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EXPANDING AND DIVERSIFYING THE DOULA WORKFORCE: CHALLENGES AND OPPORTUNITIES OF INCREASING INSURANCE COVERAGE

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SUMMARY

The White House Blueprint for Addressing the Maternal Health Crisisⁱ outlines specific actions the federal government will take to improve maternalⁱⁱ health while advancing equity. The Blueprint directs federal agencies to take action to expand and diversify the perinatal workforce. One approach, already being implemented in several states, is to increase Medicaid and private insurance reimbursement for doula services. The Department of Labor's (DOL) Women's Bureau (WB) conducted two listening sessions with doulas and doula servicing organizations. The goal of the listening sessions was to identify job qualityⁱⁱⁱ gaps for doulas, specifically with respect to state-by-state variations in insurance reimbursement.

Doulas who participated in the listening sessions indicated that widespread Medicaid and private insurance reimbursement for doula services may have multiple benefits in the industry. They identified those benefits as increased patient access to doulas, improved maternal health outcomes, and improved job quality for doulas. Together these benefits may also lead to a more diverse doula workforce. However, implementation is not without challenges. The doulas participating in WB's listening sessions also cautioned that policy choices relating to the reimbursement rate, structure of reimbursement, and training and certification requirements all influence whether Medicaid reimbursement improves their job quality and whether doulas choose to participate and take on the additional costs of participating. In addition, insurance reimbursement's impact on job quality is limited by other factors including hospital culture and interactions with clinical staff, access to trauma-informed mental health services, and access to quality, affordable childcare.

BACKGROUND

White House Blueprint for Addressing the Maternal Health Crisis

The White House Blueprint was released in June 2022 and contains 50 actions across five main goals. The Blueprint is intended to guide the work of over a dozen agencies to help improve maternal care, combat maternal mortality and morbidity, and reduce racial disparities nationwide.

The Blueprint identifies doulas among critical segments of the maternal care workforce and notes that access to community-based doulas is associated with improved maternal health outcomes,^{iv} but only about 6% of women who give birth receive doula care.^v The Blueprint cites barriers that impede efforts to expand the doula workforce, including too few pathways to training and certification, poor coverage by insurers, and insufficient reimbursement rates. These challenges have all contributed to a doula workforce that is too small and insufficiently diverse.^{vi}



Role of Doulas and Workforce Challenges

Doulas are nonclinical birth workers trained to provide continuous physical, emotional, and informational support to individuals in the prenatal, birth, and postpartum periods. Unlike licensed midwives, doulas do not provide clinical support, but instead serve as guides, advocates, and emotional support for clients as they navigate the maternal health system. As non-clinical providers, doulas are usually not required to be certified, and states determine their own requirements for doulas who choose to participate in Medicaid or private health insurance plans (where available). Someone who is interested in training to become a doula can enroll in a doula course or training through one of the large training providers or through a local doula organization. Training topics may vary depending on specialization, but often include pregnancy, childbirth, and postpartum support, and may also include topics such as infant loss and stillbirth. Doulas may choose to be certified, but there is no single form of certification. Many large training providers offer certification programs, and some states have created their own certification process for doulas seeking to obtain Medicaid reimbursement.

More than 40 percent of all births in the United States are covered by Medicaid.^{vii} Yet, coverage of doula services is an optional Medicaid benefit. Due to limited insurance coverage for doulas, access to their services is largely limited to families with higher incomes who can afford to pay for such services out-of-pocket.^{viii} Additionally, the doula profession remains overwhelmingly white—over 80% of doulas in the United States are white.^{ix} Given studies that show how beneficial care from diverse providers can be, especially for women of color,^x increasing the diversity of clinical and non-clinical birth workers, including doulas, could lead to better maternal health outcomes. More widespread Medicaid and private insurance reimbursement for doula services may simultaneously increase access to doulas and improve maternal health outcomes and improve job quality for doulas and lead to a more diverse workforce.

Existing Evidence on the Doula Workforce

The Department of Health and Human Services (HHS) has taken several actions to better understand the role of doulas in promoting positive maternal and infant health outcomes and experiences and explore ways to increase access to doula services.

In May 2022, the HHS Office of Intergovernmental and External Affairs, in coordination with the Centers for Medicare & Medicaid Services (CMS) and Health Resources and Services Administration (HRSA), held a roundtable discussion with community-based doulas. Topics included billing and reimbursement, training and credentialing, public and provider education and awareness about doulas, and other doula supports needed.

In September 2022, HRSA's Maternal and Child Health Bureau (MCHB) co-hosted a Maternal Health Listening Session with the Office of the Associate Administrator and the Division of Healthy Start and Perinatal Services (DHSPS). The listening session covered multiple topics, including growing and diversifying the doula workforce.

In December 2022, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) published an Issue Brief titled "Doula Care and Maternal Health: An Evidence Review"^{xi} that outlined challenges and opportunities for the provision of doula care, as well as existing policy efforts to strengthen and expand doula care. The challenges and opportunities identified in the issue brief included cost, coverage, payment, training, and patient and provider awareness of doulas.



CONTEXT OF THE LISTENING SESSIONS

WB's listening sessions took place in Birmingham, Alabama (a state that does not require health insurance coverage for doulas) and Providence, Rhode Island (a state that requires both Medicaid and private insurance coverage for doulas). Topics included the impact that Medicaid and private insurance coverage has made or could make on the doula industry and on job quality for doulas, barriers doulas face within their profession (including as a result of lack of Medicaid or insurance coverage for doula services), ongoing challenges for doulas, and potential solutions.

State Landscape

As of February 2023, when the WB listening sessions were held, 10 states^{xii} and the District of Columbia reimbursed doula services through Medicaid, with each program structured slightly differently and with a different maximum reimbursement amount.

At the time of the listening sessions, Alabama did not require Medicaid or private insurance coverage for doula services and there had been no state legislative proposals to expand coverage for doula services. In 2022, the City of Birmingham awarded over \$850,000 in grants for economic development programs, including \$121,806 to Birthwell Partners to train community doulas and provide doula services for free or at a reduced cost for Medicaid-eligible clients.

In July 2021, the governor of Rhode Island signed the Rhode Island Doula Reimbursement Act,^{xiii} which went into effect in July 2022. As of February 2023, Rhode Island was the only state to require doula coverage by both Medicaid and private insurance.

Participants

Participants in the sessions were predominantly women with between 2 and 14 years of experience working as doulas. Participating doulas were racially diverse and included queer participants. Participants in Rhode Island all had 5-6 years of professional doula experience, while those in Alabama varied between relatively new doulas (2-4 years) and highly experienced doulas (7-14 years). All participants were self-employed, though some also worked with agencies. None of the participants were employed directly by hospitals, birthing centers, or other medical providers. Some of the Alabama participants worked as doulas part-time while working another job (either related to their doula work or not). Most of the Rhode Island participants worked full-time as doulas, except one who had recently stopped practicing to focus on advocacy work on behalf of doulas. Among doulas in Rhode Island, one was currently participating in Medicaid and private insurance, another was in the process of enrolling in Medicaid and private insurance, and the others did not participate. Two Alabama participants had previously worked as doulas in other states (Oregon and Illinois).

FINDINGS

Despite differences in state contexts, doulas across the two listening sessions described similar experiences with compensation, hours, training, and certification. The Rhode Island doulas discussed the impact of health insurance reimbursement on these aspects of their work. The Alabama doulas discussed their current challenges and the ways in which health insurance reimbursement might or might not improve their working conditions.



Participants agreed that health insurance reimbursement could be beneficial to doulas and low-income clients because it would enable more doulas to work full-time and increase access to doula services. However, participants cautioned that the success of this goal would depend on implementation. They identified implementation considerations such as reimbursement rates, structure of reimbursement, and training and certification requirements. To be successful in improving job quality, Medicaid reimbursement rates must be sufficiently high (at least as much as doulas earn through private pay). In addition, reimbursement structure must also include the range of services doulas provide and the varied needs of clients including during prenatal and postpartum care. The insurance plan must also reduce barriers to participation, including minimizing administrative barriers and providing inclusive pathways to training and certification.

While not the primary focus of the WB's listening sessions, participants also discussed other factors that contribute to recruitment and retention challenges for their profession. Specifically, they provided ideas to support the doula workforce beyond health insurance reimbursement, including access to childcare, access to trauma-informed mental health supports, and education of clinical staff on the doula's role within the patient's birthing team.

Schedule, Pay, and Benefits

Challenge

Participants discussed challenges as a result of the demanding and unpredictable nature of doula work, both with regard to their schedules and ability to balance other responsibilities, and for their capacity to take on enough clients to earn sufficient income. Clinical providers are more likely to have predictable schedules, work in salaried positions in a medical practice or hospital with other providers who can share the patient load, and provide most of their care through scheduled and billable appointments. In contrast, doulas described how they often work alone, manage their own clients, and provide ongoing and highly personalized care. This care can include communicating with clients by text, phone call and email whenever needed, delivering meals or supplies to clients, and sometimes continuing to provide support years after a birth. Because a client may go into labor or otherwise require support at any time, including outside of scheduled prenatal and postpartum visits, doulas noted that it is difficult to take time off from providing services. Due to the intensity of the services they provide, participants estimated that they could only serve three to four clients per month.

In addition, the participants expressed an understanding of their role as doulas that encompasses more than their prenatal, birth, and postpartum work with clients, and includes additional (and often unpaid) birth work such as advocacy, social media promotion and education, outreach and education to pregnant people and families, and supporting other doulas. Furthermore, doulas maintain their own business and spend time on administrative tasks, marketing, and recruitment of new clients.

In both listening sessions, participants reported being unable to earn sufficient income from their doula work alone, in part due to limitations on the number of clients they are able to serve at one time and to private-pay or reimbursement rates that are too low and do not fully reflect the amount of work they do. As a result, almost all participants held a second job. Some combined their doula work with related work, such as doula training or nursing, while others held jobs unrelated to the maternal health field, such as teaching college courses. While some participants worked part-time as doulas voluntarily and had no desire to increase to full-time doula work, the majority did so out of financial necessity. Most of the Rhode Island doulas described themselves as full-time doulas but still took on additional work, such as app-based food delivery, placenta encapsulation, or childbirth education.



The nature of doula work, which requires that doulas be on-call and available to attend their clients' births (including births that can last over 24 hours), limits their ability to work other jobs to supplement their income. Any additional work they take on must be flexible enough to accommodate their doula work, which often means it comes with lower pay and fewer benefits than less flexible full-time or part-time work. Though some of the doulas in Alabama accessed health insurance through their other job (and relied on their other job providing this benefit), none of the participants reported having access to retirement benefits and several mentioned feeling unprepared for retirement.

The work of a doula is intense and personal. It is also unpredictable. Birthday parties are missed and holidays are celebrated with their own families on a different date. The demands of running a business, the intense and unpredictable schedule, and the need to take on other work for additional income cause many doulas to experience burnout and financial instability. This also puts strain on their families who must accommodate sudden changes in schedules and availability, including by coordinating childcare.

Listening session participants noted that the intensity of working as a doula can be particularly acute when making the transition into full-time doula work and taking on more clients to reach a level of income that is sufficient to stop other jobs. For example, one participant described having spent several months assisting with births without pay while training to become a doula. Regardless of whether they work part-time or full-time as doulas, participants highlighted that this intensity can cause doulas to shift into more predictable careers such as nursing or midwifery.

How insurance reimbursement can help

Participants indicated that a higher health insurance reimbursement rate with a flexible structure could help with schedule and pay challenges by more adequately compensating them for the work they do and by providing resources to enable them to hire employees to assist with administrative work, such as marketing and processing claims.

Having access to health insurance reimbursement for their services can help doulas have a more stable source of income. Greater reimbursement may make it possible for more families to receive doula services by reducing or eliminating the out-of-pocket cost that can be unaffordable, particularly for lower-income families. Medical providers may also recommend doulas to more patients if their services are covered by Medicaid and private insurance. For example, one doula in Rhode Island who participates in Medicaid and private insurance mentioned receiving an increase in requests, particularly from high-risk clients, due to doctors recommending that they work with a doula. The participant also noted a general increase in demand for the services of doulas who participate in Medicaid and private insurance because, at the time of the listening sessions, few doulas had completed the certification and enrollment process since the law went into effect. As a result, the pool of available doulas for clients who want to use Medicaid or private insurance to pay for their services is limited. This may change in the future if more doulas complete the enrollment process and the supply of doulas accepting insurance more closely matches demand.

Alabama doulas noted that if Medicaid and insurance reimbursement for doula services was considered in their state, the reimbursement level and structure would need to be set in collaboration with doulas and take into consideration the varied services that doulas provide. Some particular features of doula work that are not easily captured in traditional medical billing include providing unlimited access to clients by text, phone call and email, different needs for prenatal and postpartum care and how the total number of visits is distributed between the two, and billing for long labors (over 24 hours) or when a different doula takes over care for a client (mid-pregnancy, mid-labor, or for postpartum care). Accounting for this work in the reimbursement rate and structure could more fully compensate doulas for their work and provide them a more stable source of income.



In addition to accounting for their full scope of work when setting reimbursement rates, doulas discussed the need to consider the amount they can earn through private paying clients and the additional work required to participate in health insurance. Some doulas noted that obtaining reimbursement creates additional costs, such as the cost of acquiring and maintaining required certifications,^{xiv} and administrative work such as enrolling for reimbursement^{xv} and processing claims, which may not be outweighed by the additional pay if the reimbursement rate is set too low. For example, one doula in Rhode Island who has chosen not to participate in Medicaid and private insurance described being ineligible to participate due to working less than half-time in Rhode Island. Because private-pay prices in the neighboring state where this participant does most births are higher, it is not worthwhile to take more births in Rhode Island in order to be able to accept insurance.

Doulas in Alabama who had previous experience billing Medicaid, either through previous doula work in a state with coverage or through their other job, discussed the burden of obtaining insurance reimbursement and noted that this disincentivizes some providers from participating. The experience of doulas in Rhode Island illustrated some of these concerns. Participants discussed challenges with going through the process of obtaining in-network status with each insurance company, having to spend time following up with insurance companies to ensure processing of paperwork, delays in receiving payment, difficulty understanding which services are covered, and claims being denied. One doula in Rhode Island described two cases in which claims were denied by the family's insurance after having provided services. In one case, the doula was able to be reimbursed by Medicaid, but in the other case the participant was never paid for the services provided to the client. While some of these challenges were more prevalent when the law was first implemented, and some have been resolved over time, challenges remain and have contributed to instability in doulas' income, even when they participate in Medicaid and private insurance. Failure to address these barriers could result in doulas choosing not to participate in insurance, preventing success in achieving the goals of improving job quality for doulas and expanding the doula workforce. This could also prevent Medicaid reimbursement from increasing access to doula services for families who would most benefit.

Participants in Rhode Island who have begun accepting insurance noted that processing insurance claims requires a lot of time, specialized knowledge, skills, and Health Insurance Portability and Accountability Act (HIPAA) compliant software, all of which is expensive and time consuming. To help reduce the burden of processing claims, some Rhode Island doulas formed a cooperative, funded by membership fees paid by participating doulas, through which they hire staff to manage insurance claims. While the cooperative greatly eases administrative burdens, it may strain the limited financial resources of these small business owners, and may not be a feasible option for all doulas. Higher reimbursement rates could greatly reduce burnout and financial instability for doulas, whether or not they choose to use a cooperative model, enabling them to stay in the profession longer.

Doulas may also determine whether to participate in insurance based on the structure of reimbursement and how restrictive it is with regard to distribution and number of visits between prenatal and postpartum care, covered services, and mode of service delivery (in-person or virtual). Some doulas noted that, particularly as their services are increasingly recommended to high-risk patients, they need flexibility to tailor services to the needs of clients.

Alabama doulas discussed the importance of postpartum doula care for positive maternal health outcomes, as well as its relative predictability for doulas seeking more stable schedules. Because much of the instability in doulas' schedules is due to the unpredictable timing of births, doulas specializing in postpartum care have more stable schedules. However, participants talked about challenges to being a postpartum doula, including low demand for such services. They attributed this, in part, to the lower emphasis on its importance in the broader maternal



health conversation and in patient education, and to the low number of postpartum visits generally included in Medicaid and insurance reimbursement models. Allowing more postpartum visits in Medicaid and private insurance reimbursement levels and structures could help with some of the scheduling challenges that doulas face while also improving maternal health.

Training and Certification

Challenge

Participants in the two listening sessions recognized the importance of training while also acknowledging its limitations, and the potential negative consequences of creating a structured pathway to becoming a doula or requiring specific certifications. The doulas who participated in the listening sessions had all taken trainings, but not all held formal certifications. Many had trained multiple times, either as refresher training or to acquire new skills. Some had taken trainings with multiple providers until they found one that was the best fit for them.

Many doulas noted shortcomings in the trainings they have taken, including an insufficient emphasis on the business aspects of working as a doula, and on the rights of both doulas and their clients and how to manage interactions with medical providers. Participants also felt that trainings often have a particular lens based on the training provider and may be more geared toward doulas of certain backgrounds (such as white doulas), and not meet the needs of a more diverse population (including Black and queer doulas). Some participants felt that certain large training and certification providers are not safe spaces for Black and queer doulas.

In addition to the lower emphasis on the business side of being a doula, many participants found that formal training did not provide all the necessary knowledge to enable them to begin working and to be effective advocates for their clients. The participants described relying on a network of doulas to answer their questions and provide support. Some doulas felt that a certification was not necessarily a good indicator of the quality of services a doula could provide, particularly because so much of their expertise is developed through experience with clients, rather than through formal, classroom-based training. Participants described translating knowledge from classroom-based trainings into practical experience and building self-confidence as a doula as particular challenges for new doulas. To illustrate this, they highlighted that many young women of color entering the doula field are transitioning from low-wage service jobs. Classroom training may not be sufficient for those doulas to feel comfortable supporting clients and families through births and navigating interactions with clinical staff. Participants generally agreed that confidence is built through experience, but gaining experience is challenging as there are limitations in shadowing or apprenticing with a more experienced doula due to restrictions on the number of people that can be in the birth room, particularly in hospital settings, and the preferences of families.

Several participants in Rhode Island mentioned mentorship as a way to supplement formal training. Participants noted that the support of a mentor is particularly critical for doulas from disadvantaged backgrounds, and in cases where new doulas encounter a significant challenge that may make them more likely to quit, such as assisting with a complicated or traumatic birth or having an insurance claim denied. Though they found mentorship to be a useful addition to training, listening session participants acknowledged that it requires a time commitment for both mentors and mentees that may be difficult to fit in their schedules, and represents additional uncompensated work for mentors.



Cost and time were identified as barriers to both training and certification. Participants highlighted that these barriers are particularly challenging for new doulas, who may have particularly irregular or intense schedules as they increase their client load, set up their new business, and often continue working in another job to support themselves until they can earn enough from their doula work. Once they are trained, new doulas also face additional challenges in beginning to work, including difficulties in obtaining the resources to start their business (particularly if they need small business loans and have difficulty qualifying due to poor credit), low capacity to take on clients as they transition from another job, and need for reliable childcare during irregular and sometimes unpredictable work hours.

How insurance reimbursement can help

Due to the time requirement and cost of obtaining training and certification, and the challenges described above, requiring a specific training or certification for participation in Medicaid and private insurance reimbursement creates additional barriers for doulas. For example, TRICARE, the health care program for uniformed service members, retirees, and their families, requires doulas to be certified by one of five large certification providers^{xvi} to file claims with the program. Because not all doulas choose or have the ability to be certified by one of these organizations (due to cost, time, location, and other barriers), this requirement prevents many of them from participating in TRICARE. Rhode Island participants described community-based and doula-led trainings, and particularly training by and for doulas of color, as effective strategies to build a more diverse workforce while ensuring that the training meets the needs of the community.

Rhode Island doulas discussed both the positive and negative aspects of Rhode Island's state-run certifying board. They appreciated that the Rhode Island certification process accepts all training providers, but noted that doulas must still bear the cost of each training in addition to the certification fee paid to the state. Though the doulas recognized that each requirement serves a purpose, they also noted that added requirements create barriers, particularly with regard to time and money.

In describing the challenges of training and certification and approaches that can ensure doulas gain necessary skills without creating unnecessary barriers, participants drew on their personal experiences and on the history of childbirth support by Black and immigrant lay midwives in the United States. Black enslaved midwives were skilled and experienced members of the community who supported enslaved women through birth, and Black and immigrant midwives continued to be the primary providers of childbirth care for women of color and low-income women into the late 19th and early 20th centuries.^{xvii} As childbirth became increasingly medicalized, Black midwives came under particularly intense scrutiny and became the targets of efforts to regulate and professionalize their field.^{xviii} The emergence of formal nurse-midwife training alongside an increase in supervision and licensing requirements altered the field of midwifery, largely at the exclusion (often intentional) of Black midwives.^{xix} To this day, midwives are disproportionately white. The history of midwifery in the United States serves as a reminder that efforts to professionalize the doula workforce through training and certification may have unintended consequences that undermine the ultimate goal of expanding and diversifying the doula workforce and should be approached thoughtfully. States and insurance companies can consider strategies to reduce barriers to training and certification, which may include but are not limited to: including doulas in the policy design process; only requiring trainings that are necessary given doulas' scope of work; recognizing trainings from a variety of training providers, including community-based and doula-led trainings; allowing flexibility in the mode of delivery of trainings; and subsidizing the cost of training and certification.



Limitations of Insurance Reimbursement

Though the WB Doula Listening Sessions were focused on a narrow set of job quality indicators, including specifically those that might be influenced by Medicaid and private insurance reimbursement, participants also discussed other factors that impact their job quality, as well as challenges to recruitment and retention of doulas.

The two most significant factors participants discussed were doulas' interactions with medical providers and their exposure to traumatic births. Doulas in one listening session cited poor interactions with clinical staff as the primary cause of burnout among doulas and noted that health insurance reimbursement will be limited in its ability to improve their job quality without changes to hospital culture, including acceptance of doulas as a part of patients' birthing team and greater recognition of the role of doulas in improving patients' birth experience and health outcomes.

In addition to poor experiences with hospitals, participants identified trauma as the second most important cause of burnout, particularly for new doulas who lack a support system and resources to help them process witnessing traumatic births. Greater access to specialized mental health services would help doulas better cope with this aspect of their work and prevent burnout, as well as reduce burden on doulas who provide informal support to each other in the absence of accessible and appropriate formal services.

Participants also discussed access to reliable childcare, particularly for unpredictable and nonstandard schedules, as another challenge. As for many parents in the United States, and particularly those working in low-wage jobs or jobs with nonstandard work hours, lack of affordable, quality childcare is a barrier to recruitment and retention of doulas. Increasing access to childcare is a key factor that should be considered in any efforts to increase and diversify the maternal health workforce.

CONCLUSION

The feedback gathered in the WB Doula Listening Sessions indicates that increased access to Medicaid and private insurance reimbursement for doula services could significantly improve job quality in the doula profession. Improved schedules, pay, benefits, and training decrease professional burnout and improve the lives of working women. In order to improve job quality significantly, doulas also need assistance with the administrative aspects of running a small business, including navigating the complex process of participating in insurance.

Higher and consistent reimbursement may increase the size and diversity of the doula workforce and increase access to doula services for low-income patients. A larger and increasingly experienced, knowledgeable, and diverse profession could also mean improved access to doula care, and thus, improved health outcomes for the families that doulas serve. However, unless thoughtfully designed, strict training and certification requirements for participation in Medicaid and private insurance may unintentionally create barriers that prevent more doulas from enrolling. This could result in a bifurcation of the doula profession between those able to meet the requirements and accept insurance, and those unable or unwilling to do so, and deepen disparities in who has access to reimbursed doula work and who can obtain doula services. To ensure that Medicaid and private insurance reimbursement help create a more diverse workforce, policymakers should be mindful of barriers to participation and work to reduce them. Strategies may include but are not limited to: including doulas in the policy design process; only requiring trainings that are necessary given doulas' scope of work; recognizing trainings from a variety of training providers, including community-based and doula-led trainings; allowing flexibility in the mode of delivery of trainings; and subsidizing the cost of training and certification.



Insurance reimbursement cannot address every job quality gap identified by doulas. Other challenges that should be considered include access to childcare and trauma-informed mental health supports. Like other workers in low-wage jobs or jobs with nonstandard work hours, doulas need access to quality, affordable childcare that can accommodate their often-unpredictable schedules to be able to perform their jobs successfully. Greater access to trauma-informed mental health supports would also help retain doulas and reduce the time and mental health burden on doulas who provide informal support to each other in the absence of accessible and affordable services. In addition to trauma, poor experiences in hospitals and with clinical staff contribute to burnout. Changes to hospital culture, including acceptance of doulas as a part of patients' birthing team and greater recognition of the role of doulas in improving patients' birth experience and health outcomes, are also necessary to increase retention of doulas.

ACKNOWLEDGEMENTS

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- ⁱ The White House. 2022, June. *White House Blueprint for Addressing the Maternal Health Crisis*. <https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf>.
- ⁱⁱ While this report generally refers to maternal health, mothers, and women, the content of this brief is inclusive of every person giving birth, irrespective of gender identity or demographic background.
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