

Expanding Access to Doula Care

Birth Equity & Economic Justice in New Mexico



Yiya Vi Kagingdi Doula Project

Indigenous Women's Health & Reproductive Justice Program
Tewa Women United • www.tewawomenunited.org

March 2020

In deep gratitude, we acknowledge the work, input and guidance of:

Dr. Corrine Sanchez, ED
Elder Kathy Sanchez
Sayain Circle of Grandmothers
Tewa Women United Staff
Yiya Vi Kagingdi Doulas & Families

Bold Futures (Young Women United)
Care Coalition for Northern Families
Groundswell Foundation
Eirian Coronado, New Mexico Department of Health
Every Mother Counts
Fatima Muhammad Roque, BELA Mentor
Health Connect One's Birth Equity Leadership Academy
Melissa Binder, UNM
New Mexico Doula Association

Authors of *Advancing Birth Justice*:

Ancient Song Doula Services
Every Mother Counts
Village Birth International

Authors of *Sexual Abuse to Maternal Mortality Pipeline*:

Farah Tanis, Cathline Tanis and Sevonna Brown
Black Women's Blueprint, Contributors and Reviewers

Interview Participants:

Amanda Rose, Amy Chen, Chanel Porchia-Albert, Debra Catlin,
Hakima Tafunzi Payne, Melissa Gutierrez Nelson,
Nathan Roberts, Quatia Osorio, Violet Larry

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Why Expand Access to Doula Care	1
---------------------------------	---

TEWA WOMEN UNITED

Indigenous Women's Health & Reproductive Justice Program	3
Yiya Vi Kagingdi Doula Project	4
Yiya Vi Kagingdi Full Spectrum Community Doula Training	5
Community Engagement and Coalition Building for Reproductive Justice	6

WHAT IS A COMMUNITY DOULA?

Community-Based Doulas	7
A Call to Action: Commitment to Birth Equity	9

WORLDWIDE INDIGENOUS PRACTICES OF BIRTH

Community-Based Doula Care	10
Continuous Labor Support	10

RECLAIMING BIRTH KNOWLEDGE

Tewa Birthing Project	12
-----------------------	----

DOULA CARE & BIRTH EQUITY

Doula Care is Practice and Evidence Based	14
Birth Equity Impacts	14

ENDING VIOLENCE AGAINST WOMEN

Survivor-Centered Care	18
Caring for Substance Using Pregnant Families	19
Black Women's Blueprint's " <i>The Sexual Abuse to Maternal Mortality Pipeline</i> " Report	20
Uplifting Culturally Specific Birth Workers	22

EQUITABLE PAY FOR DOULA CARE

Living Wage for Community-Based Doula Work	23
New Mexico: Living Wage by County	24
Cost Effectiveness of Doula Care in New Mexico	25

BIRTH EQUITY & ECONOMIC JUSTICE

Economic Justice and Reciprocity	26
----------------------------------	----

TEWA WOMEN UNITED'S RECOMMENDATIONS

Models of Expanding Access to Doula Care	28
Medicaid Reimbursement of Doula Care	32

APPENDIX

Appendix A: Links to Key Research	44
Appendix B: Supportive Actions and Benefits of Doula Care	45
Appendix C: Black Women's Blueprint's " <i>The Sexual Abuse to Maternal Mortality Pipeline</i> " Report Recommendations Summary	49

EXECUTIVE SUMMARY



National conversations around expanding access to doula care, which include but are not limited to the creation of Medicaid reimbursement for doula care, spurred our program to begin researching the issue in 2016. Since then, we have found that Expanding Access to Doula Care can be done in diverse and powerful ways.

In the process of our research, we have come to understand that every road in this conversation should lead to community-based, healing/trauma-informed and survivor-centered doula care. While we recognize lessons learned from states that have pursued the pathway of Medicaid reimbursement, we feel it is most important to continually advocate for equitable compensation and culturally responsive models of doula care, for any community, organization or state who seeks to improve birth equity by expanding access to doula care.

Why Expand Access to Doula Care?

Doula care is practice based. Even before the word “doula” came into common use, grandmothers and aunts, sister and friends of a birthing mother circled around her to provide continuous community support. Today, even without formal training, families continue to support each other in the sacred moments of pregnancy and parenting.

Doula care is evidence based. Studies have shown that support from a doula can decrease preterm birth, low birthweight and cesarean rates, while increasing vaginal birth, breastfeeding initiation and duration rates.

Doula care contributes to birth equity. In recent decades, the authority of hospitals and clinics has replaced common knowledge around birthing and breastfeeding. Community-based doula organizations are working to restore birthing and breastfeeding knowledge to communities, by expanding access to doula training and doula care for Indigenous communities and communities of color.

Doula care options are limited for families who do not earn a living wage.

Depending on location, families will pay anywhere between \$500 and \$2500 to hire a private doula. Access to doula care is limited further by the fact that mainstream doula training organizations have historically promoted an entrepreneurial model that serves affluent families. Often, fees for doula training



and certification are prohibitively high, pricing out prospective doulas from lower-income communities, and limiting families' options for culturally relevant care.

Doula care is cost-saving and is being embraced by institutions across the United States. Doula programs are popping up within community-based organizations, State Departments of Health, Managed Care Organizations, maternity clinics and hospitals. These institutions know and prioritize the value of doula care.

In this report, we review the importance of the community-based doula model of care for achieving birth equity, review statistics and studies that show a doula's impact on important birth outcome measures, advocate for survivor-centered care training for all of New Mexico's providers, discuss doula care in the context of the maternal mortality crisis, elevate a living wage as central to creating economically just systems of payment for doulas, illustrate the diversity of ways that doulas can receive reciprocity from institutions and communities, and share our research and recommendations on the topic of Medicaid reimbursement for doula care in New Mexico.



"Having access to a doula should be available to ALL families. The value of the work and value of the outcome needs to be recognized."

Kimberly Talachy, YVK Doula Velarde, NM



Tewa Women United is an advocate for the expansion of access to doula care in New Mexico and nationwide. The following report reflects three years of research and interviews with community doulas, clients, doula trainers, midwives, obstetricians, policy advocates, administrators, DOH staff, executive directors and community members from states including OR, MN, NY, MA, RI, MO, CA & NM.

We see this report as a living document, meant to spark and guide collaboration towards the expansion of access to doula care in New Mexico.



TEWA WOMEN UNITED

Located in the ancestral Tewa homelands of Northern New Mexico, Tewa Women United is a multicultural and multiracial organization that was founded and is led by Native women.

Our name comes from the Tewa words *wi don gi mu*, which can be translated as, we are one in mind, heart and in the spirit of love for all.

Our Vision... Tewa Women United envisions movement(s) rooted in P'in Haa (Breath of Heart/Life) and P'in Nall (Touching Heart and Spirit) that nurture and celebrate the collective power of beloved families, communities and Nung Ochuu Quiyo (Earth Mother).

Our Collective Journey... Through relational-tivity we embody courageous spaces that center Indigenous women and girls to connect with ancestral knowingness, healing strengths and lifeways for the wellbeing of ALL.

Our Programs... We embody this vision and mission through our three main programs:

Indigenous Women's Health & Reproductive Justice

- Yiya Vi Kagingdi Community Doula Project
- Yiya Vi Kagingdi Full Spectrum Community Doula Training
- Community Engagement & Coalition Building for Reproductive Justice

Women's Leadership & Economic Freedom

- A'Gin Body Sovereignty & Healthy Sexuality Project
- Sayain Circle of Grandmothers
- Gender Based Violence Prevention
- Engaging Men and Boys Program

Environmental Health & Justice

- Española Healing Foods Oasis project
- Gathering for Mother Earth

How We Work... All our activities are interrelated. We seek to ensure effectiveness and cultural integrity by working methodically to overcome barriers and engage community partners within these TWU frameworks:

- **Two World Harmony Butterfly Model:** balance between Indigenous cultural ways of knowingness and Western knowledge
- **Theory of Opide, the Tewa Braiding Way of Practice to Action:** a transformative social justice framework that builds upon a multiple intersectional analysis. This model is based on the understanding that systematic oppression experienced by our collective communities, resulting in internalized oppression and intergenerational trauma, must be understood and addressed in efforts to promote positive transformative social change.



About our Indigenous Women's Health & Reproductive Justice Program

As a Native Woman led community-based organization, Tewa Women United is directly involved in addressing the challenges of reproductive health and justice for Indigenous women.

We believe that every woman and pregnant family has the right to a birthing experience that promotes autonomy, dignity, respect and empowerment for mother, parent, child and family.

We participate in grassroots organizing and movement building work for reproductive health and birthing justice to reclaim the sacredness of the birth process and the power of choice around how, when and where birth will happen. Tewa Women United sees this as a crucially important aspect for increasing health and wellness in our communities.

Indigenous Women's Health & Reproductive Justice Program welcomes families to engage in their health and wellbeing by revitalizing and reclaiming traditional practices and ways of knowing to strengthen connection and belonging for all communities.

Yiya Vi Kagingdi Doula Project (YVK)

Yiya Vi Kagingdi is Tewa for mother's helper.

Yiya Vi Kagingdi Doula Project was started in 2008 to serve first-time Native American mothers from the six Tewa speaking Pueblos of Nambé, Ohkay Owingeh, Pojoaque, San Ildefonso, Santa Clara and Tesuque.

We have since expanded our reach to provide services for families who represent the land-based Indigenous, Hispanic and mixed heritage multiculturalism of the tribal and rural areas of northern New Mexico.

Our Yiya Vi Kagingdi Full Spectrum Community Doulas provide support to families across the full range of reproductive experiences, including: preconception, miscarriage, pregnancy, birth, postpartum, planned abortion, medical termination, infant loss. Our services address the need for culturally responsive prenatal, birthing and postpartum support for families in our rural and underserved area of northern New Mexico. These services help parents to access their true voice and desires, and support the family through the birthing experience and new parenthood roles.

Our doulas provide services for the whole family, across generations, to encourage everyone to gather around the new parent(s). We value a culture of consent and seek to reclaim teachings and practices that honor the Sacredness of birth. We see this as a fundamental strategy in achieving our mission of building Beloved Families and Communities where women, girls and our Earth Mother



are honored and protected. We define and apply principles of midwifery in accordance with our Tewa traditions that honor birth as a community process and acknowledge the interconnections between Earth Mother, family and community.

We prioritize healing/trauma-informed support because we understand the impact of loss and violence on families and communities. We have seen that pregnant and parenting families need the opportunities for education that our YVK Doula Project provides within a culturally relevant framework. To meet the needs of children and families who are most vulnerable, we work to create deep, respectful relations.

Yiya Vi Kagingdi Full Spectrum Community Doula Training

Yiya Vi Kagindi Full Spectrum Community Doula Training began with its first cohort of Indigenous and Northern New Mexican students in 2018. Building upon a Reproductive Justice framework, we focus on weaving resiliency practices with the reclamation of birth knowledge in our local communities.

We created our community doula training program as a comprehensive and family-centered experience that is rooted within Tewa Women United teachings, values and beliefs. Doulas who train with us will be able to work with families by providing culturally responsive care, advocacy and support from preconception through birth to early parenting.

Our training weekends are designed to provide students with valuable practice-based and evidence-based information and hands-on experiences so that they feel ready to work with expectant parents. Our trainers include our staff, doulas and local community experts.



Throughout our Yiya Vi Kagingdi Full Spectrum Community Doula Training, we include curriculum on the following topics and create opportunities for students to learn from community experts, to enhance our community doulas' impact on social determinants of health and birth equity:

- Full Spectrum Doula Work
- Caring for Substance Using Families
- Healing/Trauma Informed Care
- Survivor-Centered Care
- Free, Prior and Informed Consent
- Body Sovereignty
- Reproductive Justice
- Perinatal Mental/Emotional Health
- Decolonization of Birth
- Client Advocacy
- Cultural Humility
- Building Professional Relationships

Community Engagement & Coalition Building for Reproductive Justice

Our **Indigenous Women's Health Program** works to strengthen community networks, partnerships and policies to improve access to maternity care and early childhood services for low income families, Indigenous women, and women of color in our rural and underserved area. We do this by advocating for policies, best practices, and strategies that uphold the health and wellbeing of families in Northern NM.

We provide training and resources to ensure leadership development for clients and community to take on active roles and participation in strategies that Tewa Women United is supporting. We also work with local providers in exchange of referrals and also as members of local collaboratives, such as the New Mexico Doula Association, the Care Coalition for Northern Families, the Rio Arriba Breastfeeding Taskforce, and the Rio Arriba Health Council. We are part of statewide efforts to promote access to qualified birth workers, and for the recognition of the value of doula services.



The following definitions frame our work at Tewa Women United:

GENDER NEUTRAL and AFFIRMING LANGUAGE

We intentionally cycle through words like **family, parent, client, woman** and **mother** to recognize and honor that not all people who birth identify as a woman or mother, as well as to uplift the identities of female-identified mothers.

HEALING/TRAUMA-INFORMED CARE

Is an emerging practice that places individual and collective emotional and spiritual well-being at the center of care, in order to positively impact health and advance communal wellness. Healing/Trauma-Informed Care builds off the work of trauma-informed care, which is now a widely accepted approach to healthcare that relies on a provider's understanding of trauma; emphasizes cultural respect, client safety and strengths; and focuses on client-centered responses to trauma.

Healing/Trauma-Informed Care engages with the ways in which trauma and healing are experienced collectively, and may include approaches related to cultural strength, civic engagement and naming of:

HISTORICAL TRAUMA occurs as the result of a traumatic event which causes cumulative emotional harm to individual, groups or a generation.

INTERGENERATIONAL TRAUMA describes cycles of trauma, where impact is passed down through generations.

INDIVIDUAL-COMPLEX TRAUMA occurs when a child is exposed to multiple traumatic events, disrupting healthy development, secure attachment and sense of self.

WHAT IS A COMMUNITY DOULA?



The role that a doula fills is an ancient one, and can be found across time, geographic regions and cultures.

Yiya Vi Kagingdi is Tewa for mother's helper.

Doula is a Greek term for a woman who supports a mother through childbirth.

A doula provides physical, emotional, informational and spiritual support to a birthing person and their family, at home, at a birth center or in a hospital. A doula may teach a pregnant person about childbirth and breastfeeding; offer continuous labor support and non-medical comfort measures; answer questions about common medical procedures; advocate for her client's voice to be heard; support with breastfeeding; offer postpartum support; assess for postpartum depression; and provide referrals to community resources.

Community-Based Doulas, or community doulas, provide care for families in their home communities and work to improve birth equity. With skills and knowledge specific to a community-based model, they support families' physical, mental, emotional, spiritual, social and cultural wellbeing.

As a provider of community-based doula care, Tewa Women United mirrors the language of the influential report, *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities*, to uplift and promote this equity-focused framework of care.

From *Advancing Birth Justice*:

"Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients and have additional training that supplements the traditional doula education curriculum.

Community-based doulas understand the importance of seeing a birthing individual, baby, and partner as a connected unit. This support is responsive to the whole birth experience and considers how physical, emotional, mental, and spiritual experiences impact pregnancy, labor, birth, and postpartum.

Community-based doulas serve in a human rights framework to ensure that all people and families have access to safe, dignified, and culturally relevant care geared toward elevating the platforms of health equity, reproductive justice, and all stages of maternal health.

Community-based programs typically provide more home visits and a wider array of services and referrals for individuals who need more comprehensive support than... a traditional doula. The support provided is low or no cost and is focused on ensuring safe, dignified and respectful care (1)."



Community-based doulas provide care for Indigenous communities, communities of color and communities that center African descended people (1). Services delivered in a community-based doula model aim to create enduring relationships of trust, by surrounding new families with trauma-informed resources and networks of support.

In our **Yiya Vi Kagingdi Full Spectrum Community Doula Training**, as well as within community-based doula training and mentorship programs nationwide, students are prepared to recognize and provide support for **SOCIAL DETERMINANTS OF HEALTH** – economic and social conditions that contribute to health disparities, including racism, poverty, trauma, and lack of access to healthy food, housing, transportation and income.

The **CORE COMPETENCIES** of a **COMMUNITY-BASED DOULA** combine knowledge and skills that support birth equity with the knowledge and skills of doula care.

At **TEWA WOMEN UNITED**, our community doulas' core competencies are similar to those outlined in the *Advancing Birth Justice* report, and include:

Doula knowledge: pregnancy, labor, medical interventions, postpartum, lactation, etc.

Doula skills: childbirth education, comfort techniques, postpartum and lactation support, etc.

Full Spectrum Doula skills: knowledge of pregnancy & infant loss, supporting grief, postpartum.

Birth Equity understanding and skills:

- An understanding of colonization and historical trauma
- An understanding of birth equity and reproductive justice
- An understanding of structural racism and implicit bias
- Healing/trauma-informed care
- Survivor-centered care
- Care that is identity and family-affirming
- Cultural humility
- Client advocacy
- Postpartum depression screening
- Culturally responsive lactation support
- Knowledge of local pregnancy and postpartum services
- Knowledge of local resources: food, shelter, income, crisis support, addiction/recovery services
- Case management, referrals and wraparound care
- Building professional relationships with medical providers
- Community education
- Whole family care (6)

“When I provide culturally aware and culturally responsive care, I am listening, learning and giving back organically by reaching deep inside my DNA.”

- Aspen Mirabal, YVK Doula
Taos Pueblo, NM



For detailed benefits of doula care, see **Appendix B: Supportive Actions and Benefits of Doula Care**

A Call to Action: Commitment to Birth Equity

Community-based doulas are further defined in the influential reports *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* and *The Perinatal Revolution by Health Connect One*. These reports show how Reproductive Justice-focused organizations are responding to major gaps left by mainstream models of reproductive health care.

As the community-based doula model is being named as a standard of care for ending racial disparities, Medicaid reimbursement and other programs will be best implemented by a workforce of doulas who are trained in this model. State programs should look to organizations historically led by Indigenous women and women of color, who have a solid record of providing community-based doula training for local communities. State standards and core competencies can center these trainings as best practice, and align their programs with community-based care.

In addition, Tewa Women United calls upon mainstream doula training organizations such as DONA, CAPPA and others, to deepen their commitment to birth equity.

Where mainstream doula training organizations continue to ignore the need for culturally responsive practitioners who are skilled in trauma-informed and survivor-centered care, continue to emphasize an entrepreneurial model of business (pricing families out of affordable doula care), and continue to serve predominantly white and affluent communities, we suggest instead that they uplift equity-focused curriculum, Indigenous doula trainers and doula trainers of color who are experienced in providing community-based doula care.

Doulas who graduate from any doula training program should have substantial exposure to, understanding of and skills around topics like birth equity, reproductive justice, healing/trauma-informed care, implicit bias, cultural humility and survivor-centered care.

Medicaid, state programs and doula training programs should rise to the occasion, reach out to build new partnerships, and ensure doulas are well prepared with in-depth training and mentorship to successfully contribute to birth equity.

Community-based doula organizations can provide this leadership.





WORLDWIDE INDIGENOUS PRACTICES OF BIRTH

Worldwide Indigenous practices of birth center mother and her relations, creating wellness through continuous, community-based care.

Worldwide Indigenous practices of birth are woven with community support, land-based practices and continuity. Traditional midwives

and birth attendants center and protect the new mother, and continuous support is given by aunts and grandmothers from conception to parenting.

Special care, attention and ceremony promote the healthiest outcomes of body and spirit. Relational knowingness to land is incorporated in food, herbal remedies, plant medicines, prayers and offerings.

The new mother is grounded in her home by a relational way of being in connection with water, land and spirit. Living in a land-based community gives her an embodied memory of a multifaceted openness,

a trust for her instincts, ways to walk forward through new possibilities and ways to engage with her world to create and recreate wellbeing (2).



Community-Based Doula Care strengthens this web of community support by attending to a mother and her relations. A community-based doula can offer culturally

responsive peer support to the whole family; show family members how to support the mother with labor comfort techniques; teach baby-wearing and healthy attachment; educate families on the benefits and skillsets of breastfeeding; assess for mental & emotional wellbeing; share natural remedies or provide warm connections to community resources.

Continuous Labor Support reflects worldwide Indigenous birthing practices, where a mother is always accompanied by social and spiritual supports.

In scientific literature, continuous labor support is an evidence-based standard of personal care, encouragement, non-medical comfort measures and information, given by a trained support person without interruption from the beginning of labor through the birth of the baby.

Numerous studies, including a Cochrane review with over 15,000 birthing participants, have demonstrated that parents

“Coming from a pueblo, it’s all like a family. When you feel a bond with somebody, it brings that closeness. We are interdependent. We take into consideration how some action will affect everyone. I was happy that my doula was open to being a part of our family.”

– Martha, YVK Doula Project Client (3),
Ohkay Owingeh Pueblo, NM

who receive continuous labor support experience measurable increases in spontaneous vaginal births; reductions in cesarean/forceps/assisted vacuum births; shortened labors; decreased use of pain medications; higher newborn Apgar scores; and greater satisfaction with the birth experience (4).

Centering a mother and her relations within practices of continuous, community support can impact maternal health outcomes. For our land-based Indigenous and Hispanic families, these practices may also provide the cultural nurturing which is so often missing from Western healthcare models.



*All Peoples of this Earth
Carry inherent understanding
Of spiritual emergence, of sacred moments
Like an infant's first breath
Original language vibrations
Activating wholeness and cellular memory
Of belonging to place, to prayed in Lands
Where we bury our babies' umbilical cords
Hold them in ceremony
Rituals of naming, rites of passage
Warrior journeys of birth and pregnancy
Natural law the only recognition we need
On Indigenous bodies who nurture these lands they are part of
Love is a rebozo embracing doorways of death and life
Nava To'l Jiya/Land Worker Mother
Wrapped in protection and care
Commitment and solidarity to ending harm
All babies and families finally welcomed
into a culture of peace*

Beata Tsosie c. 2020



RECLAIMING BIRTH KNOWLEDGE

Communities in Northern New Mexico are moving to reclaim and revitalize land-based birthing practices and ways of knowing.

Our program aims to strengthen **CONNECTION, BELONGING** and a **CULTURE of PEACE** for all communities, in response to a **Culture of Violence** that began with the occupation of Indigenous land

by Euro American people. With disregard for the land and its original

communities, Euro American power structures have replicated, deliberately

taking up space, taking lives and making the land-based practices and innate

ways of knowing of Indigenous and land-based people seem trivial. Indigenous birth practices and ways of knowing have been lost in this genocide of people and culture.

We acknowledge that this process of cultural loss is still underway. The

authoritative influence of our current healthcare system is guiding

generations of families to omit ancestral ways of knowing

and cultural practices around the birth experience. Tewa

Women United is working to revitalize these values.

Tewa Birthing Project

The Tewa Birthing Project community health assessment

reflected the voices of Pueblo women, and inquired about

their interest in reclaiming traditional birthing practices. Tewa

Women United wanted to know more about the impacts on

Indigenous families in Northern New Mexico, from the introduction of

Indian Health Services and the resulting move away from traditional birth attendants, local midwives and

Curandera Parteras. Beginning in 2003, the Tewa Birthing Project surveyed 131 Tewa women from the six

Tewa speaking Pueblos of Ohkay Owingeh, Santa Clara, San Ildefonso, Pojoaque, Nambe and Tesuque.

“We want to empower women and their families so they can have a traditional experience at childbirth that connects community members with each other.”

Elder Kathy Sanchez (5)

San Ildefonso Pueblo, NM

63% agreed that “Giving birth is a natural process that should not be interfered with unless medically necessary...”

86% said they were not familiar with Tewa birthing traditions.

50% would like their cultural practices to be more a part of the birthing experience.

65% said the loss of traditional ways was a frequent or daily concern (5).

From the results of this survey, the Yiya Vi Kagingdi Doula Project was created. Today, we continue to train doulas from our local Pueblos and surrounding communities, because we believe that solutions for community healing and wellness reside in the cultural strengths of our communities.



To contribute to a Culture of Peace, and create a foundation for revitalizing and reclaiming traditional practices and ways of knowing, we braid three central principles into our community doula training:

HEALING/TRAUMA INFORMED CARE is an emerging practice that places individual and collective emotional and spiritual well-being at the center of care, in order to positively impact health and advance communal wellness.

BODY SOVEREIGNTY is part of the continuum of Reproductive Justice and Choice and is related to Pueblo culture and history, the Culture of Affirmative Consent and Informed Decision Making. Body Sovereignty is every person's right and responsibility to have complete and unencumbered control of their body. In maternal healthcare, this includes the power of choice over: childbirth interventions; medical exams; access to culturally relevant care; sterilization procedures; child removal; etc. Respecting Body Sovereignty is a crucial element in the healing of trauma and preventing of re-traumatization.

FREE, PRIOR & INFORMED CONSENT is a human right linked to self-determination. Consent is defined as: 1) Free: when given without coercion, intimidation or manipulation; 2) Prior: when sought in advance, not only when the need arises; and 3) Informed: when based on clear, accurate and objective knowledge made available throughout the ongoing process of consensual activity (7). We teach Free, Prior and Informed Consent as it relates to doula care, Reproductive Justice, Environmental Justice, seed sovereignty and body sovereignty.



Our programs uplift culturally-specific birth workers, reflect the community-based doula model, and prepare doulas to weave birth knowledge with a culture of resiliency in our local communities.



DOULA CARE AND BIRTH EQUITY

Doulas are impacting birth equity in New Mexico by providing practice and evidence-based care to Indigenous families & families of color.

Doula Care is Practice and Evidence Based

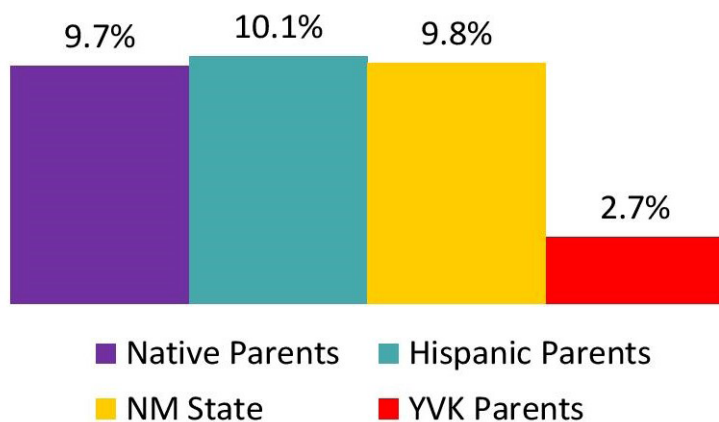
We uplift doula care as both **PRACTICE BASED** and **EVIDENCE BASED** care that supports and positively affects families' lived experience, while significantly improving birth outcomes.

We use the terms “practice” and “evidence” based, because both community knowledge and scientific studies have consistently upheld the value and impact of doula care for family wellbeing, as it has been practiced in communities throughout time and also in controlled studies, in both medical and non-medical birth settings.

Birth Equity Impacts

While we know that Indigenous communities and communities of color are disproportionately affected by high rates of preterm birth, low birthweight, postpartum depression and cesarean birth, we recognize community doula care as a method of reclaiming lost birth knowledge to improve birth equity.

Preterm Birth in New Mexico



Source: NM Vital Records 2018; YVK Doula Project

In New Mexico, we know that **PRETERM BIRTH** currently impacts Native American families at a rate of 9.7%, Hispanic families at a rate of 10.1%, and New Mexico families overall at 9.8% (8).*

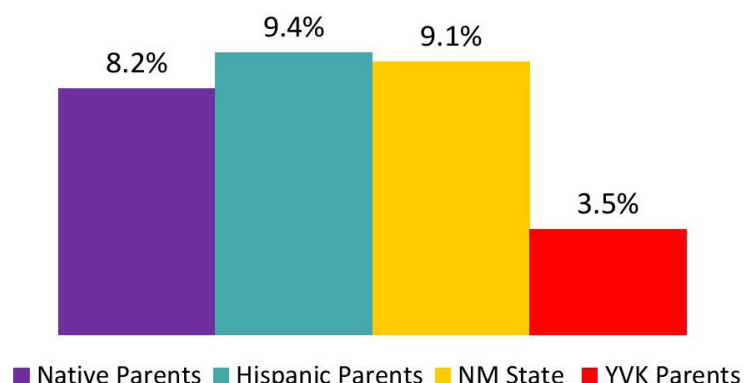
In 2006, preterm birth impacted Tewa women specifically, at a rate of 14.8% (9). Preterm birth is defined as a baby born before 37 weeks. Risk factors of preterm birth include: stress; low socioeconomic status; working long hours; late or no prenatal care; high blood pressure; diabetes; environmental toxins; domestic

violence; smoking; consuming alcohol, street drugs, or abusing prescription drugs; and being pregnant with multiples. Babies born prematurely may have more health problems, longer hospital and NICU stays, and may develop long-term health issues.

Doula care consistently impacts preterm birth rates. A study in 2016 showed that preterm birth was reduced by 22% with the services of a doula through pregnancy, labor and delivery (10). Over eight years of data collection, the **Yiya Vi Kagingdi Doula Project** has averaged a **2.7% preterm birth rate** (11).

In New Mexico, **LOW BIRTHWEIGHT** affects Native American parents at a rate of 8.2%, Hispanic parents at a rate of 9.4%, and New Mexico parents overall at 9.1% (12). In 2004, low birthweight affected Tewa women specifically at a rate of 8.6%. Low birthweight is defined by the birth of a baby weighing less than 5 pounds, 8 ounces. Risk factors for low birthweight are similar to risk factors for preterm birth. Health concerns for low birthweight babies include respiratory distress, internal bleeding, trouble eating and gaining weight, vulnerability to infection, and an increased risk for long-term health issues.

Low Birthweight in New Mexico

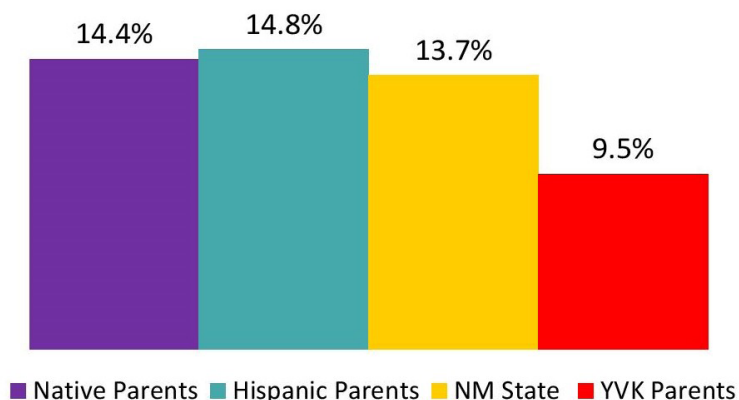


Source: NM Vital Records 2018; YVK Doula Project

Mothers receiving doula services showed a 25% reduction in low birthweight in a 2013 study, *Impact of Doulas on Healthy Birth Outcomes*, published in the Journal of Perinatal Education (13). Clients receiving community doula support from the **Yiya Vi Kagingdi Doula Project** have averaged a **3.5% rate of low birthweight** over eight years (14).

In New Mexico, Native American families experience a **PRIMARY CESAREAN** rate of 14.4%, Hispanic families at 14.8%, and New Mexico state overall at 13.7% (15). Primary cesarean rates – the number of women who experience their first cesarean surgery – are drivers of total cesarean rates. Once a woman has a cesarean birth, the likelihood of her next child being born via cesarean increases dramatically, due to increased risks in vaginal birth and a possible lack of VBAC (Vaginal Birth After Cesarean) services in her community.

Primary Cesarean in New Mexico

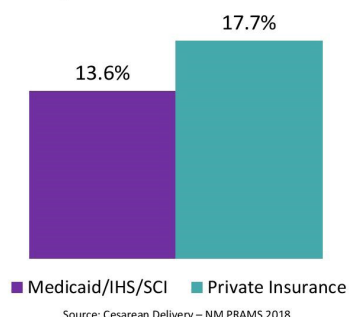


Source: Cesarean Delivery – NM PRAMS 2018; YVK Doula Project

Health factors that increase likelihood of cesarean birth include: previous cesarean, placental complications, multiples, diabetes/ gestational diabetes, indication for labor induction, high BMI, high blood pressure and pregnancy-induced hypertension. In 2017, the overall New Mexico cesarean delivery rate was 24.7%, which ranks below the United States average of 32% (16).

We know that Medicaid and Indian Health Service (IHS) providers have lower rates of primary cesarean sections in New Mexico, while private insurance providers generally have higher rates (16a). This is

Primary Cesarean in NM by Insurance Provider



important to note, 1) because it may explain why Native American parents show lower rates, and white parents show higher rates of primary cesareans, and 2) because private insurance companies may wish to take note of birth-friendly practices employed by IHS, and the growing evidence base for a doula's impact in reducing cesarean rates.

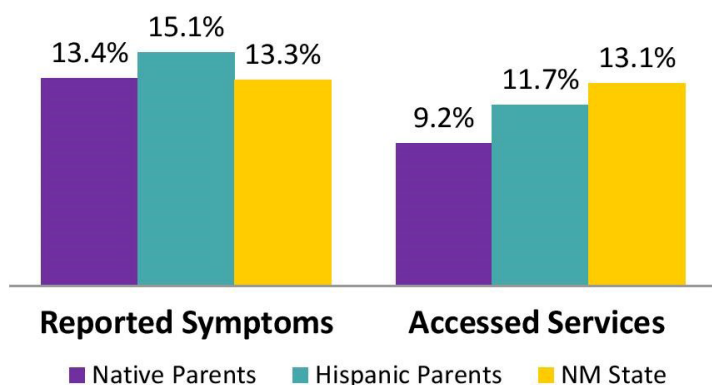
We recognize the support of **Breath of My Heart Birthplace** and **Presbyterian Espanola Hospital**, both local providers of VBAC services, in reducing our client's cesarean birth rates in Rio Arriba County!

Cesarean rates appear to be considerably impacted by doula care. In 2017, a 39% reduction in the likelihood of a cesarean birth was shown by a Cochrane systematic review of over 15,000 women who received continuous labor support (17). In alignment with this evidence, the **Yiya Vi Kagingdi Doula Project** maintains a **primary cesarean birth rate of 9.5%** and an **overall cesarean birth rate of 13.3%**, which includes clients who birthed twins, clients with multiple cesarean births and clients who hired a doula to support a pre-scheduled cesarean birth (18).

In New Mexico, symptoms of **POSTPARTUM DEPRESSION** are reported by Native American parents at a rate of 13.4% and by Hispanic parents at a rate of 15.1% (18a). Postpartum depression and mood disorders often affect up to 13% of new mothers, and are distinct from the “baby blues.” While the “baby blues” may be described as normal feelings of sadness or fatigue for the first 2-4 weeks after delivery, symptoms of sadness, anxiety, worry and fatigue after the 2-4 week mark may be caused by continued

hormonal shifting and rebalancing, and may be diagnosed as postpartum depression.

Postpartum Depression in New Mexico (PPD)



Stigma and lack of access to services may prevent some families from seeking care for postpartum depression. From 2014-2018, parents in New Mexico who reported higher rates of postpartum depression, also reported lowered access to help for postpartum depression/baby blues.

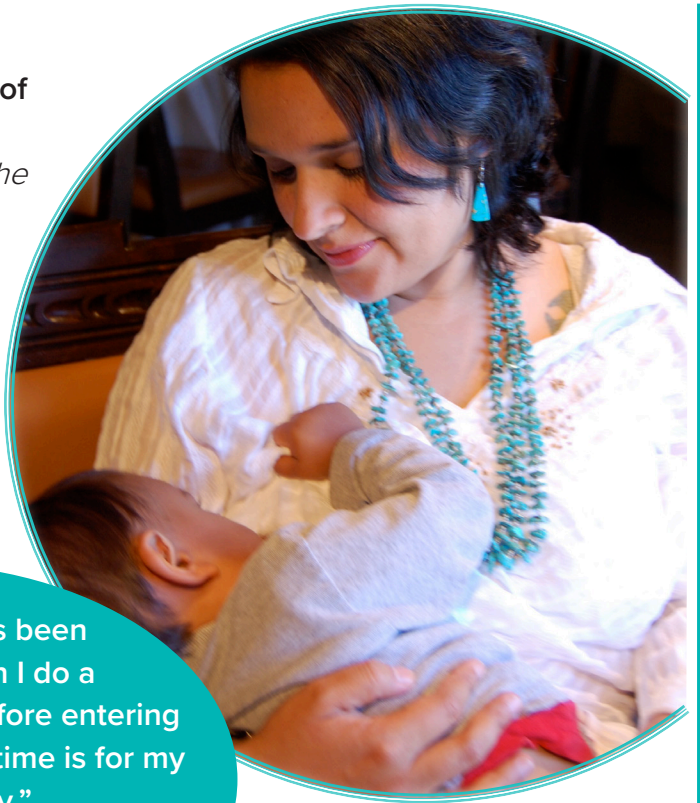
Left untreated, postpartum depression may continue for years after a baby is born. Social support, breastfeeding, nutrition, supplements, rest, counseling and a variety of complementary modalities are known to reduce and prevent postpartum depression.

Doula care's impact on preventing and reducing symptoms of postpartum depression is still being studied. What we do know, is that clients who receive doula care frequently report fewer feelings of isolation.

We are proud to say that **100% of our Yiya Vi Kagingdi Doula Project clients** receive **preventative care for postpartum depression**. Our doulas initiate caring conversations about mental/emotional health, and use the Edinburgh Postpartum Depression Scale to assess for postpartum depression in the first weeks after birth. In addition, clients receive support with infant feeding and breastfeeding, and referrals to community-based services like home visiting, mental health, and parenting circles. Over eight years, **13% of our clients who responded to the EPDS scored a 10 or above**, reflecting the need for wraparound care.

Additional Health Impacts of Doula Care

Doulas are often associated with increasing rates of **BREASTFEEDING INITIATION & DURATION**. One study mentioned in Health Connect One's report, *The Perinatal Revolution*, showed significant increases in breastfeeding rates and significant decreases in cesarean rates for families receiving care from a community based doula program (19). Doula care has also been recommended by the CDC to increase breastfeeding rates (20).



"My doula work has been more effective when I do a space/energy clearing before entering a birth, so that I know my time is for my client and family."

- Diana Halsey, IWH Program Assistant
Santa Clara Pueblo, NM

**Throughout this section, we chose to highlight statistics from Native American and Hispanic communities of New Mexico, to reflect YVK Doula Project's client base here in Rio Arriba County. Birth equity statistics for all of New Mexico can be found through NM PRAMS and NM Vital Records.*



ENDING VIOLENCE AGAINST WOMEN

*More than 1 in 2 American Indian and Alaska Native women have experienced sexual violence.
The Indian Law Resource Center (21)*

Survivor-Centered Care

Tewa Women United is at the forefront of interventions to **END VIOLENCE AGAINST WOMEN**, and recognizes how violence against women creates deep and lasting impacts for families and communities.

As one example of Tewa Women United's approach, the Yiya Vi Kagingdi Doula Project was started as a response to the child sexual abuse and sexual violence that we were seeing in our local communities.

Giving women a voice, teaching healthy touch and attachment, and creating trusted networks of support around pregnancy, birth and early childhood were among the project's original objectives.

"In a country where 1 in 3 women will have experiences with sexual assault in their lifetimes, it is imperative that community-based doulas are trained in survivor centered care. Doing so will insure that birthing parents will be supported to make informed decisions, be advocated for having consent when being touched or having a medical procedure done, and be spoken to and cared for with the utmost dignity and respect."

- Jessica Garcia Lujan, IWH Program Manager
La Puebla, NM

Our work has always focused on providing SURVIVOR-CENTERED CARE, to encourage healing and advocacy in our communities. Today, we continue to uplift survivor-centered care as a core understanding and skill set of community-based doula practice.

We are advocates for comprehensive and accessible training for birth workers across New Mexico, on a survivor-centered model of care, as outlined in the book, *When Survivors Give Birth* by Penny Simkin.

This model provides insights and practices around clinical challenges that may arise for survivors during labor and delivery, including:

Prolonged or stalled labor • Disassociation • Provider gender preference • Lack of interest in newborn
• Resistance to vaginal exam • Reluctance to breastfeed (22)

Caring for Substance Using Pregnant Families

The Yiya Vi Kagingdi Doula Project is taking steps to explore intersections of **SEXUAL TRAUMA**, **PREGNANCY** and **SUBSTANCE USE/DEPENDENCE***, as they relate to community doula care. We know that in New Mexico, the co-occurrence of substance use and sexual violence too often affects pregnant and parenting families.

We see how unresolved trauma (historical, intergenerational and individual-complex) may be passed down, embedded in cellular memory, and drive people to seek substances as a remedy for pain and loss. In a world where substance use in pregnancy often carries a heavy stigma, substance using pregnant families may experience fear, isolation, lack of access to needed resources, and postponement of medical care, all in a time when real support is essential. These experiences of unresolved trauma may be further marginalized and criminalized, continuing the cycle of harm, and impeding the life-giving experience of birthing, parenting and healing for families.

To better care for our clients with *co-occurring experiences of substance use and sexual trauma*, we are learning and practicing healing/trauma-informed understanding and skills, with the support of client-informed training from Young Women United and other community-based organizations. We have included these learnings in collaborative meetings with our local OB-GYNs, and in our work with the Care Coalition for Northern Families. We aim to make culturally responsive, land-based providers and practices more accessible to our community, to reduce stigma, resolve trauma and create healing.

Areas where we are increasing our understanding of **Caring for Substance Using Pregnant Families** (22):

- Exploring and deconstructing stigma as it occurs within and around us
- Effects of substance use on infants: low birth weight, neonatal abstinence syndrome
- Providing more opportunities for informed consent during labor and delivery
- Best practices around breastfeeding and postpartum care
- How the following experiences may impact a client during pregnancy, birth and parenthood:
 - Judgement and misinformation
 - Consent, touch, trauma and shame
 - IV placement + blood draws
 - Choice of pain medication during labor
 - Feelings of fear, sadness and feeling alone
 - Referrals to CYFD and the criminal justice system

*We invite you to join us in using person-centering language, such as a **substance using** or **substance dependent** person in place of **addict** and **addicted**, in the spirit of eliminating stigma and dehumanization, and re-centering the lives of our beloved community members affected by this experience.

Black Women's Blueprint's "*The Sexual Abuse to Maternal Mortality Pipeline*" Report



Birth justice advocates are drawing connections between **SEXUAL ABUSE, UNADDRESSED TRAUMA** and higher rates of **MATERNAL MORTALITY** in Black and Indigenous communities, and communities of color.

In their 2019 report, Black Women's Blueprint coins and defines the concept, "*The Sexual Abuse to Maternal Mortality Pipeline*." In the report, Black Women's Blueprint investigates and maps correlations between violence, gender-based abuse and trauma, and their impacts on maternal health outcomes across eight key areas.

Authored by Black women, the report focuses on the maternal mortality crisis in Black and Native American communities:

"The CDC reports that in the US, the risk of pregnancy-related deaths for Black women is 3 to 4 times higher than those of white women, and Native American women are 4.5 times more likely to die from pregnancy and childbirth related causes than non-Hispanic white mothers (23)."

In the US, higher maternal mortality rates are consolidated in the South, the highest being Louisiana's rate of 58 deaths per 100,000 births (23). In 2018, New Mexico experienced 25.6 deaths per 100,000 births, an increase from 23 deaths per 100,000 births in 2016 (24). In addition, overdose and suicide – causes of death related to both trauma and access to resources – make up nearly 50% of the top four causes of maternal mortality in New Mexico. Overdose is the most common cause, accounting for 19% of maternal mortality deaths overall, in 2017 (24a).

Black Women's Blueprint's report highlights Arline Geronimus's theory of WEATHERING, or "toxic stress resulting from racism, bias and discrimination" as a critical linkage between medical causes of maternal death and their disproportionate prevalence in Indigenous communities and communities of color (25). The report describes the impacts of exposure to toxic stress, sexual abuse, unaddressed trauma, provider bias, obstetric violence and re-traumatization as overlooked factors in higher rates of maternal mortality.

Of the stories and incidents reported by sexual abuse survivors, Black Women's Blueprint notes,

"The report illustrates the pipeline with examples, including pregnant women who do not seek gynecological and prenatal care due to childhood trauma of abuse, rape and incest, pregnant women who report experiences of virginity testing as girls with vaginal

penetration practiced with parental consent by OB/GYN professionals, and stories of young women and girls who experience non-consensual vaginal exams, non-consensual pelvic exams, or who report what they experience as ‘obstetrics violence.’ It also includes incidents reported by women who disclose non-consensual gynecological procedures, violation and stressors during labor, like ‘disrespect and abuse’ and sexualized language used in communicating with young women who won’t open their legs or refuse to push during labor (26).”

DISMANTLING the “**Sexual Abuse to Maternal Mortality Pipeline**” an urgent matter. Black Women’s Blueprint adamantly calls for the elimination of the “often unintended, but still pervasive rape-culture (27).” They ask us to notice and interrupt the ways in which misogynistic language and the objectification of women’s bodies maintain a disregard for women’s rights and safety within maternal health care settings.

Black Women’s Blueprint provides recommendations for policy, medical practice and culture change, to prevent maternal mortality and address the issue of violence that occurs both inside and outside of medical systems. The authors define the Sexual Abuse to Maternal Mortality Pipeline across the following key areas:

- Better care for the maternal health impacts of **SEXUAL ABUSE**,
- Remedies for **UNADDRESSED TRAUMA**,
- Policies & practices that counter the effects of **WEATHERING**,
- Addressing reasons for the **AVOIDANCE or DELAY** of **HEALTH CARE**,
- Accountability for and prevention of **ABUSE WITHIN OB/GYN CARE**,
- Preventing the **RE-TRIGGERING** of **TRAUMA SYMPTOMS** within medical settings,
- Accountability for and prevention of **OBSTETRIC VIOLENCE** in **LABOR & DELIVERY**,
- Immediate actions to prevent **MATERNAL MORTALITY**.

For a summary of Black Women’s Blueprint’s recommendations to address and prevent violence, sexual abuse, trauma and maternal mortality, see:

Appendix C: Black Women’s Blueprint’s “The Sexual Abuse to Maternal Mortality Pipeline” Report Recommendations Summary

For the full report, go to: www.bwbtraining.org/hands-off-our-bodies

Uplifting Culturally Specific Birth Workers

At Tewa Women United, we also advocate for an interruption to the cycles of violence against women across all sectors. In response, we seek to expand community access to **CULTURALLY SPECIFIC BIRTH WORKERS** and **HEALING PRACTITIONERS** as a way to promote healing and resolve trauma.



We know that culturally-specific birth workers have the cultural knowledge, relational approach and advocacy role to support experiences of body sovereignty.

Culturally specific birth workers trained in healing/trauma-informed and survivor-centered care may offer appropriate care for survivors and substance using pregnant families precisely because, “Part of what makes survivorship so challenging is the lack of body sovereignty (28a).”

They do so by providing care which centers the lived experiences of sexual violence, trauma, weathering, substance use and loss, moving in a client-centered way towards healing.

Culturally-specific doulas, midwives and healing practitioners are named as key interventions in the Black Women’s Blueprint report, as supportive elements in a cross-sectoral approach to addressing violence and supporting survivors of sexual abuse.



At Tewa Women United, we believe that all families deserve a doula.

We advocate for comprehensive training in **survivor-centered care** to be made accessible for all doulas, birth workers, medical providers and nurses working in New Mexico.

We advocate for broader use of **healing/trauma-informed care** practices, to better support our substance using pregnant families across New Mexico.

We uplift the knowledge shared in Black Women’s Blueprint’s report because we know that for our families, this knowledge is crucial.



EQUITABLE PAY FOR DOULA CARE

Doulas deserve equitable pay for the hours of valuable care and improved health outcomes they provide for New Mexico families.

Living Wage for Community-Based Doula Work

If doulas decrease preterm birth, low birthweight and cesarean rates and impact social determinants of health, then a **LIVING WAGE** should be a baseline model for program salaries, reimbursement rates & global fees, to guarantee equitable pay for professional work. Training doulas from low-income communities and paying them any less than a living wage would translate to keeping skilled professionals in poverty, in the name of public service. This is NOT economic justice, and instead replicates dynamics of economic domination and colonization within health systems. Doulas deserve equitable pay for the hours of labor they perform.

Data from our **Yiya Vi Kagingdi Doula Project** shows that a community doula provides an average of **38 hours of care to each client**. Often, due to inductions of labor, the needs of the client, and long distances traveling to rural homes, community doulas may provide additional hours of care, up to 60+ hrs per client.

3 prenatal home visits @ 2 hours each	= 6 hours
Continuous support during labor and delivery	= 18 hours
3 postpartum home visits @ 2 hours each	= 6 hours
Remote support (calls, texts, research, referrals)	= 2 hours
Drive time to rural homes/hospitals (1 hr/visit)	= 6 hours

Yiya Vi Kagingdi Client Services	= 38 hours
---	-------------------

To calculate an equitable pay rate for community doulas, we looked to the concept of a living wage, as defined by the Massachusetts Institute of Technology. MIT's living wage model calculates cost of living by county, taking into account: minimum food needs, housing, transportation, childcare, health insurance, basic necessities such as clothing and hygiene items, and the rough effects of income tax. Costs associated with entertainment, restaurant meals, leisure time, unpaid vacation/holidays, retirement planning, purchasing a home, savings and investments are NOT reflected in this calculation. Living wage is based on a 40-hour work week* and accounts for variations in the cost of living for families of different sizes (29).

Living wage for a single mother with 1 child in Rio Arriba is \$23.75 per hour (30).

At a living wage, this doula would be paid \$903 per client for providing 38 hours of doula care in Rio Arriba.

New Mexico: Living Wage by County

New Mexico County	Living Wage by County \$/hour for a Single parent + 1 child	Doula Hours Average work performed per client	Admin Fee To cover billing costs / support from community-based programs	Doula Payment Minimum recommended Global Fee per client
**Rio Arriba	\$ 23.75 / hour	38 hours	+ \$50	\$953
Dona Ana	\$ 24.12 / hour	38 hours	+ \$50	\$967
Taos	\$ 24.36 / hour	38 hours	+ \$50	\$976
Bernalillo	\$ 24.90 / hour	38 hours	+ \$50	\$996
Santa Fe	\$ 25.78 / hour	38 hours	+ \$50	\$1030
Doulas are COST EFFECTIVE at rate of:			--	\$986 ⁽³¹⁾
IDEAL PAYMENT to include cost of hospital meals, supplies, transportation, overnight childcare and accounting for doula work not being structured at 40 hours per week:			--	\$1500

Additional expenses of doula care should be considered. These include hospital meals, supplies, travel and overnight childcare. Administrative funds are needed to cover the additional training, supervision and mentorship that support a community-based doula model, as well as billing costs incurred by organizations and independent doulas.

***While the work of a community doula is NOT based on a 40-hour work week**, calculating an hourly pay rate based upon a living wage is a foundational step towards generating a sustainable career path for community doulas.

****The lowest living wage listed for New Mexico** was the same across Catron, Cibola, Colfax, Grant, Guadalupe, Harding, Hidalgo, Luna, McKinley, Otero, Quay, Rio Arriba, Sierra, Socorro and Union Counties.

LINK: livingwage.mit.edu

Cost Effectiveness of Doula Care in New Mexico*

There were 23,038 New Mexico resident births in 2018. Based on studies of the evidence-based impact of doula care, this chart shows how doula care may reduce the rates and costs of NICU admission, low birth weight, cesarean delivery and preterm birth in New Mexico. Average costs listed are based on national averages.

New Mexico resident births (2018) N = 23,038	NM rate per 1,000 births	Average Cost per Case ⁵	Reduction in rate per 1,000 with Doula	Savings per 1,000 births
NICU Admission (all)	105	\$76,164	1	\$76,164
Low birthweight baby (< 5.5 lbs)	90.1	\$27,200	22.25	\$605,200
Low birthweight baby (singletons)	77	\$27,200	19.25	\$523,600
Cesarean Delivery (private payer)	250	\$16,673	97.5	\$210,680
Cesarean Delivery (Medicaid patients)	170	\$7,983	66.3	\$529,273
Preterm Birth (<37 weeks gestational age)	98	\$32,325	21.6	\$698,220

NICU ADMISSIONS

Doula care prevents 1 NICU admission per 1,000 births (1), potentially saving \$76,164 per 1,000 births in New Mexico.

LOW BIRTHWEIGHT (< 5.5 lbs)

Doula care reduces the rate of low birthweight babies by an average of 25% (2), potentially saving \$523,600 per 1,000 singleton births in New Mexico.

CESAREAN DELIVERY

Doula care creates a 39% reduction in the likelihood of cesarean delivery (3), potentially saving \$210,680 per 1,000 private payer births and an additional \$529,273 per 1,000 Medicaid births in New Mexico.

PRETERM BIRTH (< 37 gestational weeks)

Doula care reduces preterm birth by 22% (4), potentially saving \$698,220 per 1,000 births in New Mexico.

----- Statistical Citations

1. Pilliod R, Leslie J, Tilden E, Page J and Caughey A. *Doula Care in Active Labor: a Cost Benefit Analysis*. American Journal of Obstetrics and Gynecology. Vol. 208, Issue 1. January 2013
2. Gruber KJ, Cupito SH and Dobson CF. *Impact of Doulas on Healthy Birth Outcomes*. Journal of Perinatal Education, Winter 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>
3. Bohren M.A., Hofmeyr G., Sakala C., Fukuzawa R.K. & Cuthbert A. *Continuous Support for Women During Childbirth*. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6. https://www.cochrane.org/CD003766/PREG_continuous-support-women-during-childbirth
4. Kozhimannil K. M., Hardeman R. R., Alarid-Escudero F., Vogelsang C. A., Blauer-Peterson C., & Howell E. A. *Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery*. Jan 14, 2016. <https://doi.org/10.1111/birt.12218>
5. Gebel, Christina. *Summary of Doula Town Halls and Doula Survey in Massachusetts*. March of Dimes, May 2019.

*Developed in September 2019 as a collaboration between **Tewa Women United & New Mexico Department of Health**.



BIRTH EQUITY & ECONOMIC JUSTICE

Compensation and reciprocity for care that contributes to birth equity should create economic justice for New Mexico doulas and families.

Doulas receive **COMPENSATION** for their services in a variety of ways: informal community exchanges of goods and services, private practice/fee-for-service, direct service programs funded by grants that pay stipends or monthly salaries, and MCO/insurance payments.

We acknowledge **RECIPROCITY** as a traditional way of respect for the simultaneity of giving and receiving, where gifts and services are given freely and all benefits multiply exponentially. Doula work is traditional work for many of our Indigenous, Hispanic and land-based acequia communities, and reciprocity for care might be expressed in the form of work provided for another family, foods, medicines, gifts, kind actions and prayers.

By practicing Reciprocity, the nurturing energy of kindness ripples out, touching and cleansing all members of the family and community.

“Compensation” through community reciprocity acknowledges the sacred element of what a doula or traditional birth worker provides, beyond any numerical value.

Expanding access to doula care should create **ECONOMIC JUSTICE** for New Mexico doulas and families. Economic Justice is an ethic of distributing social and financial benefits equally to all people, through careful crafting of economic policy. Policies that are economically just provide benefits for both the individual and the community as a whole. Within Economic Justice, all people are supported to “engage creatively in unlimited work” and to “create a sufficient material foundation upon which to have a dignified, productive and creative life (32).”



What does **ECONOMIC JUSTICE** look like in the expansion of access to doula care for New Mexico’s families?

1. Expanding the pool of Indigenous doulas and doulas of color,
2. Supporting doulas to work in communities of their choosing,
3. Allowing affordable access to doula care for all families, and
4. Paying doulas a living wage for the substantial hours of care they provide.

Economic Justice and Reciprocity

Our vision of **ECONOMIC JUSTICE** reflects the **RECIPROCITY** inherent in **ecological wholeness**. Through Economic Justice, social and economic benefits circulate to where they are needed most, as in the biology of a forest. People, like trees, are supported in their purpose and creativity, always contributing to new life in their environments.

In this model, we value jobs and work that contribute to the healing and wellbeing of all communities, without incurring damage or cost to our water, land and air.

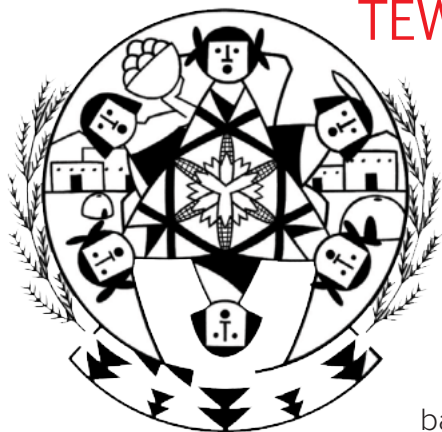
If Economic Justice were based in Reciprocity, working people would make daily contact with sources of regenerative energy. Working three jobs, coming home dispirited, and battling toxic stress would not be a method of distributing wealth, but rather the symptoms of a society running in reverse of Reciprocity.



How can both **ECONOMIC JUSTICE** and **RECIPROCITY** be woven into the expansion of access to doula care for New Mexico's families?

- By training community doulas to provide life-giving, creative and purposeful work,
- By connecting doulas and families in a way that does not deplete the resources of either party, and
- By compensating doulas equitably, so that their life-giving contributions for New Mexico's families give them a "sufficient material foundation" from which they can live in the blessing of reciprocity and wellbeing.

We know that doulas **IMPACT BIRTH EQUITY** by decreasing preterm birth, low birth weight and cesarean rates. From a public health perspective, community doula work is deserving of both equitable compensation and true Reciprocity. This work has become a source of income and a purposeful career choice for New Mexico doulas, and deserves Reciprocity, not poverty wages.



TEWA WOMEN UNITED'S RECOMMENDATIONS

Models of Expanding Access to Doula Care

Many paths, including but not limited to Medicaid reimbursement, are available as methods of expanding access to doula care. In this section, we suggest seven different models that communities and organizations can explore, to find a best fit for both doulas and families. With the guidance and expertise of existing community-based doula models, new programs can successfully increase access, develop community-based care, and create payment systems that reflect true reciprocity and Economic Justice.

1) State and Federal Legislation for Medicaid Reimbursement

Three states - Oregon (2011), Minnesota (2013) and New York (2018) have passed legislation and are in the implementation stage of funding doula care for Medicaid recipients. Medicaid reimbursement for doula care was also passed in 2019 in Indiana, New Jersey and Washington.

At least nine other states have recently introduced legislation to create Medicaid reimbursement for doula care: Arizona, Connecticut, Illinois, Massachusetts, Rhode Island, Texas, Vermont, Wisconsin and Washington DC. On the federal level, five different bills promoting Medicaid reimbursement of doula care were introduced in 2019, including the Mamas First Act, sponsored by Deb Haaland of New Mexico. The National Health Equity Law Program has created an online resource called the [Doula Medicaid Project](#), for those who wish to stay up to date on related legislation.



Everyday Miracles in Minnesota provides birth doula services to around 30 Medicaid recipients per month. The organization disperses state funds to community doulas, while providing doula support to families. The Everyday Miracles model also includes daily prenatal wellness classes, access to car seats and breast pumps. The organization also provides financial support for enrollment on the MN state registry, to doulas in their program. To provide these services, Everyday Miracles takes an administrative fee from the state reimbursement. The organization has helped successfully advocate for a reimbursement rate increase in MN. The new rate went into effect in January 2020 (33).

2) Managed Care Organization (MCO)-Led Reimbursement

MCOs in some states have chosen to provide doula care to Medicaid recipients, and in some cases, private insurance recipients. Even without legislation requiring doula care to be provided, MCO-led pilot programs are popping up around the country.

Steward Health Choice in Massachusetts is a Managed Care Organization that implemented a pilot program in 2019, to provide community-based doula services free-of-charge to its members. As Massachusetts has yet to pass legislation that would require MCO's to provide doula care, Steward Health Choice is unique in initiating this program. The growing number of MCO-led doula programs reaffirms what we know: doula care impacts maternal health outcomes, is cost-effective, and may be in the best interest of healthcare organizations (34).

3) Expanding Access to Doula Training

Expanding the pool of trained doulas infuses resiliency and birth knowledge into communities. Whether or not trained doulas ever certify (most doula training organizations require a doula to provide services to 3-5 clients, write book reports, attend additional classes, and pay a fee, on top of attending the initial doula training, in order to receive an official certification), or ever choose to operate within a state-managed program, the training they receive ripples out.

Trained doulas may choose to work from a community reciprocity model, freely offering doula care to friends and family, teaching their peers about doula care, and improving birth outcomes.

Tewa Women United's Yiya Vi Kagingdi Full Spectrum Community Doula Training in Espanola, NM, completed training its first cohort of fifteen student doulas in March 2019. Restoring birth knowledge to communities and developing birth workers to provide culturally responsive care in Northern New Mexico are among the program's primary intentions. The training was offered at no cost to students, with an agreement that each student would give back to the community by providing doula care to three families at no cost. By providing training at no cost, and offering, but not requiring certification, Tewa Women United encourages grandmothers, aunties, sisters, fathers and young people to provide care for their local communities.

State health departments, MCOs and NGOs might also consider offering community doula trainings at low to no cost, as a method of expanding access to care. In some states where Medicaid reimbursement for doula care legislation has passed, MCOs are finding that the pool of community-based doulas is not large enough. As a remedy, MCOs have invested grant money in providing doula training and certification in their state. Funding for doula training has also been written directly into state legislation, in preparation to expand the doula workforce and increase access to doula care.

In 2018, a **Care Coordination Organization** in Oregon allotted \$200,000 to train 30 doulas from diverse communities. The funding covered costs for doula training, completion of additional core competency requirements (to qualify for the state registry), and even paid the doula for providing services to her first three clients. The grant also funded collaboration with a local university for the purpose of data collection and analysis (35).

4) Grant Funded Direct Service Programs

Community-based doula organizations are often funded by private grants. Funding covers a doula's stipend or monthly salary, as well as administrative support and other benefits for doulas. Client outreach, provider collaboration, reflective supervision, peer support and mentorship are provided by dedicated staff, creating a supportive container for professional development and effective service delivery. Many community-based doula organizations commit to pay doulas a living wage, prioritizing Economic Justice.



Ancient Song Doula Services in Brooklyn, NY is a community-based doula organization committed to addressing racism and implicit bias in the healthcare system. Their programs provide birth doula, postpartum doula, bereavement doula and prison doula services to all pregnant and parenting families, regardless of ability to pay. As of March 2019, Ancient Song community-based doulas received \$1,555 in compensation for their services, per client (36, 37).

Tewa Women United's Yiya Vi Kagingdi Doula Project in Espanola, NM offers full spectrum doula care for pregnancy, birth, postpartum, miscarriage, abortion and infant loss. Birth doula care includes 3 prenatal visits, continuous labor support and 3 postpartum visits. The program is grant funded and is able to pay doulas \$900 per client. Clients receive services at low/no cost.

Uzazi Village in Kansas City, MO was established to decrease maternal and infant health disparities for African American women and medically marginalized families in our community. Uzazi Village provides Sister Doula services, childbirth education classes and a walk-in breastfeeding clinic. Sister Doulas are accessed by families in various ways: fee-for-service, sliding scale, scholarship and insurance coverage. Uzazi Village pays its Sister Doulas \$1200 per client. Founder Hakima Payne advocates for a living wage for all doulas, and notes that fees for doula services can reach \$1500-1800 in some regions (38, 39).

5) Hospital-Based Programs

Doula programs are sometimes housed in hospitals and maternity clinics, providing doula care that is either volunteer/no cost, fee-for-service, and in some states, a service that is covered by insurance. In hospital-based programs, doulas are often seen as a valuable addition to patient care. In a recent survey of nurses whose patients received volunteer doula support, 100% agreed or strongly agreed that

doulas were important members of the maternity care team (39a). Still, advocates for community-based models of doula care have critiqued volunteer-based programs as exploitative, and some hospital-based programs as ineffective, not community-based, and at risk of serving the medical system instead of the woman and her family.

Various hospital-based programs have provided doula care to patients in New Mexico, but most have closed due to the financial inaccessibility of a fee-for-service model, a gap in administrative support, or a lack of provider/community awareness of the benefits and scope of doula care. Efforts to revitalize hospital-based doula programs are underway, and many advocates agree that insurance coverage for doula care is needed.

University of New Mexico Hospital (UNMH)'s [Birth Companion Program](#) in Albuquerque, NM started training volunteer doulas in 2018, in the basics of doula care for labor and delivery. The doulas are integrated with UNMH's volunteer program, receive ID badges, and sign up for two 24-hour on-call shifts per month. Nurses, OBGYNs, physicians and CNMs can call on a doula when the need arises, and the doula arrives to the hospital to meet the patient and offer support at no cost. Additional training around Caring for Substance Using Pregnant Families from Young Women United supports doulas to volunteer with UNMH's Milagro Clinic and Focus Program, providing doula care to women who have a past or current experience of substance dependence.

6) Tribal-Led and Community-Led Initiatives

Doulas may be trained, connected with clients and possibly compensated by tribal-led and community-led initiatives. This model allows local community to control the shaping of doula work and to weave cultural knowledge into their own community's care.

Wiji'idiwag Ikwewag: Manitoba Indigenous Birth Helpers Initiative is an Indigenous community-led program of doulas or Birth Helpers in Manitoba. Through the Restoring the Sacred Bond Initiative, up to 200 Indigenous mothers who are at risk of having their infant removed by the child welfare system will be connected with Indigenous Birth Helpers to provide pregnancy, birth and postpartum support for up to one year. As a community-led initiative, the program is positioned to reconnect mothers with traditional cultural practices and strengthen their personal support networks (40).

7) Community Reciprocity for Birth Work

This model will continue to exist in all human cultures, as long as we continue supporting each other in giving birth! We believe that reciprocity for traditional birth work in Indigenous communities, inclusive of informal exchanges of gifts and services; family members and friends supporting new families; as well as private doula businesses that charge a fee for service will perpetuate regardless of state involvement or funding for new programs. This is a good thing! In this model, the doula and community decide on what services will be offered and what reciprocity or compensation will be given.



TEWA WOMEN UNITED'S RECOMMENDATIONS

Medicaid Reimbursement of Doula Care

We recognize Medicaid reimbursement of doula care as just one of many paths of expanding access to doula care, and offer the following recommendations to ensure that new systems will functionally support the work of community-based doulas.

The following recommendations aim to support our communities of color and Indigenous communities here in New Mexico to more easily access doula care and doula care reimbursement, while avoiding excess administrative barriers and prohibitive costs. These recommendations also support the independent practice of doulas who choose not to engage with Medicaid reimbursement or other state programs.

**Note that current state reimbursement programs in Oregon, Minnesota and New York do NOT yet reflect equitable processes, structures or reimbursement rates. We include research about these state programs and other legislation, to encourage informed conversations in New Mexico around how we can advance the cause of birth equity.*

1) MEDICAID and PRIVATE INSURANCE REIMBURSEMENT PROGRAMS

RECOMMENDATION: Any action taken to expand access to doula care should include thorough input from New Mexico's doulas.

Research: Three states - OR (2011), MN (2013) and NY (2018) have passed and implemented legislation requiring state Medicaid to fund doula care. Medicaid reimbursement for doula care was passed in 2019 in IN, NJ and WA. At least eight other states and Washington DC have recently introduced legislation to do the same: AZ, CT, IL, MA, RI, TX, VT, WI and WDC. Five different federal bills promoting Medicaid reimbursement of doula care were introduced in 2019, including the Mamas First Act, sponsored by Deb Haaland of New Mexico (41).

2) THE QUESTION of LICENSURE

RECOMMENDATION: A doula's scope is non-medical, and should NOT be subject to the regulation and costs associated with state licensure.

Research: No state that has approved Medicaid reimbursement for doula care requires a doula to receive a state licensure. Doula certification and/or minimum contact hours of doula training is considered sufficient for state registry in OR, MN, NY and NJ. Two states, OR and WA, have linked doula care provision to already established Traditional Health Worker/Community Health Worker programs. THWs/CHWs are non-medical, and are not required to be licensed in either state (42, 43, 44, 45).

3) PROTECTION of INDEPENDENT DOULAS

RECOMMENDATION: Doulas should be protected to continue to practice independently, as non-medical providers, under the scope of their training or certification, when they are providing care that is not connected with state-regulated services for recipients of Medicaid.

Research: Doulas and advocates consistently agree that doula work should remain protected as a non-medical and un-licensed practice, recognized as legitimate and independent, largely outside of state regulation. To date, no state has brought the practice of doula work fully under its jurisdiction.

4) DOULA CERTIFICATION

RECOMMENDATION: States should NOT provide “doula certification,” at any level. Doula training organizations should remain the sole providers of this credential. We do not support state requirements of doula proficiency exams, certification fees and assessments of character, as these should be recognized as barriers to community-based doula practice.

Research: In OR, MN and NY the state requirements for state registry and Medicaid reimbursement include a state “certification” process. In the case of New York, problematic language found in Assembly Bill A364B and Senate Bill S3344B has been challenged and denounced by doulas and community-based doula organizations.

In an open letter submitted to New York State by Ancient Song Doula Services, Chanel Porchia-Albert responds to the bill’s proposal, regarding: state certification of doulas; a rule around who can use the term “certified doula;” a regulatory fee of \$40; a doula proficiency exam; and an assessment of moral character.

Certification

Assembly Bill A364B:

(A) “CERTIFIED DOULA” means an individual certified under this section who provides certified doula services [...]

2. USE OF TITLE. Only a person certified under this section shall be authorized to use the title “CERTIFIED DOULA”.

Ancient Song:

“Following the passage of these bills, New York will require all doulas to be professionally certified under state guidelines—only those certified may provide doula services. We believe that the state certification process and legislation, as it currently stands, will negatively affect community-based doula organizations of color and communities of color disproportionately.”

“The term ‘certified doula’ has been in place for a long time and is used by many different certifying organizations. We don’t believe New York State can lay claim to it and suggest that they use the term ‘NYS-certified doula’ or ‘New York State certified doula.’”

Regulatory Fee

Assembly Bill A364B:

(F) FEE: Pay a fee of forty dollars to the department for consideration of an application for certification.

Ancient Song:

“New York State will require a fee of \$40 to the department for application consideration and certification, which can provide a barrier for community-based doulas. We also need clarity on which doulas would be exempt from taking this examination.”

Doula Proficiency Examination

Assembly Bill A364B:

(C) EXAMINATION: Pass an examination satisfactory to the department and in accordance with the commissioner's regulations.

Ancient Song:

“An examination requirement administered by the state is redundant and a potential barrier for community-based doulas. Proof of certification from a credible organization is evidence of a high level of training and preparation for doula work. Instead of an examination requirement, we believe that the focus should be on requiring skills-building for community-based doula work, including in birth/health equity, racism/implicit bias, case management.”

Moral Standing

Assembly Bill A364B:

(E) CHARACTER: Be of good moral character as determined by the department.

Ancient Song:

“We would like to know how ‘good moral character’ will be determined? Is this standard for Medicaid providers? The unknown parameters of this assessment can create a barrier to community-based doula care and support” (46, 47, 48).

5) STATE REGISTRY and FEES

RECOMMENDATION: Creating a state registry is a good precedent for reimbursing doulas through Medicaid. To promote access for doulas from low-income communities, registry fees should be waived or covered by a third party. A doula's eligibility for state registry can be guided by core competencies and minimum contact hours, as is the precedent in OR and NY. States should NOT determine eligibility based upon a list of approved doula training organizations, as is the precedent in MN and was suggested in the 2019 federal legislation, Mamas First Act.

Research: Requirements for doula state registries in OR, MN and NY are as follows:

**Note, that for a doula to register in OR, MN or NY, these states provide "certification," something that we do not feel is equitable or necessary, to approve a doula's eligibility for reimbursement.*

OREGON (from OR Health Authority)

Certificates of attendance for the following education:

- At least 28 contact hours of in-person education that includes any combination of childbirth education and birth doula training.
- At least 6 contact hours of cultural competency
- At least 6 hours total in one or more of the following topics as they relate to doula care:
 - Inter-professional collaboration
 - HIPPA compliance
 - Trauma Informed Care
 - An OHA-approved Oral Health Training
 - Current CPR certification for children and adults
 - Verification of attendance at three births, and three postpartum visits per client
 - Proof of completed community resource list (49.)

MINNESOTA (from MN Department of Human Services)

**Note that Minnesota's original legislation approved a number of doula training organizations, but left out Commonsense Childbirth, an equity-focused doula training institute. Doulas with this certification were not consulted in the law making process, and had to wait for an amendment to be made, before qualifying for the state doula registry. Currently, MN lists eight approved doula training organizations that have been in operation for over 10 years.*

- MN state verifies a doula's certification with one of eight approved doula training organizations.
- MN state does not have a list of standards or core competencies for doula registry.

- An application fee of \$200 is required to apply for the state registry.
- Application and approval is good for 3 years.
- A background check is required for state registry (50).

NEW YORK (from NY Department of Health)

**Note that New York State's pilot program requirements have been challenged by community-based doula organizations, with the critique that they do not reflect a model that contributes to birth equity.*

One issue advocates are focused on, is that substituting a “signed and dated letter” for a certificate, undermines the work of doulas of color, whose training institutes are currently setting the standard for community-based care. Advocates maintain that standards to determine a doula’s eligibility for reimbursement should be agreed upon by that state’s community-based doula organizations, as a method of accountability to communities.

- At least 24 contact hours of education that includes any combination of childbirth education, birth doula training, antepartum doula training, and postpartum doula training.
- Minimum doula training requirements:
- Attendance at a minimum of one (1) breastfeeding class.
- Attendance at a minimum of two (2) childbirth classes.
- Attendance at a minimum of two (2) births.
- Submission of one (1) position paper/essay surrounding the role of doulas in the birthing process.
- Completion of cultural competency training.
- Completion of a doula proficiency exam.
- Completion of HIPAA / client confidentiality training (51).
- Substitute for a certificate: a signed and dated letter on the doula training organization’s letterhead stating the doula has completed a doula training course.

MAMAS FIRST ACT, 2019

This federal legislation which is supportive of doula and midwifery care, and sponsored by Deb Haaland, was critiqued for listing an eligibility requirement that doula training organizations must have been established for no less than five years. This requirement would limit community-based doula organizations, as well as newly formed trainings run by experienced community-based doulas.

“(1) DOULAS DEFINED.—The term ‘doula’ means an individual who—

“(A) is certified by an organization, which has been established for not less than five years... (52).”

6) EXPANDING A DOULA WORKFORCE

RECOMMENDATION: Training doulas from Indigenous communities and communities of color is the foundation of a community-based model of care. All training, certification and state registry fees should be covered, to ensure entry into the profession by community-based doulas who are best situated to provide culturally relevant peer support to Medicaid recipient communities.

Research: In 2018, a CCO in Oregon allotted \$200,000 to train thirty doulas from local communities. The funding covered costs for basic skills training, completion of additional core competency requirements (to qualify for the state registry), and paid each doula for providing services to her first three clients. The grant also funded collaboration with a local university for the purpose of data collection and analysis (53).

7) CORE COMPETENCIES for BIRTH EQUITY

RECOMMENDATION: We support a birth equity approach to Medicaid reimbursement, without barring access to previously trained/certified doulas. Core competency standards in OR and NY currently reflect contact hours in: cultural competency, trauma-informed care and basic doula skills. This is a good start, however, the core competencies of a community-based doula are much broader in scope. Defining core competencies for birth equity requires additional input from community-based doula training organizations, whose history and expertise make them leaders in preparing doulas to be effective providers in low-income communities.

Our partners can support New Mexico's doulas to meet core competencies for birth equity by:

Doula training organizations can support a new standard of doula care by shifting their programs to center Indigenous doula trainers, doula trainers of color and curriculum in birth equity, reproductive justice, healing/trauma-informed care, implicit bias, cultural humility and survivor-centered care.

Funding sources (state funds, grants, community health funds) can support access to low/no cost training in birth equity and community-based doula work, for previously trained/certified doulas whose training organizations did not include core competencies for birth equity.

In addition, we do NOT support a doula proficiency exam being required, as a method of proving competency (NY requires this exam). Instead, we support doula self-assessment and the availability of doula mentorship, as key elements of the community-based doula model.

Research: In the report, Advancing Birth Justice, core competencies unique to community-based doula work, as well as Elements of Community-Based Doula Practice are outlined. Doula core competencies that support birth equity have been named in both state and federal legislation:

Trauma Informed Care	Current OR requirement
Cultural Competency	OR, NY, IL & DC's state legislation, Healthy Mommies Act
Implicit Bias Training	DC's legislation and the Maternal CARE Act
Racial Bias Training	Healthy Mommies Act
Health Equity	Healthy Mommies Act
Reproductive & Birth Justice	Healthy Mommies Act
Home Visiting Skills	Healthy Mommies Act
Respectful Communication & Listening	Healthy Mommies Act
Skills for Maternal Health (54)	

8) REIMBURSEMENT MUST BE EQUITABLE

RECOMMENDATION: Equitable pay that reflects a LIVING WAGE is necessary to support doula engagement, and has been shown to be cost effective. Failure to pay a living wage to doulas and other New Mexico birth workers would be exploitative, would create major barriers for families to access care, and would continue to burden community-based providers who are committed to birth equity.

A doula providing 38 hours of care per client in Rio Arriba County would make \$903 per client, at a living wage. This standard can be applied for all state, MCO and grant-based doula care.

Some advocates recommend monthly salaries and benefits for all doulas, to create sustainability for the spontaneous nature of doula work (doulas often schedule part-time work around client's due dates, must locate daycare and other forms of backup during a client's labor, and remain "on-call" for weeks at a time).

Research: Cost effectiveness studies have suggested that a global fee reimbursement rate anywhere between **\$929 and \$1047 per client would be offset by savings** in cesarean rates and preterm birth (55).

Other studies also take into account the savings incurred by reduced pain medication use, medical interventions, NICU admissions, low birthweight rates, and increased breastfeeding initiation and continuance rates, which are all found to be evidence-based impacts of doula care (56, 57, 58).

Reimbursement rates for doula care in OR, MN and NY, and doula care proposed in MA, RI, VT are as follows. **Note that state reimbursement programs are NOT currently paying doulas a living wage.*

Oregon: Medicaid

Legislation approved \$350 as a global/minimum fee per client.

- \$50 per prenatal visit (max 2).

- \$150 for labor and delivery support.
- \$50 per postpartum visit (max 2) (59, 60, 61).

Some doulas have negotiated a higher rate directly with MCOs.

The Oregon Doula Association recommends a rate of \$600-\$800 per client, to MCOs.

Minnesota: Medicaid

Original global fee was \$411 per client.

- Up to 6 visits
- Labor and delivery support
- One agency has to retain \$111 per client, to cover administrative costs.

New legislation: \$770 per client. (Effective January 2020)

- \$47 per visit (6 visits total)
- \$488 for labor and delivery support (62, 63).

New York: Medicaid pilot

Doulas can make up to \$600 per client. Back up doulas may bill separately.

- \$30 per prenatal visit (max 4 visits).
- \$360 for labor and delivery support.
- \$30 per postpartum visit (max 4 visits) (64).

Massachusetts: Legislation

Proposed \$1,500 reimbursement rate per client, in 2019.

Has not yet passed in legislature (65).

Rhode Island: Legislation

Proposed \$1,500 reimbursement rate per client, in 2019.

Doula can bill for up to one year postpartum.

Has not yet passed in legislature (66).

Vermont: Legislation

Proposed \$750 reimbursement rate per client, in 2019.

Has not yet passed in legislature.

- \$25/hr for prenatal visits, up to 4 hours
- \$550 for labor and delivery support
- \$25/hr for postpartum visits, up to 2 hours
- \$50 for administrative costs (67).

9) SUPPORTING DOULAS to BILL for SERVICES

RECOMMENDATION: To support a variety of doula practices, geographical service areas and levels of accessibility to billing resources, doulas should have the option to bill directly for their services, as well as the option to work with a clinic, hospital, billing agent or community-based organization.

Research: In 2017, OR went through a rule change that made the Medicaid reimbursement program more accessible to independently practicing doulas. Originally, doulas were not given NPI numbers, and were instead required to bill through another medical provider with an NPI number (i.e. an OBGYN). This process proved cumbersome, disempowering and prohibitive for many doulas.

With the help of doula advocacy efforts, this OR rule was corrected to ensure that doulas have the option to bill directly for themselves, in addition to the options of billing through hospital, clinic or billing agency services. NPI numbers are now available for the doula profession, nationally (68, 69, 70).

The NY Medicaid pilot program allows doulas to bill directly, and provides online tutorials (71).

10) REQUIRE DOCUMENTATION, not SUPERVISION

RECOMMENDATION: If documentation of a doula's presence at a birth is to be required for reimbursement, the relationship between a doula and the provider who provides their signature as proof of a doula's attendance at a birth, ought to be structured in a way that is supportive to the doula's work, and NOT as a hierarchical "supervision" requirement from the state.

Doulas should be trusted and uplifted to perform work described in their non-medical scope, and not be subjected to a status that is "under" another medical provider, for the purpose of reimbursement.

Options for provider signatures that affirm a doula has attended a client's birth (if required) should be broad and include: attending nurses (RN), nurse practitioners (NP) midwives (LM, CPM, CNM), OBGYNs and other attending or referring family practice/primary care providers.

Research: Oregon currently requires two separate documents, as proof of supervision, in order for a doula to be reimbursed. First, the doula is required to provide proof of supervision by submitting documentation of the original request or referral for doula services, from their client's primary physician. Second, doulas must receive a signature, including the time of doula's arrival and departure from birth site, from an attending medical staff person who was present during labor and delivery. Originally, the second signature was required to be given by the client's attending physician, but doulas found that often, the physician was too difficult to track down after the birth. This narrow requirement created a

barrier for doulas to receive payment for work performed. Recently, the Oregon Doula Association worked with the Oregon Health Authority to expand the list of acceptable supervisory persons at labor and delivery, to include nurses. Now, doulas can easily receive a signature from attending nurses, making it easier to submit for reimbursement (72, 73).

Minnesota requires that all doula services are provided under the “supervision” of an enrolled provider, either a physician, nurse practitioner or a certified nurse midwife. Documentation is required for the doula to receive reimbursement, which shows proof of supervision (74).

11) SUPPORT for ADMINISTRATION COSTS

RECOMMENDATION: Community-based doula care requires peer support, mentorship, referral networks, and often, an organizational structure to support it. As the standard for ending racial disparities, community-based doula models should be centered with the financial plans of any Medicaid or private insurance initiatives. In addition, independent doulas in regions without a community-based doula network will incur billing costs, and should receive administrative support through reimbursement, as well. This can be accomplished through the provision of an administrative or facility fee as part of reimbursement, and through grant funding to community-based organizations who employ doulas.

Research: The 2019 report, *Advancing Birth Justice*, outlines supports needed for a community-based doula model to effectively deliver services to Medicaid recipient communities. These include: “Adequate training and certification for appropriately serving Medicaid population,” “Doula supervision and mentorship,” and “Peer support for newly trained... doulas (75).” These supportive elements require adequate staff time and programming budgets.

In Minneapolis MN, Everyday Miracles provides direct doula services to around 360 clients per year, utilizing Medicaid funds. As of February 2019, the reimbursement rate they received from Medicaid was \$411 per client. They covered overhead costs by keeping \$111 of that amount and paid the doula \$300 in total, for providing prenatal visits, continuous labor support and postpartum visits. As of January 2020, the MN reimbursement rate has increased to \$770. The organization keeps \$170 for admin costs, and the doula receives \$600. Everyday Miracles covers half of the \$200 state registry fee for newly trained doulas who are contracted with the organization, and the entire \$200 recertification fee after three years (76).

Everyday Miracles has a small staff and a need for additional funding to continue administering Medicaid-covered doula care. While there are many doulas and organizations providing community doula support in Minnesota, few other than Everyday Miracles have successfully been able to bill Medicaid (77).

12) CONTINUING EDUCATION

RECOMMENDATION: Doulas should NOT be subject to recertification or CEU requirements set by the state, as these may be cost-prohibitive for doulas from lower-income communities.

To avoid creating a structural barrier, funding should be secured for free, statewide specialty trainings that increase doulas' access to continuing education. Doula training organizations will continue to set their own requirements for certification and recertification.

Research: MN does not appear to require CEUs, but does require re-application to the state registry every 3 years, for a fee of \$200 (78).

The 2019 federal legislation, Mamas First Act, sponsored by Deb Haaland, caused controversy by listing CEUs as a requirement for state registry and Medicaid reimbursement.

*“(1) DOULAS DEFINED.—The term ‘doula’ means an individual who—
“(A) is certified by an organization, which has been established for not less than five years and which requires the completion of continuing education to maintain such certification, to provide non-medical advice, information, emotional support, and physical comfort to an individual during such individual’s pregnancy, childbirth, and postpartum period; and
“(B) maintains such certification by completing such required continuing education (79).”*

OR requires 20 hours of Oregon Health Authority approved CEUs, every three years, of all Traditional Health Workers including birth doulas (80).

13) COLLABORATION with COMMUNITY-BASED DOULA ORGANIZATIONS

RECOMMENDATION: Expanding access to doula care for Medicaid recipients means collaboration with Indigenous communities, communities of color, and lower-income communities. Any new legislation, MCO-based or state programs should collaborate with established community-based doula organizations, accepting their guidance as critical to successful implementation.

Research: The 2019 report, Advancing Birth Justice, describes successful models of community-based doula programs. The research and guidance provided in this report comes from organizations with years of expert experience providing doula care to Indigenous communities and communities of color (81).

14) RAISING AWARENESS about DOULA CARE

RECOMMENDATION: Expanding access to doula care should involve doulas, families, midwives, medical providers, MCOs and community-based organizations. Community education about the benefits of doula care and how a doula works collaboratively with families and providers should be included as an integral part of any new legislation, MCO or state program.

Research: Doula Associations are forming in many states, providing advocacy and consultation to state programs, education and outreach to providers and families, and support and mentorship for doulas.

The New Mexico Doula Association is positioned as an advocacy organization for the doula profession, and has stated goals of increasing access to doula care, and providing community/provider education around the state (82).

The Oregon Doula Association has provided education and advocacy for the doula profession in Oregon since 2013. Many doula training organizations have also been key collaborators on the task of community and provider education (83).

15) ADVOCACY for FURTHER RESEARCH

RECOMMENDATION: Develop research around the evidence-base for doula care, specifically in the areas of how a doula impacts: the full spectrum of a family's reproductive life-course including the experiences of miscarriage, abortion and infant loss; rates of infant mortality and maternal mortality; outcomes for substance using pregnant families; and outcomes for survivors of sexual abuse.

Research is also needed on the reproductive impacts upon land-based peoples of cumulative and multiple exposures to environmental toxicity over time, from nuclear production and other toxic industries. We are interested in research which includes a community-based doula model, research which names environmental racism, and research that is practice-based.

Appendix A: Links to Key Research

Research from community-based doula organizations, universities, non-profits and state departments.

Community-Based Doula Model

[Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities](#). Ancient Song Doula Services, Village Birth International & Every Mother Counts, 2019.

[Birth Justice in Northern New Mexico](#). Video by Tewa Women United, 2018.

[Sustainable Funding for Doula Programs](#). Health Connect One, 2017.

[The Perinatal Revolution](#). Health Connect One, 2014.

Analysis of Medicaid Reimbursement Programs

[Expanding Access to Doula Care: State of the Union](#). Maternal Health Task Force, 2020.

[The State of Doula Care in NYC 2019](#). NYC Department of Health and Mental Hygiene, 2019.

[Expanding Access to Doula Care](#). Facebook Group.

[Health Connect One Issue Brief: Creating Policy for Equitable Doula Access](#). Health Connect One, 2019.

[Summary of Doula Town Halls and Doula Survey in Massachusetts](#). March of Dimes, 2019.

[Routes to Success for Medicaid Coverage of Doula Care](#). National Health Law Program, 2018.

[Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment](#). Oregon Doula Association, 2018.

[Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year](#). University of Minnesota, 2015.

Evidence-Based Studies

[Continuous Support for Women During Childbirth](#). Cochrane Review, 2017.

[Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery](#). Birth: Issues in Perinatal Care, 2016.

[Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health](#). Choices in Childbirth, 2016.

[Impact of Doulas on Healthy Birth Outcomes](#). Journal of Perinatal Education, 2013.

Appendix B: Supportive Actions and Benefits of Doula Care

Prenatal Visit Supportive Actions	Benefits
Home visits in which the doula establishes a therapeutic relationship with client by extending welcome, acceptance, kindness, compassion, and positive regard. Uses communication skills and emotional support techniques with all interactions.	Creates a therapeutic relationship with client that carries into the labor and birth and postpartum periods; Increases sense of self-worthiness; Instills confidence; Promotes trust; Client more likely to ask for and utilize help; Improves maternal mental health and may avoid birth trauma
Identifies client needs for other services	Promotes wrap around service model
Coordinates with service providers, health plans and community resources involved in client care	Enhanced continuity of care, Effective utilization of services based on client/family need
Elicits client birth priorities and preferences and fosters ways to manifest them	Helps client to articulate priorities and take more responsibility for their birth
Reviews past pregnancy and birth experiences, identifies helpful aspects, areas for improvement, and previous difficulties/trauma	Care is tailored to individual needs-increased patient satisfaction; Improved maternal mental health
Explains Doula's role and scope of practice; Doula does not project own values or goals upon client	Creates boundaries by clarifying doula's role, responsibilities, limits to practice, and differences among care team members; Clients feels support is unconditional
Assesses labor and birth support needs in regards to safety, trust, respect, communication, encouragement, autonomy, and nurturing	Care is tailored to individual needs; Decreases stress and anxiety; Mother feels more secure and in control; Increased patient satisfaction; Improved maternal health
Provides a counter-narrative of labor and birth as compared to negative images and stories clients often hear. Creates a coping mindset about labor pain, and relates factors that facilitate a positive birth experience.	Reduces maternal stress and fear; Instills confidence in ability to birth; Decreases need for pain medication and interventions; Shortens labor; Reduces complications and re-hospitalization of mother and newborn
Explains birth process in relation to physiology, hormonal orchestration, sensations, and emotions.	Normalizes birth process; Facilitates client's knowledge of factors that enhance or inhibit physiological birth; Improves birth outcomes
Addresses any client disclosed special needs including history of abuse, trauma, or previous difficult birth	Identifies needs for professional help; Care is tailored to special needs-increased patient satisfaction; Mother feels more secure and in control; Improved maternal mental health
Educates client on ways to enhance physiologic birth such as calming techniques, mental focusing, mobility, hydrotherapy, massage, etc.	Optimizes hormonal output for mother and baby resulting in shorter labors, less intervention use, breastfeeding success, enhanced bonding, and improved maternal mental health.
Reviews warning signs and preterm labor signs, refers as needed; Offers pregnancy comfort measures	Timely referrals for early intervention in potential complications; Improves birth outcomes; Reduces hospital admissions
Identifies any challenges to healthy lifestyle practices; offers supportive measures, resources; Offers referrals; Screens for antepartum mood disorders	Better compliance with healthy behaviors; Reduces health complications; Early identification of mental health issues

Assesses and personalizes labor coping strategies	Facilitates better coping with labor; less or later pain medication use; Fewer interventions
Teaches pre-labor positioning to encourage optimal fetal positioning	May facilitate anterior fetal positions, shortening labor and reducing mal-presentations
Discusses pain management options and their effects; Supports client's choice	Informed decision making; Maximizes benefits of pain medication use while reducing side effects
Works out role with partner/helpers so as to maximize their partner involvement at their comfort level	Supports partner/helpers role; Enhances father/partner's birth experience and involvement
Explores parent's pregnancy experience, including readiness for parenthood and relationships with family and availability and quality of support	Fosters more positive relationships with the family's support system; Identifies needs for professional help; enhances partner involvement
Identifies cultural practices/language considerations in regards to childbearing	Culturally appropriate care and communication; Identifies need for interpreter services
Assists client to create strategies to address fears and concerns about birth, especially when they feel frightened, ashamed, and overwhelmed	Reduces stress and anxiety; Mother feels more secure and in control; Enhances physiologic birth; improved birth outcomes; Increased patient satisfaction; Improved maternal health
Empowerment support- Teaches communication strategies and tools for shared decision making with care team; Educates in general about benefits/risks of common interventions and Cesarean birth;	Informed decision making, reduces non-medical use of interventions; Active participation improves client satisfaction; Reduces complications and hospitalization of mothers/newborn; Decreases possibility of obstetrical violence and birth trauma; Improves maternal mental health
Develops a birth care plan for several contingencies, includes a newborn care plan	Enhances communication with care team; Facilitates patient-centered care; Improves patient satisfaction
Offers local resources for education on birth, breastfeeding, infant care, early parenting Fills in any gaps in education	Education is proven strategy for enhancing birth and infant outcomes
Provides parents with a postpartum care plan and information on maternal mental health	Facilitates family adjustment; Early identification and treatment of postpartum mood disorders
Arranges a back-up doula in the event of illness, emergency, or primary doula's unavailability	Facilitates continuity of care; Promotes security and trust with client

Labor and Birth Supportive Actions	Benefits
Client contacts doula at beginning of labor, reminds clients of reasons to contact caregiver	Review signs of true labor and active labor; Client contacts provider and goes to hospital as directed, reducing hospital triage use
Doula with client during established early labor Keeps calm, reminds to rest, hydrate, nourish Recommends coping strategies for early labor Make sure family is ready to transport	Client in good physical and emotional state with entry into active labor; Fewer complications of long labors; Reduces possibility of unattended birth

Review signs of active labor with client	Client contacts provider and goes to hospital or birth center as directed
Provides continuous companionship with high quality emotional care	Reduces maternal stress; Less disruption in hormonal output, Increases spontaneous vaginal birth; Improves birth outcomes and maternal mental health
Encourages mobility and pelvic opening positions throughout labor	Improves labor progress and reduces mal-presentations; Less intervention use; ; Reduces complications
Uses comfort measures, massage, pressure, hydrotherapy and other pain relief techniques	Reduces pain-less need for pain medication or delayed use
Supports client and partner in using relaxation, breathing, focusing and rhythmic guidance techniques to cope with labor	Improved coping; Less need for pain medication or delayed use; Positive perception of self and partner; Enhances bonding
Knows, supports, and facilitates client's preference on use of pain medication	Improved communication with staff, better patient satisfaction
Reassures, validates, gives feedback, keeps up confidence, encourages, checks in	Emotional support helps mother to cope, reduces stress and anxiety, reduces pain, shortens labor
Roadmaps the birth process, explains to mother and helpers as needed	Reduces stress and anxiety
Encourages upright pushing positions and guides effective pushing techniques	Increased progress in second stage; Reduced instrumental delivery; No or less tearing of perineum; decreased Cesarean birth
Supports information gathering and shared decision making if needed	Informed decision making; Reduces non-medical use of interventions; Enhances communication with care team; Active participation improves client satisfaction; Mother feels more secure and in control; Reduces possibility of obstetrical violence and birth trauma; Improved maternal mental health
Helps parents cope with changes in plans	Reduces stress; Improves patient satisfaction
Helps with coping techniques for uncomfortable or painful procedures or dealing with unpleasant side effects	Reduces stress and anxiety; Greater comfort; Improves patient satisfaction
Cesarean birth support	Reduces stress and anxiety; Improves patient satisfaction; Improves maternal mental health

Immediate Postpartum Supportive Actions	Benefits
Supports delayed cord cutting and immediate skin-to-skin contact with mother	Promotes successful breastfeeding; Improved newborn transitioning; Promotes seeding of infant's microbiome; Improves parent-infant attachment- mother has higher regard for newborn, increased sensitivity and responsiveness toward newborn
Support provided with any post birth problems or complications, or NICU admission	Reduces stress and anxiety; Improves patient satisfaction; Improves maternal mental health
Early Breastfeeding support measures	Facilitates good positioning and latch, early and frequent feeding; Promotes adequate infant weight gain
Helps parents get to know their newborn- appearances and behavior	Parents understand infant's cues; appropriate and immediate responses; facilitates parent-infant bonding

Postpartum Visits Supportive Actions	Benefits
Assesses physical recovery of mother; Offers comfort measures; Reviews warning signs and refers to provider as needed;	Timely referrals for early identification and treatment of complications; Reduces hospital readmissions
Reviews warning signs for infant, refers to provider as needed	Timely referrals for early identification and treatment of complications; Reduces hospital readmissions
Assess and troubleshoots breastfeeding; Refers to professional help for problems beyond the scope of the doula	Breastfeeding problems are addressed immediately; Milk supply and infant weight gain problems are reduced; Improves breastfeeding success and duration; Improved infant health
Address any infant care and behavior questions, and teaches infant soothing techniques	Parents more responsive to their infant's cues; increases parent's confidence in the role; Reduces parent's stress and improves their mental health; Reduces chance of shaken baby syndrome
Assesses parent-infant attachment dynamics	Identifies need for professional help; Reduces incidence of child abuse
Assesses emotional status and adjustment of parents; Offers tips for self-care	Differentiates between normal transitions of early parenthood and mental health concerns; Improves parental adaptation and self-care, thus reducing stress and improving mental health; Timely referrals for professional help
Promotes partner involvement in infant care and family	Safety and infant development enhanced by partner involvement;
Uses screening tool to identify signs of Postpartum Mood Disorders	Timely referrals for early evaluation and treatment; Improved maternal mental health; Reduces incidence of child abuse
Debriefs and processes the birth experience with the parents	Facilitates mother's and partner's integration of the birth experience; Identifies any negative repercussions or possible birth trauma; refers for early evaluation and treatment; Improved maternal mental health
Elicits feedback on the doula's role and service	Continuous improvement of doula care

*Created and shared by Debra Catlin, member of the Oregon Doula Association,
as a reference document for the actions and benefits of doula care.*

Contact: debracatlin@gmail.com

Appendix C: Black Women's Blueprint's "*The Sexual Abuse to Maternal Mortality Pipeline*" Report Recommendations Summary

Reported in three categories: Policy, Medical Practice & Culture Change, across the pipeline

To better care for the maternal health impacts of SEXUAL ABUSE, the report suggests improvements in screening and communication around a patient's history of sexual abuse; patient control over who is present in the room during cervical exams; providers avoiding language that mirrors sexual trauma; and sensitivity, gender-bias & discrimination training to be required in physician/nurse education.

To remedy UNADDRESSED TRAUMA, Medicaid could cover the costs of trauma-related care, including assessment for maternal depression/anxiety, and home or community-based services, to be guided by culturally-specific organizations such as doula agencies. Strengthening research around sexual assault, trauma & maternal health, and positioning trauma-informed counselors within hospitals and OBGYN clinics.

Countering the effects of WEATHERING will require accountability mechanisms to enhance state response to gender-bias; leadership from sexual assault, domestic violence & sex trafficking experts; public health strategies that identify and reduce toxic stress; integration of culturally specific healers within medical systems, and improved collaboration between education and healthcare systems.

Too often, AVOIDANCE or DELAY of HEALTH CARE leads to preventable deaths. The report suggests: policies to encourage accountability & transparency in health care; coverage of midwifery & doula services; partnerships with community-based organizations; integration of holistic prenatal care; consistent provision of information re: women's rights; offering privacy; protections for survivors of female genital mutilation.

Eliminating ABUSE WITHIN OB/GYN CARE can be addressed in the Violence Against Women Act. Interventions in the medical field include making survivors aware of their right to a chaperone during medical examinations; developing survivor-center curriculum to inform routine procedures as new standard through ACOG; and dismantling power structures that keep medical providers from being held accountable.

To prevent RE-TRIGGERING TRAUMA SYMPTOMS such as PTSD, medical practice can revise pelvic exams; ask about sexual trauma before an exam; allow the option for women to decline or self-insert speculums; redesign gynecological instruments; increase empathetic communication; and drop the idea that "women must accept and resign themselves to pain as a 'natural' part of the process of vaginal examination."

Addressing OBSTETRIC VIOLENCE in LABOR & DELIVERY, including abuse, coercion and disrespect means expanding notions of "safety" to include women's rights to dignity, feelings, choice and autonomy in birth; the consistent use of birth plans that engender respect for survivors' preferences; hospital creation of Community Accountability Boards; and establishing cultures of consent and cultural humility in L&D.

Immediate actions to prevent MATERNAL MORTALITY include: expand the Preventing Maternal Deaths Act; gather data that reflects the impact of trauma & gender-based violence on maternal health; include trauma-informed education in teaching hospitals; integrate doulas in the birthing process; encourage providers to acknowledge their own bias; move away from hospital rules that undermine women's agency.

END NOTES

1. Bey A., Brill A., Porchia-Albert C., Gradilla M., & Strauss N. Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. March 25, 2019. <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>
2. Sanchez, Kathy. Conversation. 15 Sept 2019.
3. Tenorio, Martha. Client interview. 17 Jan. 2018.
4. Bohren M.A., Hofmeyr G., Sakala C., Fukuzawa R.K. & Cuthbert A. Continuous Support for Women During Childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6. https://www.cochrane.org/CD003766/PREG_continuous-support-women-during-childbirth
5. Peixinho M, Sanchez C, Duran B, Wallerstien N, Lucero J, Center for Native American Health, ... Goodfriend J. Tewa Birthing Project: Maternal Health Survey Final Report. Tewa Women United, 2010.
6. See (1)
7. Free, Prior and Informed Consent: An Indigenous People's Right and a Good Practice for Local Communities. Food and Agriculture Organization of the United Nations. <http://www.fao.org/3/a-i6190e.pdf>
8. New Mexico Vital Records 2018. <https://ibis.health.state.nm.us/query/result/birth/BirthCntyPreterm/PretermAll.html>
9. See (5)
10. Kozhimannil K. M., Hardeman R. R., Alarid-Escudero F., Vogelsang C. A., Blauer-Peterson C., & Howell E. A. Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. Jan 14, 2016. <https://doi.org/10.1111/birt.12218>
11. Yiya Vi Kagingdi Doula Project Database, 2011-2019. Tewa Women United.
12. New Mexico Vital Records 2018. <https://ibis.health.state.nm.us/query/result/birth/BirthCntyPreterm/PretermAll.html>
13. Gruber KJ, Cupito SH and Dobson CF. Impact of Doulas on Healthy Birth Outcomes. Journal of Perinatal Education, Winter 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>
14. See (11)
15. Cesarean Delivery – New Mexico PRAMS.NMHealth.org, Issue 2018-02. <https://prod.nmhealth.org/data/view/maternal/2206/>
16. National Center for Health Statistics: Stats of the State of New Mexico. CDC.gov. <https://www.cdc.gov/nchs/pressroom/states/newmexico/newmexico.htm>
17. 16a. See (15)
18. See (4)
19. See (11)
- 20.18a. Postpartum Depression Statistics. New Mexico PRAMS Surveillance, 2014-2018. Provided by Eirian Coronado, January 2020.
21. The Perinatal Revolution. Health Connect One. www.healthconnectone.org
22. Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. Jan 2016. <http://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicare-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf>
23. "End Violence Against Native Women." The Indian Law Resource Center. <https://indianlaw.org/>
24. Peer Support Resource Guide: Caring for Substance Using Pregnant Families. Care Coalition of Northern New Mexico, March 2019.
25. The Sexual Abuse to Maternal Mortality Pipeline. The Institute for Gender and Culture (IGC) at Black Women's Blueprint, 2019. www.blackwomensblueprint.org.

26. Maternal Mortality, New Mexico, United States. CDC WONDER Online Database. America's Health Ranking, United Health
27. Foundation. [https://www.americashealthrankings.org/explore/health-of-women-and-](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/NM)
28. [children/measure/maternal_mortality/state/NM](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/NM)
29. 24a. Phelan S and Nardini K. Update on Maternal Mortality in New Mexico. Power Point presentation. New Mexico Perinatal
30. Collaborative Conference, Oct 26, 2019.
31. See (23)
32. Brown, Sevonna. Email exchange with Black Women's Blueprint. Oct 8, 2019.
33. See (23)
34. See (23)
35. 28a. See (23)
36. Living Wage Calculator. Massachusetts Institute of Technology. <http://livingwage.mit.edu>.
37. See (29)
38. See (10)
39. Economic Justice Law and Legal Definition. USLegal.com. <https://definitions.uslegal.com/e/economic-justice/>
40. Gutierrez Nelson, Melissa. Telephone interview. 7 Feb. 2019.
41. Steward Healthy Beginnings Program Now Offers Free Doula Care for Steward Health Choice Members. May 15, 2019. www.steward.org
42. Catlin, Debra. Telephone interview. 21 Mar. 2018.
43. Ancient Song Doula Services. www.ancientsongdoulaservices.org
44. See (1)
45. Uzazi Village. www.uzazivillage.org
46. Tafunzi Payne, Hakima. Telephone interview. 17 Dec. 2018.
47. 39a. Lanning, Rhonda K. Evaluation of an Innovative, Hospital-Based Volunteer Program. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2019. [https://www.jognn.org/article/S0884-2175\(19\)30426-5/fulltext](https://www.jognn.org/article/S0884-2175(19)30426-5/fulltext).
48. Restoring the Sacred Bond Initiative. <https://www.restoringthesacredbond.ca/site/Indigenous-doula-initiative>.
49. Doula Medicaid Project. National Health Law Program. <https://healthlaw.org/doulamedicaidproject/>
50. See (41)
51. Doula. Oregon Health Authority, Office of Equity and Inclusion. <https://www.oregon.gov/oha/OEI/Pages/THW-Doula.aspx>.
52. Doula Services. Department of Human Services, Minnesota. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_190890
53. New York State Doula Pilot Program. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm.
54. Assembly Bill A364B. The New York State Senate. <https://www.nysenate.gov/legislation/bills/2019/A364>
55. Porchia-Albert, Chanel. An Open Letter on Assembly Bill A364B and Senate Bill S3344B. "Expanding Access to Doula Care" Facebook group. June 19th, 2019.
56. A New Law Aiming to Combat Maternal Mortality is More of a Setback than a Win, Say Doulas. Wellandgood.com. June 20, 2019. <https://www.wellandgood.com/good-advice/doula-certification-new-york-bill/>
57. See (43)

58. See (44)
59. See (45)
60. Text: H.R.2751 — 116th Congress (2019-2020). Congress.gov. <https://www.congress.gov/bill/116th-congress/house-bill/2751/text>
61. See (35)
62. See (41)
63. See (10)
64. Gebel, Christina. Summary of Doula Town Halls and Doula Survey in Massachusetts. March of Dimes, May 2019.
65. Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health. Jan 2016. <http://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicare-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf>
66. Gruber KJ, Cupito SH and Dobson CF. Impact of Doulas on Healthy Birth Outcomes. Journal of Perinatal Education, Winter 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>
67. See (43)
68. Roberts, Nathan. Telephone interview. 25 Apr. 2018.
69. See (35)
70. See (33)
71. See (44)
72. See (45)
73. See (41)
74. See (41)
75. See (41)
76. See (35)
77. See (66)
78. Rose, Amanda. Telephone interview. 21 Feb 2018.
79. See (45)
80. See (35)
81. See (70)
82. See (44)
83. See (1)
84. See (33)
85. See (33)
86. See (44)
87. See (55)
88. See (43)
89. See (1)
90. New Mexico Doula Association. www.nmdoula.org
91. Oregon Doula Association. www.oregondoulas.org

BIBLIOGRAPHY – Additional Sources

- Birth Doula Certification Curriculum Standards*. Health Systems Division: Medical Assistance Programs, Oregon Health Authority. Filed 6 July 2018. <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=248089>
- Catlin, Debra. *Core Competencies for Birth Doulas*. Oregon Doula Association.
- Catlin, Debra. *Supportive Actions and Benefits of Doula Care*. Oregon Doula Association.
- Chen, Amy. *Routes to Success for Medicaid Coverage of Doula Care*. Dec 14, 2018. <https://9kqpww4dcaw91s37kozms5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/12/NHeLP-PTBi-Doula-Care-Report.pdf>
- Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas. Urban Indian Health Institute, A Division of the Seattle Indian Health Board. Oct 2016. http://www.uihi.org/wp-content/uploads/2017/08/UIHI_CHP_2016_Electronic_20170825.pdf
- Complex Trauma*. The National Child Traumatic Stress Network. <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma>
- Everson C. L., Crane C. & Nolan R. *Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment*. Sept 30, 2018. http://media.wix.com/ugd/612d84_e71f24be41bf4461825e48b023b2d327.pdf
- Low Birthweight*. March of Dimes. <https://www.marchofdimes.org/complications/low-birthweight.aspx>
- Intergenerational Trauma*. Healing Foundation. <https://healingfoundation.org.au/intergenerational-trauma/>
- Kennedy, Annie. Telephone interview. 24 May 2018.
- Kozhimannil K. B., & Hardeman R. R. Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality. May 10 2016. <https://doi.org/10.1111/birt.12213>
- Kozhimannil K. B., Vogelsang C. A. & Hardeman R. R. Medicaid Coverage of Doula Services in Minnesota: Preliminary Findings from the First Year. July 2015. http://media.wix.com/ugd/612d84_e71f24be41bf4461825e48b023b2d327.pdf
- Murphy, Carrie. Medicaid Reimbursement for Doula Support in New Mexico: Evidence, Possibility, and Feasibility. 2015.
- Osorio, Quatia. Telephone interview. 7 Feb. 2019.
- Parkes I, Kabiri D, Hants Y and Ezra Y. The indication for induction of labor impacts the risk of cesarean delivery. The Journal of Maternal-Fetal and Neonatal Medicine, Volume 29, 2015 - Issue 2. <https://www.tandfonline.com/doi/abs/10.3109/14767058.2014.993965?journalCode=ijmf20>
- Premature Babies. March of Dimes. <https://www.marchofdimes.org/complications/premature-babies.aspx>
- Porchia-Albert, Chanel. Ancient Song Doula Services. Telephone interview. 20 Sept. 2018.
- What is Historical Trauma? Sharing Culture. <http://www.sharingculture.info/what-is-historical-trauma.html>
- Sturtevant, Cate. The Doula Option: An Opportunity to Improve Birth Outcomes in Washington State. Center for Health Innovation & Policy Science, University of Washington. March 2019. <http://uwchips.org>
- The Indian Law Resource Center. www.indianlaw.org.

