

Advocating for Medicaid Coverage of Doula Services: An Intersectional Approach to Addressing Perinatal Health Disparities and Outcomes.



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Note on Terminology

As the authors of this report we acknowledge that the words "woman," "women," and "maternal" are used periodically throughout the report. This language is not meant to be exclusionary. We recognize that many people may relate to the experiences we present on our report, and that people of many identities including cisgender women, transgender men, and nonbinary people are able to get pregnant. To reflect this, we have limited the use of "woman," "women," and "maternal" to quoted statements or cited research or data statistics. Our overall goal with this research is to highlight the intersectionality within the issue of perinatal health care, while advocating for the Medicaid coverage of doula services for all eligible pregnant people regardless of gender, gender identity, or gender expression.

I. Introduction

Doulas have been shown to produce positive health outcomes for birthing people. Specifically, studies have suggested improved outcomes for minority groups, low-income people, recovering addicts, single parents, and other peoples of traditionally marginalized groups. Interest in the potential effects of doulas on health outcomes has led seventeen states to consider or implement legislation that cover the cost of doula services on state Medicaid programs. In 2019 Vermont became one of the states to consider Medicaid reimbursement programs for doulas. Bill H.219, supported by many Vermont organizations of child and maternal health, advocated addressing issues of disparities in health outcomes through public policy, by funding Medicaid sponsorship of doula care. Although the bill never passed, we argue in this report that doula coverage under medicaid needs to be revised and considered again. Furthermore, other states should consider implementing similar legislation in an attempt to address the widespread health disparities in maternal health outcomes that faces the United States today.

The health disparities present in these marginalized groups are a result of many compounding and variable factors. Because of this, we recommend an intersectional approach to addressing this policy change. An intersectional lens will ensure that the needs of all birthing people of all identities are taken into account when it comes to revising this legislation. Doulas will act as advocates for the birthing person, ensuring the birthing person will have each aspect of their identity, and each intersection within that identity addressed, supported, and advocated for. The coverage of doula services by state Medicaid is a great example of how an intersectional framework can be applied to public health policy interventions.

II. What is a Doula?

Childbirth can, and often is, an exhaustive process - emotionally, physically, and mentally. It is vital that expectant birthing people have access to resources that can alleviate some of the stressors and pain that often go hand-in-hand with the birthing process. Doulas provide emotional support and services before, during, and after childbirth ranging from partnership and guidance during birth, a buffer between a medicalized birth and a natural one, a support system during painful or uncertain times, and much more (Papagni & Buckner, 2006). Doula services can include home-visiting, breast-feeding assistance, mentoring, involving partners in the birthing process, acting as guides to navigate the healthcare system, and more (Wint 2019) (Chen 2020).



Image 1. Ancient Roman carving of a doula (left) assisting a birthing person (middle) (Favrel 2020).

The contemporary understanding of a doula did not gain wide recognition and demand until the 1970s (Papagni & Buckner, 2006). Before this, similar non-medical supports were used during birth in the same ways doulas are today. The use of these supports are recorded as far back as ancient Roman civilization (Image 1). Starting in the 15th century enslaved African Americans used the support of birth workers as a way to “preserve tradition and custom” and “resist the dehumanizing autocracy” of slavery. As Olivia Dockery explains in her *Honoring Black Birth Workers of the Past*,

“Black birth workers traveled all over the south to make sure that Black families received the care that was needed regardless of their geographic location or ability to pay. They bridged the gap between disenfranchised communities and the health care system. Advancement in medicine, systemic racism, and patriarchy pushed Black midwives out and provided space for the white, male doctors that conquered U.S. medical institutions” (Pando 2020)

As Dockery explains, doula figures were pushed out of birthing spaces by the current medical system, making it hard for communities of color to gain access to this care. Unfortunately, the need for doulas has not diminished. Discrimination and racism by white medicalists is still a major issue that plagues the US medical field, and has been for centuries. Historically, white medical professionals exploited and invaded Black women slaves in the name of ‘science’ in an effort to learn, “. . . experiment on, to examine, and in their words, ‘cure’ or ‘fix’ diseases and disorders” (Manke 2020). This unconsensual invasion was used ‘in the name of science’ to further modernize and develop medical practices, especially in gynecology (Manke 2020). However, these progressions came at the cost of Black women. Doctors such as James Marion Sims in the mid 1800s, or as he is often referred to, the “father of modern gynecology”

(Holland 2018), only gained this title of propelling the study of gynecology forward at the expense of Black women and their bodies (Holland 2018). His lack of use of anesthetics or medical consent has resulted in a much needed examination of medical ethics (Holland 2018). Flash forward to the mid 1900s, Henrietta Lacks, a Black woman, was again violated and unethically treated by white physicians in the name of science (Holland 2018). Samples of Henrietta's cells as she was battling cervical cancer were taken without her consent, and further analyzed and shared with others, again without her or her family's knowledge (The Legacy of Henrietta Lacks). Again, although white medicalists claimed these processes were being done in the name of science and to continue modernizing the medical field, it was done at the cost of Black birthing bodies Presently, sobering facts such as Black birthing people being three times more likely to die during the birthing process compared to white birthing people (CDC 2019) and being more likely to be ignored or brushed off when requesting pain medications or expressing to medical providers that they are experiencing pain/discomfort, have a massive role in why some Black birthing people do not want to be under the care of white doctors (Sabin 2020). In fact, according to a piece written by Dr. Janice A. Sabin of the Association of American Medical Colleges, she found that “[h]alf of white medical trainees believe such myths as black people have thicker skin or less sensitive nerve endings than white people” (2020). It is clear that the medical field's discriminatory practices and mindsets are still in effect today, which is why it is vital that doulas remain an important member of the birthing team, especially for the groups who need them most.

In recent years doulas have become re-popularized - this time among white birthing people, with the resources and money to afford them (Wint 2019). Dula services have become privatized and expensive. In Vermont, the University of Vermont Medical Center (UVM Medical

Center 2021) provides an entire sector of the hospital dedicated to doulas in an attempt to make their care more accessible. Doulas can be requested through the birthing person's nurse or through the birthing person's "prenatal provider" (UVM Medical Center 2021). However, there are some caveats to this. The UVM Medical Center provides free doulas to birthing people *only* if they are "laboring and delivering at the UVM Medical Center" (UVM Medical Center 2021). For those looking to have limited medical intervention during their birthing experience, this option is not possible, as it would force them to deliver in the hospital setting, which in turn would involve a number of medicalists and medical processes. The second caveat is the expenses. If a birthing person is looking for a demedicalized birthing experience in Vermont but does not have the resources to pay the cost for a doula, they would almost certainly be at a standstill, as doulas outside of the UVM Medical Center would have a charge. This is especially true if community doulas are scarce. Expenses for non-community based doulas often hinder accessibility for birthing people (Wint 2019). Because of these expenses, community based doulas have been a utilized resource as they are often a more accessible and lower-cost sector of doulas (Wint 2019). However, further accessibility to and awareness of these services to birthing people in Vermont is essential in fostering the best birthing experience for each and every birthing person - both in Vermont and across all 50 states.

III. Vermont Bill H.219

In 2019, multiple Vermont representatives introduced bill H.219, a proposal to add Medicaid coverage for doula services during labor and birth and for the prenatal and postpartum periods. These representatives included Gonzalez of Winooski, Rachelson of Burlington, Brumsted of Shelburne, Cina of Burlington, Colburn of Burlington, Cordes of Lincoln, Haas of Rochester and McCarthy of St. Albans City.

The bill asks that The Department of Vermont Health Access provide reimbursements to qualified doulas for providing varying childbirth education and other support resources for individuals going through pregnancy. In order for the doula to be recognized by the state and receive payment reimbursements, the doula has to follow specific requirements outlined. These requirements include receiving and maintaining certification by an approved national certification agency, obtaining additional training (at the doula’s own expense) focused on doula care for special populations as well as becoming a Medicaid participating provider, submitting a background check and maintaining personal liability insurance. The state Medicaid program would then cover up to \$750 in doula services. This reimbursement rate would remain the same for each pregnant individual, regardless of pregnancy type (multiple pregnancy, high risk pregnancy, etc.) (H.219 2019). The cost breakdown of this coverage is depicted in Image 2.

Doula Service	Maximum Cost Reimbursement (per pregnant person)
prenatal parental visits <small>(can not exceed 4 hours)</small>	\$25
physical + emotional support - entire labor and delivery	\$550
postpartum visits <small>(can not exceed 2 hours)</small>	\$25
administrative fees	\$50
total doula services	\$750

Image 2. Medicaid coverage of doula services per pregnancy, per pregnant person in the state of Vermont under the proposed H.219 bill in 2019.

Doula services provide a way to address disparities facing pregnant individuals and offer financial relief in the long-run to Medicaid programs. Currently birth doulas are most accessible to those who can pay out-of-pocket for their services. Doula costs can range between \$600 and \$2,000 (Nguyen, 2021). Though, research has shown that doulas are most beneficial for those who are low income and/or face other social disparities (Vermont Early Childhood Advocacy Alliance). The United States faces a steadily increasing rate of maternal mortality with significant racial, ethnic and socioeconomic disparities in birth outcomes. More specifically, it disproportionately impacts Black, Native American, and Pacific Islander communities (Platt & Kaye 2020). Doulas provide support during and after pregnancy which can be especially helpful for individuals dealing with additional stress, such as racism or the pandemic that may possibly worsen their maternal health outcomes (Nguyen 2021).

The current private pay model does not guarantee consistent access to those who may need it most. Medicaid coverage for doula services would provide coverage for all pregnant individuals, regardless of their socioeconomic status.

Additionally, investing in the reimbursement of doula services is possibly a cost-effective approach to Medicaid sponsored births. Organizations such as the MotherBaby Childbirth Initiative, the Mother-Friendly Childbirth Initiative, Rights of Childbearing Women, and the World Health Organization have all studied and advocated for the continuous support of people through their birthing experiences. Across these studies, the use of trained doulas suggests to offer the highest impact among all the support initiatives studied. The support offered by doulas can minimize unexpected medical interventions and reduce the likelihood of complications during a birth (Voices for Vermont's Children, 2021).

Possibly one of the most cost-effective outcomes for increasing access to doula services is the reduced risk of cesarean section (C-section). Approximately one-third of all births covered by Medicaid are C-section births. Due to the nature of C-sections, these births are more expensive than vaginal births. On average a C-section birth covered by Medicaid is \$20,680, while a vaginal birth is \$12,599 (Price 2021). Some literature suggests that having a doula can lower the chance of having a C-section by 25%, thus lowering the cost of birth reimbursement for Medicaid programs. Additional benefits to having doulas included in the perinatal experience include decreased use of pain medication during birth, shorter labors, increased likelihood of vaginal birth, reduction in the use of labor inducing drugs, and reduced odds of newborns requiring special care nursery services (Dekker 2013) (Voices for Vermont's Children 2021).

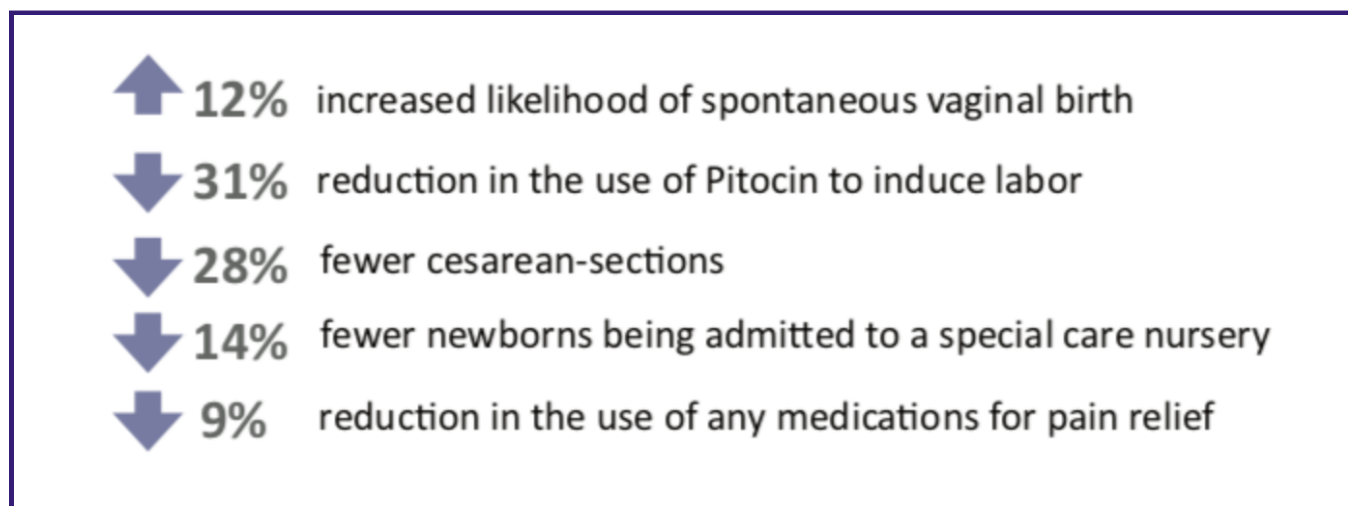


Image 3. Studies produced these statistics of outcomes associated with the use of doula services (Voices for Vermont's Children 2021).

Although Vermont bill H.219 did not get signed into law, due reprioritization during the COVID-19 pandemic, several key organizations in Vermont are still fighting for the state to consider covering doula services by Medicaid. Beyond expanding health services for perinatal

healthcare, bill H.219 attempted to address and resolve disparities in maternal and child health outcomes. Medicaid coverage for doula services has already been picked up in Oregon (since 2017) and Minnesota (since 2014). New Jersey and New York are states that are currently proposing bills to allow Medicaid coverage for doula services. As public health officials and policy makers attempt to address the issues of maternal and child health disparities nationwide, it will be relevant for them to consider the issue of Medicaid coverage for doula services.

IV. Benefits for Addressing Health Outcomes

All pregnant people in the U.S. face challenges; The U.S. has the worst rates of maternal mortality compared to any other developed country, at 17.4 deaths for every 100,000 births (Peterson 2019). Low income and Black persons, however, account for a disproportionate amount of those deaths. Specifically, Black women have the highest rates of maternal mortality of any other racial group in the U.S., by a factor of 1.5 if they are under the age of 20, and 4.3 if between the ages of 30-34. Black women are also twice as likely to suffer postpartum depression compared to white women (CDC 2019). Black infants experience disadvantages, as well; Infant mortality for black neonates is more than twice that of white neonates, and preterm births are more than 50% higher among blacks than whites. As for low income communities, housing insecurity and homelessness has been associated with pregnancy complications, preterm birth, and low birth weight in multiple studies. There is a 73% higher risk of low birth weight or preterm birth in people who faced severe housing insecurity during pregnancy versus those who did not (Leifheit 2020). If doula services become more widely accessible through the medicaid health care package, maternal health will improve and ideally, if executed with the intersectional feminist framework in mind, disparities will decrease.

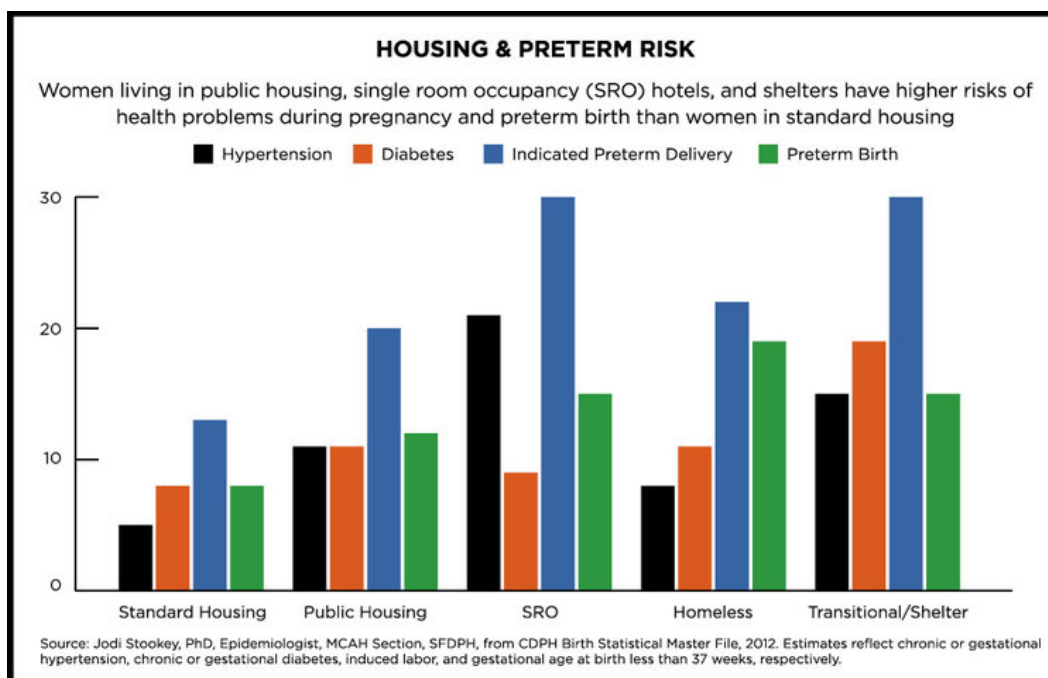


Image 4. Risk of various pregnancy related issues by housing situation (Health Impacts and Housing Insecurity).

Why do these communities face worse health outcomes than the rest of the country? One clear disadvantage for these populations lies in the inherent stress of being a housing insecure and/or black person; there is an increased likelihood of delivering a preterm or low birth weight infant if the pregnant person experiences depression, anxiety, and/or stress. Chronic stress in particular causes a plethora of health problems, including risk of hypertension, enlarged heart, damage to the kidneys, heart, and other organs, diabetes, higher levels of depression and anxiety, and more; the list is seemingly endless. There are health risks for the fetuses of chronically stressed pregnant people, as well; high levels of stress hormones present in the pregnant person can lead to issues in brain development within the fetus (Greenburg 2020). Chronic stress as a factor in physical health is referred to as allostatic load. Alissa Greenburg explains, “The term ‘allostatic load’ was coined by Bruce McEwen and Elliott Stellar in 1993. It refers to damage wrought by persistent stress, which overtaxes the body’s delicate, overlapping regulatory

mechanisms—including the immune, endocrine, and circulatory systems, and those regulating blood sugar and mood” (2020).

Housing insecure people have a much greater chance of developing anxiety, depression, and/or stress disorder. One study which compares low-income urban mothers who have moved 2 or more times in the past two years with those who moved less found that low-income mothers are 1.7 times more likely to have depression, and 2.5 times more likely to have a generalized anxiety disorder (Leifheit 2020). Black people, as well, have a greater likelihood of having chronic anxiety. This stress is most obviously due to systemic racism. The idea that structural inequities affect people on a cellular level, an idea called weathering, explains this lifelong stress. As Alissa Greenburg explains in her article,

‘Just *being* in this society, as a Black person or a brown person means the recognition that you are potentially at risk for some sort of negative encounter,’ Parker Dominguez says, ‘whether it’s with the police or elsewhere. Your level of threat perception in the environment is higher.’ That threat perception leads to hypervigilance, which leads to heightened allostatic load. It’s that ‘pervasive, persistent’ experience of stress that can be so damaging to the health of Black Americans and other marginalized communities, Bennefield says. ‘It’s integrated into our housing, our education, our criminal justice system.’ (2020)

Black people also face added stress not only throughout their lives due to implicit, structural, and overt racism, but also during labor due to poor service inside hospital settings. Minority women report “disrespectful care, stressful social interactions, racial discrimination, lack of staff empathy, unmet informational needs and inconsistent social support” (Ogunwole, Bennett, Williams, & Bower, 2021).

There is a large and continuously growing body of evidence showing that doula services significantly decrease some of the added risks of childbirth for low income and minority people. As argued above, low-income and minority groups face added challenges in the birthing process because of increased lifelong stress, among other reasons. Doulas provide support in the non-medical aspects of labor and delivery, including emotional, physical, and informational support; areas in which stress and emotional well-being can be addressed. They are advocates for the pregnant person throughout the birthing process, an especially essential role for pregnant people who are members of underserved communities. Community-based doulas in particular aid in the overall ease of the birthing experience by being trusted members of the pregnant persons community (Ogunwole et al. 2021). Doulas often connect mothers to additional resources outside of the traditional healthcare system as well, as this doula explains in an interview;

“WIC for example, Nurse-Family Partnerships, Healthy Start. These are all organizations that provide support to mothers free of charge. We might want to remind her the importance of getting a library card...we will connect her with organizations that will provide either Uber service at no charge to her, or she would get a ConnectCard...We want to connect her with some of those resources in the community.” (Wint 2020)

A medical professional, alternatively, provides only medical support to the pregnant person and thus faces constraints if they wish to aid their patients in other facets of the birthing process. Similarly, medical professionals are an integrated part of the healthcare system which causes so many added barriers to these communities; finding an advocate in the form of a doula to navigate this healthcare system becomes essential for these populations if they are to have successful birth outcomes.

Doula services are linked to lower cesarean rates, shorter labors, increases in breastfeeding initiation and retention, and more (Wint 2020). Evidence for the benefits of doulas to minority and low income pregnant people, in particular, is plentiful. A 2019 study compared several community-based doula programs with Pregnancy Risk Assessment Monitoring System (PRAMS) participants, specifically low-income and ethnically and racially diverse participants. PRAMS is a surveillance project led by the CDC and health departments, collecting jurisdiction specific data on maternal experiences throughout the birthing process since 1987. This study found a number of benefits in utilizing the doula programs. Compared to participants in the PRAMS group, black and hispanic mothers utilizing doula programs were more likely to be exclusively chestfeeding in 6 weeks, 3 months, and six months. The benefits of chestfeeding can regrettably get lost in the shuffle of non-doula supported birth. The practice is associated with improvements in both maternal and infant health and well-being (Ogunwole et al. 2021). Another study compared medicaid-funded births nationally with doula supported births in Minneapolis, Minnesota, from 2010 to 2012. This study found the odds of a cesarean delivery to be a staggeringly 40.9% lower for doula supported births (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien 2013).

Research across internationally diverse settings and populations continuously point to the fact that people who have continuous support during labor from an experienced, nonmedical caregiver have shorter labors, use less pain medication, have more spontaneous vaginal births, and are more satisfied with their birthing experience (Hodnett, Gates, Hofmeyr, & Skala, 2013). Low income and minority groups are already at a disadvantage when it comes to birthing outcomes; they report higher rates of all health outcomes. Doula services are a cost effective, demedicalized, and natural way to counteract the birth outcome disparities across racial and

socioeconomic groups. Doulas are present during the pre-, intra-, and post- natal phases of a person's birthing process; during this time, they develop a personal relationship with their patient, advocating for their wants and needs in clinical settings that may otherwise discriminate against them, and supporting them emotionally throughout. These added supports, which a clinician alone cannot provide, lead to better birth outcomes and decrease stress, both of which are common major factors in poor birth outcomes. Doulas are a part of the answer to improving the health outcomes of minority and low-income groups; but they can only help if they are accessible to the general population.

V. The Hyper Medicalization of Natural Life Cycle Processes

A large part of reducing negative health outcomes in birthing experiences and the disparities between populations is reducing the externalities of medicalized birth. Western society is bearing witness to the medicalization of the life cycle, an extension of coloniality. As medical technology advances, the population exponentially grows, and life expectancy increases, there has been an increased importance and prioritization placed on biomedical solutions to health problems. Our society views biomedicine very highly as it values control. Evidence of medicalization of life can be seen in all stages of life in terms of how the stages are discussed and how these discussions inform societal opinions. For example, menopause is phrased as an estrogen deficiency. The language that we choose to use when we talk about these subjects has an enormous impact on how we think about them. 'Deficiency' denotes a certain significant *lack* on the behalf of the woman that demonizes this organic stage and dehumanizes the person experiencing this natural part of life. Another more universal example, death. The only concrete fact of life, intrinsic to our humanity, is that it will one day inevitably end for everyone. Even with this eventual fate that no one has been able to stop but merely temporarily delay, death in

biomedicine is viewed as a medical defeat. The most natural and reliable outcome is seen as a shortcoming (Shea 10/30/2019). Because this fight is constantly looming over the medical establishment and its patients, the biomedical reaction is to wield science against the whimsy of the life cycle (Shea 11/4/2019).

Biomedical interventions are undeniably incredible feats of human creativity, ingenuity, and invention. While enthusiastically welcomed as essential tools in cases of emergency or health crisis, the reach of biomedicine crosses the line at the threshold of woman's bodily autonomy, embodying the label *hyper* medicalization. To address the disparities among birth outcomes across race and class, the solution must be aware and combat the continued colonization of the natural life cycle. This phenomenon is most prevalent in women-specific natural processes. Medicalization happens in fertility, pregnancy, sexuality, puberty, old age, and menstruation (Manfield 2007, 1087). At each stage, patients are offered medication, isolation, hospitalization, and/or artificial interventions that attempt to hinder or mitigate instead of foster or celebrate the naturally occurring processes that women are built to experience. The medical community, following the development of anesthesia and the field of obstetrics, has come to view natural birth through a pathological lens as a condition; something to be managed, controlled, and mystified. This ideology which elevates hospital deliveries over home births (or natural births) has contributed to the hyper medicalization of the birthing process; natural processes are condemned, stigmatized, eliminated or controlled until they are no longer seen as healthy. It is counterintuitive to view these processes as medical issues or failures as they are the essence of human procreation. Biomedicine becomes burdensome and invasive when these interventions over-facilitate birth and alienate the birthing people from the process. This is not to say there is no appreciation or need for biomedical intervention. There are many cases that

require intervention to prevent fatalities or injury. Abortion, for example, can be life-saving healthcare. C-sections, as well, have their place in dire situations. Physicians who are motivated by profit (or fitting the birth into their schedule instead of the other way around) have incentive to recommend interventions that may be unnecessary or even harmful to the birthing person or the baby. Jennifer C. Nash writes, “While doulas emphasize that they are not medical practitioners...It is doulas’ capacities to reside in medical spaces while maintaining minimal (if any) medical training that can make the relationship between birth work and medical care” (Nash 2019 pp. 34). Henley and Nash, among other authors, make clear the fact that doulas make space within the clinical setting for birthing people to voice their desires or concerns regarding their birthing experience. They also understand, from interviews conducted with doula, the birthing person needs to have confidence in their body, and the use of unnecessary biomedical interventions takes away this embodied, intimate experience turning it into something transactional and artificial.

There’s an understanding that a natural birth is not what the majority of births in America look like anymore as the medicalization of childbirth has been normalized and sustained as common practice for decades. The term ‘natural’ birth holds many varying connotations such as “hospital birth without painkillers to birth without any medical intervention at all” (Mansfield 2007, 1084). Though, all definitions try to forge independence from the ever-tightening biomedical grasp whether that be a cesarean section surgery, a hospital setting, or an epidural. A critique of the birthing person’s support team is in order. In the age of hyper-medicalized birth, the championed and prioritized members are those decorated with the most medical prestige; namely the physician and nurses. The current typical “support” system for women in the hospital is composed of doctors, nurses, and other faculty. Reclamation of body, birth, and baby for a

birthing person looks like shifting focus back to the parent and their personal advocates on the support team. Making doula services available through the medicaid package is an opportunity to interrupt biomedical overreach by replacing the clinical staff with the natural, built-in support system of doulas, partners, and family.

The unsung hero of a birthing person's support team is the doula. Doula's offer physical and emotional support during labor, and advocate for the birthing person and their pre-ordained birth plan. While they are well-versed in the birthing process, it is important that they are not medical professionals. Untethered to the hospital, their loyalty resides with the birthing person, assuring them space for self-determination and control over what happens to their bodies, "A woman's choice of how, where and with whom she gives birth is as important as her decision to become pregnant, to end or to continue a pregnancy" (Demanele 2013). The presence of a Doula during labor can prevent obstetric violence, unnecessary C-sections, the vicious struggle between pitocin/epidural, and, in extreme cases, mortality. Doula's have a long history in traditional birthing practices and an esteemed place within communities of color. To ignore the conception and culture intimately tied to the doula practice would be to further colonize the birthing process. In the same vein, the impacts of hyper-medicalization can be seen in the egregious disparity across maternal mortality rates between races. Black birthing people bear the brunt of the dehumanizing results of medicalization. The black maternal mortality rate in the United States is the ultimate failure of the healthcare system and indicates the need for an intersectional approach to restructuring the institution. Demedicalizing pregnancy, labor, and birth starts with recentering the person in labor and investing in the birthing person's biggest supporter: the doula.

Demedicalization goes hand in hand with decolonization. The expertise and credibility of doulas have been forcibly lost to the reign of biomedicine. It is crucial that we acknowledge and appreciate the impact of African midwives who brought their ancestral knowledge and birthing traditions under the inhumane and horrific conditions of slavery during the early 1600s. Before the field of obstetrics emerged in the mid to late 1700s, African midwives provided care and improved birth outcomes for black *and* white women alike despite their enslavement. Shafia Monroe, a midwife and healthcare consultant versed in birth outcomes and cultural competency, remarks, “One of the darkest moments in US history was the systematic eradication of the African American midwife from her community, resulting in a legacy of birth injustices” (Terreri 2019). The reliable and respected practice of black midwifery is eliminated from black communities as a lethal act of colonization, casting rippling effects which can be quantified now as the racial disparity among maternal mortality rates. Black maternal mortality is particularly exacerbated by “an inescapable atmosphere of societal and systemic racism” which undeniably conjures a damaging “toxic physiological stress” (Terreri 2019). Common markers of a black woman’s hospital birthing experience include neglected pleas for medical attention, disregarded emotional or physical pain, dismissal of concern, and blatant racial bias. To begin to combat this systemic racial injustice, new legislation must aim to support the populations most affected by the medicalization of birth. It is important that community-based doulas are covered under the medicaid health care package for the sake of accessibility, maternal health, and starting the long process of decolonization.

VI. Feminism, Intersectionality, Decoloniality

Attempts to address health disparities and improve health outcomes related to birth extend beyond addressing the ways birth has been medicalized in western society. There is a need to emphasize the many layers that contribute to health outcomes for birthing people in the US. Scholars and activists recognize the important role doulas play in bridging the gap between addressing health disparities while accounting for issues of systemic racism, forgotten history and tradition, wealth disparities, and limited access to birth support resources. Activist and doula Sarah Coldwell describes birth as a feminist issue, in an attempt to acknowledge the complexity and high stakes of the matter - recognizing that birth is more than a medical issue. Coldwell emphasizes the need for birthing people to be re-centered in the birth process, much like in the arguments made for de-medicalizing birth. In Coldwell's idea of birth as a feminist issue, doulas can act as the mechanism that brings power and ownership over the experience to the birthing person (Caldwell 2017). By bringing doulas into the birthing process, it is an attempt to combat the medical sexism and violence that has historically made birth a traumatizing experience for so many. It is an argument that has started the conversation of "birth justice," in which "women and trans folks are empowered during pregnancy, labor, childbirth and postpartum to make healthy decisions for themselves and their babies (Black Women Birthing Justice)." The concept of birth justice, however, diverges from the understanding of birth as a purely feminist issue and seeks to "dismantle inequalities of race, class, gender, and sexuality that lead to negative birth experiences, especially for women of color, low-income women, survivors of violence, immigrant women, and queer and transfolks" (Black Women Birthing Justice). While some people might understand feminism to include dismantling and addressing sweeping inequities that lay outside of gender issues, there is compelling literature that suggests reducing an issue as

broad as birth to be defined only as feminist is grossly underrepresenting the magnitude of the issue. Women of color are often excluded from the feminist narrative because the voices championed at the forefront of the movement are normally privileged voices, effectively prioritizing middle to upper class white women and ignoring the experiences of women who are the most disenfranchised. Kimberlé Crenshaw highlights these underrepresentations in the context of race: “The failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women” (1991, pp. 1252). The failure of feminism to acknowledge race as an integral axis of gender equality, and feminism, will inherently leave people behind and reproduce existing issues of disparity. So, we must not look at birth as a purely feminist issue. Instead, we must consider the many intersections of identities and experiences that relate to the birthing person - only then can we truly change the context of birth to create better health outcomes and experiences for people.

Looking at birth through this intersectional lens offers a new perspective on who has access to the resources that can help facilitate positive birthing experiences, and more specifically, who has access to doula services. One study concluded that only 6% of birthing people receive doula care, but 27% of people would have liked to have accessed a doula (Dekker 2019). One of the main barriers to birthing people receiving doula care is the cost associated with the services. Overwhelmingly, the cost of doula support is an out-of-pocket expense, on top of any pre-existing fees for birth. Depending on geographic location, doula services can cost anywhere from \$1,500- \$2,000 per pregnancy (Saffon 2021). Because of these costs, doula care is often seen as a “privilege reserved for wealthy white people capable of

paying for the resource (Wint 2019) .” The increased privatization of doula services and associated out-of-pocket- costs have been detrimental for those who want to access that form of birth care, but can not afford it. The birthing people who need the most protection and support during the course of pregnancy through birth are those who are getting left behind as doula services are increasingly white-washed and privatized. Birthing people of color or low socio-economic status are often disregarded in hospital settings, yet stand to benefit the most from the very services which have regrettably become inaccessible.

However, providing doula services under Medicaid could attempt to address this problem. The coverage of doula services by Medicaid would make what has become a privatized and expensive service, public and accessible. Birth care is essential health care for nearly half the population and doula services should be treated as such, rather than as a luxury for some. Passing legislation like H.219 to cover the cost reimbursements of doula services by Medicaid would remove financial barriers to obtaining doula support, creating more equitable access. The majority of Medicaid-sponsored births cover births for non-white birthing people (Image 5). Additionally, Medicaid serves a population that is low-income. By adding doula services to Medicaid programs, people of color and people of low socio-economic status will have greater opportunities to be supported by doulas during their perinatal and birthing experiences.

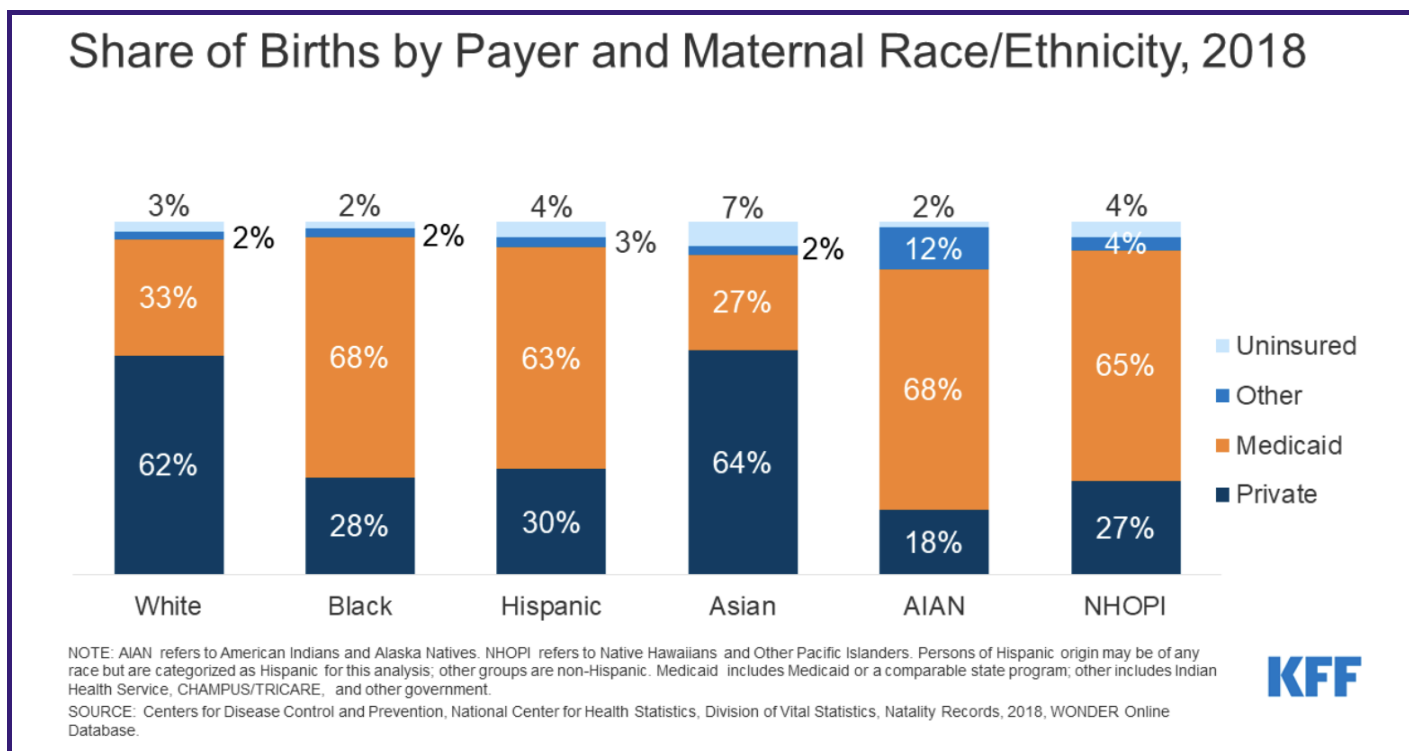


Image 5. Births categorized by race of birthing person, and broken down within each racial group by payer/coverage. (Artiga 2020)

People covered under Medicaid are the ideal recipients of doula care, as these populations also face some of the worst birth and perinatal health outcomes. With the known benefits of using doula care, the coverage of doula services by Medicaid has the potential to transform health outcomes for these target populations, greatly broaden the access to doula services, and account for a history of doula care that has often been forgotten. As mentioned early on in this piece, doula care was commonly used by birthing people in Black communities, until privatization of the service caused the shift towards white birthing people being the primary beneficiaries of doula care (Wint 2019). Thus, embellishing the current Medicaid health care package will reprioritize birth care for the communities that were historically disenfranchised from their doula practices. Not only does this approach counter the medicalization that is inherently colonial in nature, but it attempts to promote healthy birth outcomes and respect

toward an undervalued cultural practice; approaches that are both intersectional and decolonial in nature. Decolonization of birth is about giving birthing people the resources to “give birth in safe spaces that respect and honor their intuition, autonomy, cultural traditions, and desires” (Porterfield-Finn). Implementing new medicaid coverage of doula care prioritizes these conditions AND gives consideration to the intersectionalities of birthing people’s identities and lived experiences.

VII. Conclusion

Overall, the addition of doulas to a person's birthing team brings positive outcomes that are worth investing in. Doulas can provide emotional support, home-visiting services, breast-feeding assistance, mentoring, guidance through the medical system, support in involving partners in the birthing process, and more (Papagni & Buckner, 2006). They can also serve as advocates for birthing people, especially those who are members of historically marginalized groups, for the medical system has failed to serve them properly before. These services lead to better health outcomes; specifically, doula care is linked to lower cesarean rates, shorter labors, increases in chestfeeding initiation and retention, and more (Wint 2020). Furthermore, because of these reduced complications doulas become a cost-effective option. If Medicaid programs invested in doula care, this would enable a large and wide variety of birthing people to have access to doulas and a safer birthing experience. Beyond health outcomes, doulas as an addition to the birth support team aids in the demedicalization of birth, as they have no connection to the hospital, and are there purely for the benefit of the birthing person. Doulas are the birth person’s greatest proponent, supplementing and mediating the care that physicians provide - tending to the mental and emotional aspects of birth, doulas provide holistic support, specifically tailored to the

birthing person. From the intersectional perspective, doulas have the potential to provide access to equitable birth care and the ability to advocate for historically marginalized groups.

The Vermont bill proposed in 2019, H.219, which asks for Medicaid coverage for doula services during labor and birth, as well as for the prenatal and postpartum periods, deserves to be revisited. States that choose to pursue the coverage of doula services in Medicaid should consider utilizing an intersectional approach to this coverage. Proposed bills must specifically address the health disparities that the United States faces - including but not limited to race, class, and gender. Doulas serve to advocate for the individual. Their primary focus is to meet their client wherever they are, to acknowledge each birthing person's identity, and to address any inequalities and adversities the birthing person may be facing both in and out of the medical field. By placing emphasis on the understanding that birthing people experience different outcomes based on their intersecting identities, health policy can address health disparities, creating better health outcomes.

Today in the United States, a successful birthing experience is dependent upon the identity of the birthing person. This can be changed with the right approach, and doulas are a part of this approach. With Medicaid coverage, doulas will become more accessible to the communities who could benefit from them most. In this way, doula coverage under Medicaid is an unequivocally positive addition that Vermont and the rest and other states should look to prioritize.

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