section are derived from interviews with community-based midwives and doulas. The recommendations are also in line with a 2020 consensus study from the National Academies of Sciences, Engineering, and Medicine titled “Birth Settings in America: Outcomes, Quality, Access and Choice.” The conclusions from that study include the following: a need to improve quality and provide a range of options for care that is respectful and collaborative within hospitals; increase access to and integration of home birth and birth center settings; establish pathways to licensure and full scope of practice for certified nurse midwives, certified midwives, and certified professional midwives across the United States; provide Medicaid coverage for midwives and community-based doulas at equitable rates; and invest in growing a diverse maternity care workforce.<sup>97</sup>

## Reaching a progressive vision for pregnancy-related care

*Safe, supported, informed, and empowered pregnancy and births.*<sup>98</sup> – Ray Rachlin

Many of the doulas and midwives interviewed expressed shared views for their visions of what pregnancy, birth, and postpartum care and support could look like in their communities. Central to this shared vision is community-centered, patient-centered, and humanity-centered care.

*[People] understand as they are growing up what it means to center their bodily autonomy, what it means to make an informed decision about their care, and what it means to access health care services in an equitable way.*<sup>99</sup> – Chanel Porchia-Albert

They envision a world in which the individual needs and experiences of the birthing person and their family and community are the driving forces for pregnancy-related care. This vision also includes care that considers the whole person beyond the moment of pregnancy and birth. It is a vision of care and support that meets people where they are, provides a nonjudgmental space for birthing people to fully be themselves, and helps people connect to and navigate resources to support their holistic well-being.

*Everybody knows what quality, safe maternity care looks like, feels like . . . because it's so solid, it's so automatically, always, every time dependably safe and respectful and careful because of your humanity.*<sup>100</sup> – Jennie Joseph

This progressive vision also emphasizes the autonomy to choose and the ability to access a range of options for pregnancy-related care settings and providers. Among those options are where to give birth—in a hospital, birth center, or at home—and who to have present during

pregnancy and birth—including a midwife, an OB-GYN, a doula, family, and community members. True autonomy over birthing experiences includes knowledge about and access to the different options, including a range of providers and affordable choices.

*A myriad of affordable choice.*<sup>101</sup> – Ashley Hill Hamilton

Returning power to the birthing person to have the pregnancy, birth, and postpartum experience that they want is key to combating systemic racism, which has undermined and erased traditional birthing knowledge and removed agency from pregnant people of color by devaluing their voices and experiences and using coercive medical practices without informed consent. Having agency over where and with whom birth takes place can also be extremely empowering for LGBTQ families, allowing them to shape birthing experiences that are affirming and culturally competent. Once again, the doulas and midwives interviewed emphasized the need to train and support more birth workers of color, especially those who are Black and Indigenous, and LGBTQ birth workers.

A final—but no less important—shared tenet is a vision of birth that is not seen as an inherently medical event.

*They [the medical system] treat everyone as high risk, which is not appropriate.*<sup>102</sup> – Alexis Hall

In this reframing, the medical system is not the center of the experience of pregnancy; the pregnant person is the center, and the medical system is part of the network of support around a birthing person. This does not mean forgoing medical attention in pregnancy, but rather that medicalized care is just one of the supports that a person receives in order to have a healthy and positive pregnancy experience.

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## Fund existing community-based organizations

While opinions on the role of government in regulating doula and midwifery care varied, the doulas and midwives interviewed nearly universally supported directing funding to community-based organizations already doing the work. These organizations, including those represented in this report, such as Ancient Song Doula Services, Mama Sana Vibrant Woman, Tewa Women United, along with many others, are already embedded in their communities. These groups have worked to build relationships and trust within the community and with hospitals and have developed models to deliver culturally competent care and support that is guided by the unique needs of their individual communities. Yet, as many of the doulas and midwives interviewed shared, a lack of adequate funding is a persistent issue that impedes their ability to expand their work and have long-term sustainability. Increased funding to existing community-based organizations would allow them to expand services, expand capacity for clients, support more clients who lack the ability to pay, and ensure that their birth workers are paid a living wage and are provided with professional and social supports. Rather than reinvent the wheel by establishing new programs, state and federal governments can provide grant funding to support the ongoing work and expansion of the community-based organization models already in place.

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## Expand access to training and education

A diverse doula and midwife workforce is key to breaking down bias and creating strong relationships for birth support. As discussed earlier in the report, the current midwifery and doula workforce in the United States is overwhelmingly white, as is the OB-GYN profession.<sup>103</sup> In order to build a birth workforce that is reflective of the communities most at risk for discrimination and adverse maternal health outcomes, policymakers should direct funding to training programs focused on training doulas and midwives who are people of color—particularly those who are Black and Indigenous—as well as LGBTQ people and others who are part of and/or work with communities most affected by the maternal health crisis. In addition, funding should prioritize programs that include anti-racist frameworks and training around systemic racism, implicit bias, and cultural humility, as well as those that are designed and led by affected communities.

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## Improve integration in and support from the medical system

Policymakers should support education that provides culturally competent care and integrates the support of doulas and midwives for all maternity care providers. Providers should be educated on the evidence-based positive effects on maternal health outcomes that midwifery care and doula support provide. Facilitating knowledge about the role of midwives and doulas will help break down tensions based on a lack of understanding and would support collaboration that puts the pregnant person's autonomy and care first. In addition, all staff who interact with pregnant people—from physicians to front office staff to nurses—should receive training focused on systemic racism, implicit bias, cultural humility, and trauma-informed care. Training all providers in the midwifery model of care—which emphasizes patient-centered care that considers the whole person and prioritizes autonomy, consent, and collaboration—could also have significant benefits for pregnancy outcomes and experiences, regardless of whether care is provided in a hospital, a birthing center, or at home.

### **The Washington state model of midwifery integration**

According to the University of British Columbia Birth Place Lab's state ranking of midwifery integration, Washington state ranked highest. In Washington, both CNMs and CPMs are licensed to practice; can practice independently and in home birth and birth center settings; are covered by Medicaid; can write prescriptions; and can easily make referrals to physicians.<sup>104</sup> The Midwives' Association of Washington State notes that midwives' scope of practice in the state includes "all of the procedures that may be necessary during the course of normal pregnancy, birth, and the postpartum/newborn period": prenatal care and education; support during labor; delivery of the infant; and postpartum care for parents and infants.<sup>105</sup>

Washington is above the U.S. average for percentage of births attended by midwives and has higher-than-average rates of positive maternal and infant health indicators, including spontaneous vaginal delivery, vaginal birth after C-section, and breastfeeding, as well as lower rates of negative indicators of C-sections, induction, low birth rate, premature birth, and neonatal mortality.<sup>106</sup>

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## Establish clear guidelines for government regulation of practice

While there was a lack of consensus related to government regulation of their practices among the midwives and doulas featured in this report, some parameters for potential legislation emerged. Specifically, any regulation should serve the purpose of making midwifery and doula care more accessible and affordable. In addition, regulations should not interfere with the autonomy of birth workers, such as policies requiring midwives to practice under the supervision of physicians, nor should they impose onerous requirements that exclude low-income birth workers, birth workers of color, or those with traditional birth knowledge. In addition, efforts to expand insurance coverage of midwifery and doula care through Medicaid and private insurance must include reimbursement rates set at a living wage. Finally, any standards for scope of practice and core competencies for doulas and midwives should be determined by advisory boards made up of birth workers representing the communities they serve—and not by politicians or by physicians. Doulas and midwives already have training and certifying bodies with established core competencies; state policies should adopt these established standards.

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## Provide access and the autonomy to choose a range of birth options

Key to the vision of nearly every midwife and doula interviewed was giving birthing people access to and the autonomy to choose from a range of birth options. Returning this power to birthing people is crucial to combating racism in the health care system, which has removed choice and devalued birthing people's knowledge of their own needs and experiences. Such autonomy is also central to refocusing the maternity care system around the pregnant person, rather than around one specific method of medicalized, hospital-based birth.

This progressive vision can only become a reality by removing barriers to the availability and accessibility of the full range of pregnancy-related care options. This includes ensuring that in every state, midwives—including both CNMs and CPMs—are able to legally practice in hospitals, birth centers, and home birth settings without limiting scope of practice or requiring collaborative agreements with a physician. It also requires creating pathways to affordability for the range of options, including public and private insurance coverage and funding for community-based organizations, as discussed earlier in this report. Finally, providing education encompassing different birth options is key to birthing people having true autonomy over their pregnancy experiences.

## The Black maternal health omnibus

Proposed federal legislation spearheaded by Rep. Lauren Underwood (D-IL), Rep. Alma Adams (D-NC), Sen. Kamala Harris (D-CA), and the congressional Black Maternal Health Caucus—referred to as the Black maternal health omnibus—would provide critical support for many of the midwives’ and doulas’ recommendations presented here.<sup>107</sup> Among the proposed bills, which were introduced in March 2020, is legislation that would address policies focused on supporting community-based organizations, expanding access to doulas and midwives, building a diverse, culturally competent maternity care workforce, and addressing the social determinants of health:

- **The Kira Johnson Act** would provide funding support for community-based organizations and to implement racism, bias, and discrimination trainings and accountability measures.<sup>108</sup>
- **The Perinatal Workforce Act of 2020** supports building racially, ethnically, and professionally diverse maternity care teams and funds education and training for community-based birth workers.<sup>109</sup>
- **The Social Determinants for Moms Act of 2020** would help address the maternal health impacts of social determinants, including housing, transportation, food and water security, environment, and child care.<sup>110</sup>

# Conclusion

Community-based midwives and doulas are certainly not monolithic in their views, yet those interviewed for this report shared a largely common vision: one of care before, during, and after birth that centers humanity and offers a range of accessible options and the autonomy for birthing people to determine what is best for them. It is a progressive vision of pregnancy-related care that is supported by community-based birth workers who build strong relationships of trust and meet people where they are. And it is a vision that makes room for the medical system but rightfully does not place it at the center of pregnancy-related care.

The current COVID-19 crisis acutely demonstrates the need for access to a range of options for pregnancy-related care, including birth outside of a hospital setting with the support of midwives and doulas.<sup>111</sup> The evidence around the benefits of midwives and doulas in improving maternal health outcomes is strong. Moreover, the doulas and midwives interviewed for this report demonstrate how crucial community-based birth workers are in confronting systemic racism and bias that harms community and individual health, retuning power to communities and returning to a model of pregnancy-related care that values, centers, and honors birthing people.

It is crucial that policymakers recognize the importance of doulas and midwives and seek to incorporate their work in developing solutions to the maternal health crisis. Just as importantly, lawmakers must center the voices and follow the guidance of the individuals doing the work—most critically, those who are embedded in the communities most affected by the maternal health crisis—in any policy decisions that affect their practice and livelihoods.

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## Endnotes

- 1 Recognizing that people with the capacity for pregnancy do not all identify as women, including some transgender men and nonbinary and gender-nonconforming people, this report will use gender-neutral language such as birthing people, pregnant people, and parents. If the term “women” is used, it is in reference to research that was particularly focused on those who identify as women.
- 2 Centers for Disease Control and Prevention, “Pregnancy Mortality Surveillance System,” available at [https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fproductive-health%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm](https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fproductive-health%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm) (last accessed April 2020).
- 3 Centers for Disease Control and Prevention, “Severe Maternal Morbidity in the United States,” available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html> (last accessed April 2020); Andreea A. Creanga and others, “Racial and ethnic disparities in severe maternal morbidity: a multistate analysis, 2008–2010,” *American Journal of Obstetrics and Gynecology* 210 (5) (2014): 435.E1–435.E8, available at <https://www.ncbi.nlm.nih.gov/pubmed/24295922>.
- 4 Elizabeth A. Howell, “Reducing Disparities in Severe Maternal Morbidity and Mortality,” *Clinical Obstetrics and Gynecology* 61 (2) (2018): 387–399, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/>.
- 5 Ibid.; Elizabeth A. Howell and others, “Severe Maternal Morbidity Among Hispanic Women in New York City: Investigation of Health Disparities,” *Obstetrics and Gynecology* 129 (2) (2017): 285–294, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5380443/>; March of Dimes, “Maternal and Infant Health in US Hispanic Populations: Prematurity and Related Health Indicators” (White Plains, NY: 2014), available at [https://www.marchofdimes.org/Peristats/pdflib/991/MOD\\_2014HispanicReport.pdf](https://www.marchofdimes.org/Peristats/pdflib/991/MOD_2014HispanicReport.pdf); U.S. Department of Health and Human Services Office of Minority Health, “Infant Mortality and Hispanic Americans,” available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=68> (last accessed April 2020).
- 6 Jamila Taylor and others, “Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint” (Washington: Center for American Progress, 2019), available at <https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/>.
- 7 Sandy E. James and others, “The Report of the 2015 U.S. Transgender Survey” (Washington: National Center for Transgender Equality, 2016), available at <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>; Shabab Ahmed Mirza and Caitlin Rooney, “Discrimination Prevents LGBTQ People From Accessing Health Care,” Center for American Progress, January 18, 2018, available at <https://www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>; s.e. smith, “For Nonbinary Parents, Giving Birth Can Be Especially Frightening,” *Rewire.News*, January 25, 2018, available at <https://rewire.news/article/2018/01/25/nonbinary-parents-giving-birth-can-especially-fright/>.
- 8 DONA International, “What is a doula?,” available at <https://www.dona.org/what-is-a-doula/> (last accessed April 2020).
- 9 Midwives Alliance of North America, “What is a Midwife?,” available at <https://mana.org/about-midwives/what-is-a-midwife> (last accessed April 2020).
- 10 Midwives Alliance of North America, “Types of Midwives,” available at <https://mana.org/about-midwives/types-of-midwife> (last accessed April 2020).
- 11 National Advocates for Pregnant Women, “What We Can Learn From Hospital Restrictions on Birth Support During the Coronavirus Pandemic,” March 26, 2020, available at [http://advocatesforpregnantwomen.org/blog/2020/03/what\\_we\\_can\\_learn\\_from\\_hospita.php](http://advocatesforpregnantwomen.org/blog/2020/03/what_we_can_learn_from_hospita.php).
- 12 Katharine Gammon, “Should You Have a Home Birth Because of Coronavirus?,” *The New York Times*, March 30, 2020, available at <https://www.nytimes.com/2020/03/30/parenting/home-birth-coronavirus-hospital.html>.
- 13 Foundation for the Advancement of Midwifery, “FAM Statement on Out-of-Hospital Birth and Pandemic Planning,” Press release, March 23, 2020, available at <https://formidwifery.org/wp-content/uploads/2020/03/out-of-hospital-birth-and-pandemic-planning-fam-march-23-2020.pdf>; National Advocates for Pregnant Women, “What We Can Learn From Hospital Restrictions on Birth Support During the Coronavirus Pandemic.”
- 14 Taylor and others, “Eliminating Racial Disparities in Maternal and Infant Mortality.”
- 15 Monica R. McLemore, “COVID-19 Is No Reason to Abandon Pregnant People,” *Scientific American*, March 26, 2020, available at [https://blogs.scientificamerican.com/observations/covid-19-is-no-reason-to-abandon-pregnant-people/?fbclid=IwAR3ikD5sh72-wGU\\_zmQcTmqem-1LXrtQSAKzWustT0woKwrqsAng8fu0h4](https://blogs.scientificamerican.com/observations/covid-19-is-no-reason-to-abandon-pregnant-people/?fbclid=IwAR3ikD5sh72-wGU_zmQcTmqem-1LXrtQSAKzWustT0woKwrqsAng8fu0h4); Katie Van Syckle and Christina Caron, “Women Will Not Be Forced to Be Alone When They Are Giving Birth,” *The New York Times*, March 28, 2020, available at <https://www.nytimes.com/2020/03/28/parenting/nyc-coronavirus-hospitals-visitors-labor.html>.
- 16 Sherronda J. Brown, “The Racist Roots of Gynecology and What Black Women Birthed,” *Wear Your Voice*, August 29, 2017, available at <https://wearyourvoicemag.com/race/racist-roots-gynecology-black-women-birthed>.
- 17 Erin Blakemore, “The Little-Known History of the Forced Sterilization of Native American Women,” *JSTOR Daily*, August 25, 2016, available at <https://daily.jstor.org/the-little-known-history-of-the-forced-sterilization-of-native-american-women/>; Katherine Andrews, “The Dark History of Forced Sterilization of Latina Women,” *Panoramas*, October 30, 2017, available at <https://www.panoramas.pitt.edu/health-and-society/dark-history-forced-sterilization-latina-women/>; Lisa Ko, “Unwanted Sterilization and Eugenics Programs in the United States,” *Public Broadcasting Service*, January 29, 2016, available at <http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/>; Nadra Kareem Nittle, “The U.S. Government’s Role in Sterilizing Women of Color,” *ThoughtCo.*, January 9, 2020, available at <https://www.thoughtco.com/u-s-governments-role-sterilizing-women-of-color-2834600>.
- 18 National Association to Advance Black Birth, “History,” available at <https://thenaabb.org/index.php/history/> (last accessed April 2020).
- 19 Coburn Dukehart, “Doulas: Exploring A Tradition Of Support,” *NPR*, July 14, 2011, available at <https://www.npr.org/sections/babyproject/2011/07/14/137827923/doulas-exploring-a-tradition-of-support>.
- 20 Miriam Zoila Pérez, “#TBT: ‘Granny Midwives’ of the South,” *Colorlines*, March 19, 2015, available at <https://www.colorlines.com/articles/tbt-granny-midwives-south>.

- 21 Ibid.
- 22 Johana-Marie E. L. K. Williams, "The Midwife Problem: The Effect of the 1921 Sheppard-Towner Act on Black Midwives in Leon County" (Baton Rouge, LA: Southern Conference on African American Studies, 2014), available at [https://www.researchgate.net/publication/319631627\\_The\\_Midwife\\_Problem\\_The\\_Effect\\_of\\_the\\_1921\\_Sheppard-Towner\\_Act\\_on\\_Black\\_Midwives\\_in\\_Leon\\_County](https://www.researchgate.net/publication/319631627_The_Midwife_Problem_The_Effect_of_the_1921_Sheppard-Towner_Act_on_Black_Midwives_in_Leon_County).
- 23 Zoila Pérez, "#TBT: 'Granny Midwives' of the South."
- 24 Richard Johanson, Mary Newburn, and Alison Macfarlane, "Has the medicalisation of childbirth gone too far?," *BMJ* 324 (7342) (2002): 892–895, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1122835/>.
- 25 Saraswathi Vedam and others, "The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States," *Reproductive Health* 16 (77) (2019), available at <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2>; Chloë FitzGerald and Samia Hurst, "Implicit bias in healthcare professionals: a systematic review," *BMC Medical Ethics* (18) (2017): 19, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/>; David A. Ansell and Edwin K. McDonald, "Bias, Black Lives, and Academic Medicine," *New England Journal of Medicine* (372) (2015): 1087–1089, available at <https://www.nejm.org/doi/full/10.1056/NEJMp1500832>.
- 26 Carol Sakala and others, "Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report" (Washington: National Partnership for Women and Families, 2018), available at [https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf?utm\\_source=National%20Partnership&utm\\_medium=PDF\\_Link&utm\\_campaign=Listening%20to%20Mothers](https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf?utm_source=National%20Partnership&utm_medium=PDF_Link&utm_campaign=Listening%20to%20Mothers).
- 27 Polina Bachlakova, "Indigenous Doulas Are Reclaiming Birthing Practices Colonization Tried to Erase," *Vice*, October 25, 2016, available at [https://www.vice.com/en\\_us/article/7xz98z/indigenous-doulas-are-reclaiming-the-birthing-practices-colonization-destroyed](https://www.vice.com/en_us/article/7xz98z/indigenous-doulas-are-reclaiming-the-birthing-practices-colonization-destroyed).
- 28 smith, "For Nonbinary Parents, Giving Birth Can Be Especially Fraught"; Lindsay King-Miller, "How Doulas and Midwives Around the Country Are Filling the Gaps in Birth Care for Queer Families," *Rewire.News*, March 22, 2018, available at <https://rewire.news/article/2018/03/22/doulas-midwives-around-country-filling-gaps-birth-care-queer-families/>; James and others, "The Report of the 2015 U.S. Transgender Survey"; Mirza and Rooney, "Discrimination Prevents LGBTQ People From Accessing Health Care."
- 29 U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, "Social Determinants of Health," available at <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> (last accessed April 2020); Rejane Frederick, "The Environment That Racism Built: The Impact of Place on Maternal and Infant Health," Center for American Progress, May 10, 2018, available at <https://www.americanprogress.org/issues/race/news/2018/05/10/450703/environment-racism-built/>.
- 30 Health Connect One, "Community-Based Doula Program," available at [https://www.healthconnectone.org/our-work/community\\_based\\_doula\\_program/](https://www.healthconnectone.org/our-work/community_based_doula_program/) (last accessed April 2020); Asteir Bey and others, "Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities" (New York: Ancient Song Doula Services, Village Birth International, and Every Mother Counts, 2019), available at <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>.
- 31 American College of Obstetricians and Gynecologists, "Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery" (Washington: 2014), available at <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery>.
- 32 Kenneth J. Gruber, Susan H. Cupito, and Christina F. Dobson, "Impact of Doulas on Healthy Birth Outcomes," *The Journal of Perinatal Education* 22 (1) (2013): 49–58, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>; Katy B. Kozhimannil and others, "Modeling the cost effectiveness of doula care associated with reductions in preterm birth and cesarean delivery," *Birth* 43 (1) (2016): 20–27, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5544530/>; Meghan A. Bohren and others, "Continuous support for women during childbirth," *Cochrane Database of Systematic Reviews* (2017), available at <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003766.pub6/full>; Katy B. Kozhimannil and others, "Doula Care Supports Near-Universal Breastfeeding Initiation among Diverse, Low-Income Women," *Journal of Midwifery & Women's Health* 58 (4) (2013): 378–382, available at <https://onlinelibrary.wiley.com/doi/abs/10.1111/jmwh.12065>.
- 33 Gruber, Cupito, and Dobson, "Impact of Doulas on Healthy Birth Outcomes"; Bohren and others, "Continuous support for women during childbirth"; Wendy-Lynne Wolman and others, "Postpartum depression and companionship in the clinical birth environment: A randomized, controlled study," *American Journal of Obstetrics and Gynecology* 168 (5) (1993): 1388–1393, available at <https://www.sciencedirect.com/science/article/abs/pii/S0002937811907704>.
- 34 Kozhimannil and others, "Modeling the cost effectiveness of doula care associated with reductions in preterm birth and cesarean delivery."
- 35 Olga Khazan, "The High Cost of Having a Baby in America," *The Atlantic*, January 6, 2020, available at <https://www.theatlantic.com/health/archive/2020/01/how-much-does-it-cost-have-baby-us/604519/>; Jessica Glenza, "Why does it cost \$32,093 just to give birth in America?," *The Guardian*, January 16, 2018, available at <https://www.theguardian.com/us-news/2018/jan/16/why-does-it-cost-32093-just-to-give-birth-in-america>.
- 36 Niall McCarthy, "The U.S. Is The World's Most Expensive Nation for Childbirth [Infographic]," *Forbes*, January 29, 2020, available at <https://www.forbes.com/sites/niallmccarthy/2020/01/29/the-us-is-the-worlds-most-expensive-nation-for-childbirth-infographic/#72e12cb42ec7>; Khazan, "The High Cost of Having a Baby in America."
- 37 Saraswathi Vedam and others, "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes," *PLOS One* 13 (2) (2018), available at <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523>; University of British Columbia Birth Place Lab, "Key Findings/Full Report," available at <https://www.birthplacelab.org/key-findings/> (last accessed April 2020).
- 38 Vedam and others, "Mapping integration of midwives across the United States"; University of British Columbia Birth Place Lab, "Key Findings/Full Report."
- 39 Ibid.
- 40 Ibid.

- 41 National Academies of Sciences, Engineering, and Medicine, "No Hospital, Birth Center, or Home Birth Is Risk-Free — But Better Access to Care, Quality of Care, and Care System Integration Can Improve Safety for Women and Infants During Birth, Says Report," Press release, February 6, 2020, available at [Obstetrics & Gynecology 134 \(5\) \(2019\): 1056–1065, available at \[https://journals.lww.com/greenjournal/Fulltext/2019/11000/Comparison\\\_of\\\_Midwifery\\\_and\\\_Obstetric\\\_Care\\\_in.20.aspx\]\(https://journals.lww.com/greenjournal/Fulltext/2019/11000/Comparison\_of\_Midwifery\_and\_Obstetric\_Care\_in.20.aspx\).](https://www8.nationalacademies.org/onpinews/news-item.aspx?RecordID=25636&fbclid=IwAR22BRWma53t6HscQFWKivgGpXoNwjAxsv0Nm4Zo-rYgxJMEDFsl7EY0jD0; Vivienne Souter and others, )
- 42 National Association of Certified Professional Midwives, "Legal Recognition of CPMs," available at <https://nacpm.org/about-cpms/who-are-cpms/legal-recognition-of-cpms/> (last accessed April 2020).
- 43 Ranjani Chakraborty, "The culture war between midwives and doctors, explained," *Vox*, May 29, 2018, available at <https://www.vox.com/videos/2018/5/29/17406838/midwives-doctors-united-states>; Paula M. Lantz and others, "Doulas as childbirth paraprofessionals: Results from a national survey," *Women's Health Issues* 15 (3) (2005): 109–116, available at <https://www.sciencedirect.com/science/article/abs/pii/S1049386705000046>; Katy Backes Kozhimannil and others, "Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries," *American Journal of Public Health* 103 (4) (2013): e113–e121, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617571/>.
- 44 Jeretha McKinley, interim executive director, Health Connect One, interview with author via video, February 27, 2020, on file with author.
- 45 Jennie Joseph, Midwife, founder and executive director, Commonsense Childbirth Inc., interview with author, Washington, D.C., March 11, 2020, on file with author.
- 46 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 47 Ray Rachlin, certified professional midwife, interview with author via video, March 3, 2020, on file with author.
- 48 Elena Colón, birth companion (doula) and student-midwife at Mama Sana Vibrant Woman, and director at the Queer and Transgender Midwives Association, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 49 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 50 Elena Colón, birth companion (doula) and student-midwife at Mama Sana Vibrant Woman, and director at the Queer and Transgender Midwives Association, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 51 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 52 Ray Rachlin, certified professional midwife, interview with author via video, March 3, 2020, on file with author.
- 53 Corinne Westing, certified nurse midwife, home birth midwife, and member of the Queer and Transgender Midwives Association, interview with author via phone, March 11, 2020, on file with author.
- 54 Steph McCreary, Yiya Vi Kagingdi doula project coordinator, Tewa Women United, interview with author via phone, March 16, 2020, on file with author.
- 55 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 56 Jeretha McKinley, interim executive director, Health Connect One, interview with author via video, February 27, 2020, on file with author.
- 57 Alexis Hall, doula and birth companion, Mama Sana Vibrant Woman, interview with author via phone, March 17, 2020, on file with author.
- 58 Ashley Hill Hamilton, doula, Birthmark Doula Collective, interview with author via video, March 5, 2020, on file with author.
- 59 Jennie Joseph, midwife, founder, and executive director, Commonsense Childbirth Inc., interview with author, Washington, D.C., March 11, 2020, on file with author.
- 60 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 61 Steph McCreary, Yiya Vi Kagingdi doula project coordinator, Tewa Women United, interview with author via phone, March 16, 2020, on file with author.
- 62 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 63 Jennie Joseph, midwife, founder, and executive director, Commonsense Childbirth Inc., interview with author, Washington, D.C., March 11, 2020, on file with author.
- 64 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 65 Alexis Hall, doula and birth companion, Mama Sana Vibrant Woman, interview with author via phone, March 17, 2020, on file with author.
- 66 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author; Ashley Hill Hamilton, doula, Birthmark Doula Collective, interview with author via video, March 5, 2020, on file with author.
- 67 Taylor and others, "Eliminating Racial Disparities in Maternal and Infant Mortality."
- 68 Ibid.
- 69 Centers for Disease Control and Prevention, "Pregnancy-related deaths," available at <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html> (last accessed April 2020).
- 70 Visionary Vanguard Group Inc., "The JJ Way: Community-based Maternity Center, Final Evaluation Report" (Orlando, FL: 2017), available at <https://www.commonsense-childbirth.org/wp-content/uploads/2019/07/The-JJ-Way%20AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf>.
- 71 Vedam and others, "Mapping integration of midwives across the United States"; American College of Nurse-Midwives, "Midwifery linked to better birth outcomes in state-by-state 'report card,'" Press release, available at <https://www.midwife.org/Midwifery-linked-to-better-birth-outcomes> (last accessed April 2020).
- 72 Ashley Hill Hamilton, doula, Birthmark Doula Collective, interview with author via video, March 5, 2020, on file with author.

- 73 Corinne Westing, certified nurse midwife, home birth midwife, and member of the Queer and Transgender Midwives Association, interview with author via phone, March 11, 2020, on file with author.
- 74 Amanda Waters and Lisa Asbill, "Reflections on cultural humility," American Psychological Association, August, 2013, available at <https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx>.
- 75 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 76 Corinne Westing, certified nurse midwife, home birth midwife, and member of the Queer and Transgender Midwives Association, interview with author via phone, March 11, 2020, on file with author.
- 77 Kortney Lapeyrolerie, co-founder, Queer Doula Network, interview with author via email, March 13, 2020, on file with author.
- 78 Alexis Hall, doula and birth companion, Mama Sana Vibrant Woman, interview with author via phone, March 17, 2020, on file with author.
- 79 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 80 Steph McCreary, Yiya Vi Kagingdi doula project coordinator, Tewa Women United, interview with author via phone, March 16, 2020, on file with author.
- 81 Ibid.
- 82 Elena Colón, birth companion (doula) and student-midwife at Mama Sana Vibrant Woman, and director at the Queer and Transgender Midwives Association, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 83 Jennie Joseph, midwife, founder, and executive director, Commonsense Childbirth Inc., interview with author, Washington, D.C., March 11, 2020, on file with author.
- 84 Christina Gebel and Sarah Hodin, "Expanding Access to Doula Care: State of the Union," Harvard Chan School Center of Excellence in Maternal and Child Health Maternal Health Task Force, January 8, 2020, available at <https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/>.
- 85 National Health Law Program, "Doula Medicaid Project," available at <https://healthlaw.org/doulamedicaidproject/> (last accessed April 2020).
- 86 Alexis Robles, "Issue Brief: A Guide to Proposed and Enacted Legislation for Medicaid Coverage for Doula Care" (Washington: National Health Law Project, 2019), available at <https://healthlaw.org/resource/issue-brief-a-guide-to-proposed-and-enacted-legislation-for-medicaid-coverage-for-doula-care/>.
- 87 Taylor and others, "Eliminating Racial Disparities in Maternal and Infant Mortality"; Kaiser Family Foundation, "Medicaid Benefits: Nurse Midwife Services, Timeframe: 2018," available at <https://www.kff.org/medicaid/state-indicator/nurse-midwife-services/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%22%7D%7D%7D&sortModel=%7B%22colid%22:%22Location%22,%22sort%22:%22asc%22%7D> (last accessed April 2020).
- 88 National Association of Certified Professional Midwives, "Legal Recognition of CPMs."
- 89 US Midwifery Education, Regulation, & Association, "Principles for Model U.S. Midwifery Legislation and Regulation" (2015), available at <http://www.usmera.org/wp-content/uploads/2015/11/US-MERALegislativeStatement2015.pdf>.
- 90 National Association of Certified Professional Midwives, "Certified Professional Midwives: Frequently Asked Questions," available at [https://www.nacpm.org/wp-content/uploads/2016/11/CPM\\_FAQ.pdf](https://www.nacpm.org/wp-content/uploads/2016/11/CPM_FAQ.pdf) (last accessed April 2020).
- 91 Jeretha McKinley, interim executive director, Health Connect One, interview with author via video, February 27, 2020, on file with author.
- 92 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 93 Brittany "Tru" Kellman, certified professional midwife, doula, founder, and executive director, Jamaa Birth Village, interview with author via phone, March 6, 2020, on file with author.
- 94 Steph McCreary, Yiya Vi Kagingdi doula project coordinator, Tewa Women United, interview with author via phone, March 16, 2020, on file with author.
- 95 National Health Law Program, "Doula Medicaid Project"; ASTHO Staff, "State Policy Approaches to Incorporating Doula Services into Maternal Care," Association of State and Territorial Health Officials, August 9, 2018, available at <https://www.astho.org/StatePublicHealth/State-Policy-Approaches-to-Incorporating-Doula-Services-into-Maternal-Care/08-09-18/>; Gebel and Hodin, "Expanding Access to Doula Care."
- 96 Taylor and others, "Eliminating Racial Disparities in Maternal and Infant Mortality."
- 97 National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America: Outcomes, Quality, Access, and Choice* (Washington: The National Academies Press, 2020), available at <https://www.nap.edu/catalog/25636/birth-settings-in-america-outcomes-quality-access-and-choice>.
- 98 Ray Rachlin, certified professional midwife, interview with author via video, March 3, 2020, on file with author.
- 99 Chanel Porchia-Albert, doula, founder, and executive director, Ancient Song Doula Services, interview with author, Washington, D.C., March 6, 2020, on file with author.
- 100 Jennie Joseph, midwife, founder, and executive director, Commonsense Childbirth Inc., interview with author, Washington, D.C., March 11, 2020, on file with author.
- 101 Ashley Hill Hamilton, doula, Birthmark Doula Collective, interview with author via video, March 5, 2020, on file with author.
- 102 Alexis Hall, doula and birth companion, Mama Sana Vibrant Woman, interview with author via phone, March 17, 2020, on file with author.
- 103 William F. Rayburn and others, "Racial and Ethnic Differences Between Obstetrician-Gynecologists and Other Adult Medical Specialists," *Obstetrics and Gynecology* 127 (1) (2016): 148–152, available at <https://www.ncbi.nlm.nih.gov/pubmed/26646119>.
- 104 University of British Columbia Birth Place Lab, "Midwifery Integration State Scoring (MISS) System Report Card: Washington State" (Vancouver, BC: 2018), available at <https://www.birthplacelab.org/wp-content/uploads/2018/02/Washington.pdf>; Midwives' Association of Washington State, "FAQ – Licensed Midwifery in Washington State" (Kenmore, WA: 2019), available at [https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/licensed\\_midwifery\\_in\\_washington\\_state\\_fact\\_sheet\\_2019.pdf](https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/licensed_midwifery_in_washington_state_fact_sheet_2019.pdf).

- 105 Midwives' Association of Washington State, "FAQ – Licensed Midwifery in Washington State."
- 106 University of British Columbia Birth Place Lab, "Midwifery Integration State Scoring (MISS) System Report Card: Washington State."
- 107 Black Maternal Health Caucus, "Black Maternal Health Momnibus," available at <https://underwood.house.gov/sites/underwood.house.gov/files/Black%20Maternal%20Health%20Momnibus.pdf> (last accessed April 2020).
- 108 Kira Johnson Act, H.R. 6144, 116th Cong., 2nd sess. (March 9, 2020), available at <https://www.congress.gov/bill/116th-congress/house-bill/6144?q=%7B%22search%22%3A%5B%22hr3031%22%5D%7D&s=1&r=5>.
- 109 Perinatal Workforce Act of 2020, H.R. 6164, 116th Cong., 2nd sess. (March 10, 2020), available at <https://www.congress.gov/bill/116th-congress/house-bill/6164>.
- 110 Social Determinants for Moms Act of 2020, H.R. 6132, 116th Cong., 2nd sess. (March 9, 2020), available at <https://www.congress.gov/bill/116th-congress/house-bill/6132?s=1&r=9>.
- 111 Foundation for the Advancement of Midwifery, "FAM Statement on Out-of-Hospital Birth and Pandemic Planning."

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