

# GOAL 4

WHITE HOUSE  
BLUEPRINT  
EVIDENCE TO  
ACTION BRIEFS



## Expand and Diversify the Perinatal Workforce



**Maternal Health**  
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**THE WHITE HOUSE BLUEPRINT  
FOR ADDRESSING THE  
MATERNAL HEALTH CRISIS**



The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Goal 4 of the White House Blueprint.

#### **Maternal Health Goal 4**

Expand and diversify the perinatal workforce.

# CONTRIBUTION TO QUALITY OF LIFE

The [White House Blueprint](#) is a “whole-of-government approach to combating maternal mortality and morbidity” so that all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe.

Expanding and diversifying the perinatal workforce can help to expand access to maternity care in underserved areas and improve the quality of maternal health care in the United States.

## BASIC FACTS

The US is facing a critical shortage of maternal health care professionals. Currently, 7 million people of childbearing age live in counties with limited or no access to maternity care services, and they are giving birth to more than 500,000 infants a year (see Figure 1).<sup>1</sup> Markedly, fewer than half of all rural counties have a practicing obstetrician, and midwives are even less available for the US birthing population (see Figure 2a).<sup>2</sup>

Compounding the limited access to maternal health care providers and other health care professionals (such as family medicine physicians), racial and ethnic diversity among health care professionals serving pregnant persons (e.g., nurses, doulas, mental and behavioral health specialists, social workers, community health workers, and nutritionists) is often misaligned with the demographics of the US birthing population.<sup>3</sup> Roughly half of all births that occur in this country each year are to individuals of color, yet fewer than one fifth of obstetricians come from underrepresented racial and ethnic communities (see Figure 2b).<sup>4,5</sup> Similarly, there are insufficient numbers of doulas and midwives of color.<sup>6</sup> A 2021 report found that only 7% of certified nurse midwives (CNMs) and certified midwives (CMs) identified as Black or African American—despite Black persons accounting for 14% of the US population.<sup>7</sup> Another study found that midwives and doula professionals are overwhelmingly White; it is estimated that between 60% and 80% of doulas in the US, depending on the community, are White (see Figure 3 and Figure 4).<sup>3,8</sup>

Numerous leading maternal health experts collectively stated at the US Commission on Civil Rights virtual briefing in November 2020 that “... disparities in maternal health outcomes could be reduced by increasing workforce diversity and having more cultural congruent maternity care in the US.”<sup>9</sup> Expanding, diversifying, and continually supporting the maternal health care workforce, including doulas, midwives, and perinatal health support workers, can help to improve maternal health outcomes by increasing connection and shared understanding with patients, bettering patient satisfaction, and remediating inequities in services and outcomes.<sup>10</sup>

CNMs, CMs, and certified professional midwives (CPMs or midwives) play an important role in maternity care. Midwives have an increased understanding of a community’s traditions, which facilitates provision of culturally appropriate care; they are relationship-based and spend significantly more time with their patients as compared to obstetricians.<sup>11,12</sup> The US lags significantly behind other high-income countries in the number of midwives. Australia has 68 midwives per 1,000 live births compared with the US, which has 11 midwives per 1,000 live births.<sup>13</sup>

There is good reason to bolster the presence of midwives throughout the country—data shows that disparities among racial and ethnic groups can be reduced when mothers receive midwifery care.<sup>14</sup> Research also has demonstrated that states that have made significant efforts to integrate midwives into obstetric care (e.g., New Mexico, Oregon, and Washington) have some of the better outcomes for families, whereas states with the most restrictive midwifery policies and practices (e.g., Alabama, Mississippi, and Ohio) have overall worse maternal and neonatal health outcomes.<sup>15</sup> Furthermore, research has found that midwife-attended births result in lower rates of cesarean sections, increased rates of breastfeeding, increased communication, increased patient autonomy, and increased patient satisfaction, thus resulting in better maternal and infant outcomes.<sup>16,17</sup> There also is evidence that midwives provide significant cost-savings to parents, insurers, and taxpayers.<sup>3</sup>

Doulas are another important yet underutilized maternal health resource. Doulas are nonclinical birth workers responsible for physical, emotional, and informational perinatal support to birthing people and postpartum people, as well as their families.<sup>17</sup> Doulas also act as advocates for the birthing parent throughout the perinatal period—notably, doulas can support birthing families to navigate and enhance relationships with professionals in the maternal health care setting. The support that doulas provide for birthing people and their families has been shown to have a positive impact on birth outcomes, including a lower risk of a birth ending in a cesarean section.<sup>17</sup>

Evidence also supports the use of lactation consultants, community health workers (CHWs), and freestanding birth centers to improve maternal (and infant) health outcomes. A systematic literature review found that breastfeeding interventions using lactation consultants or counselors increased the number of lactating people initiating breastfeeding, including exclusively breastfeeding, and also had a positive effect on breastfeeding rates overall.<sup>18</sup> Critically, tools coupled with knowledgeable, empathetic, and accessible people are most effective.<sup>19</sup> A separate review found that CHW interventions, when combined with clinical services, positively impacted birth outcomes and showed improvements in the receipt of antenatal care.<sup>20</sup> CHWs also have a role to play in providing outreach, education, referral and follow-up, case management, advocacy, and home visiting services, all of which have been shown to have a positive impact on maternal health outcomes. In particular, CHWs may have an important impact on pregnant individuals at high risk for poor birth outcomes, providing these individuals with emotional and practical support and education on topics such as family planning, pregnancy, childbirth, breastfeeding, and vaccination.<sup>21</sup> Finally, robust evidence supports freestanding birth centers as a model of care that can improve both maternal and infant outcomes and reduce racial disparities, yet these facilities are rare and face numerous operating challenges.<sup>22,23</sup>

To build the holistic, diverse, and affordable perinatal workforce that every pregnant woman and individual with reproductive capability deserves, the [White House Blueprint](#) commits to the following actions:

**Action 4.1. Train more family medicine and obstetric providers in underserved settings through the Primary Care Training and Enhancement** to improve care for at-risk populations and those living in underserved areas. The Community Prevention and Maternal Health Program will help to support adding more primary care physicians with obstetric expertise.

**Action 4.2. Expand and diversify the number of nurses and certified midwives in underserved areas** by using a set-aside for the Nurse Corps to support maternal and women's health registered nurses, advanced practice nurses, and certified nurse midwives.



**Action 4.3. Increase the number of community health workers and health support workers** in underserved areas via the Community Health Worker Training Program.

**Action 4.4. Expand access to doulas, licensed midwives, and freestanding birth centers** by releasing guidance for states regarding coverage options in Medicaid. Further expand access in other programs by launching a doula services and training program for incarcerated women and encouraging [Federal Employees Health Benefits] FEHB carriers to improve reimbursement rates and expand coverage for certified nurse midwives, freestanding birth centers, and perinatal support services, including lactation consultants and doulas.

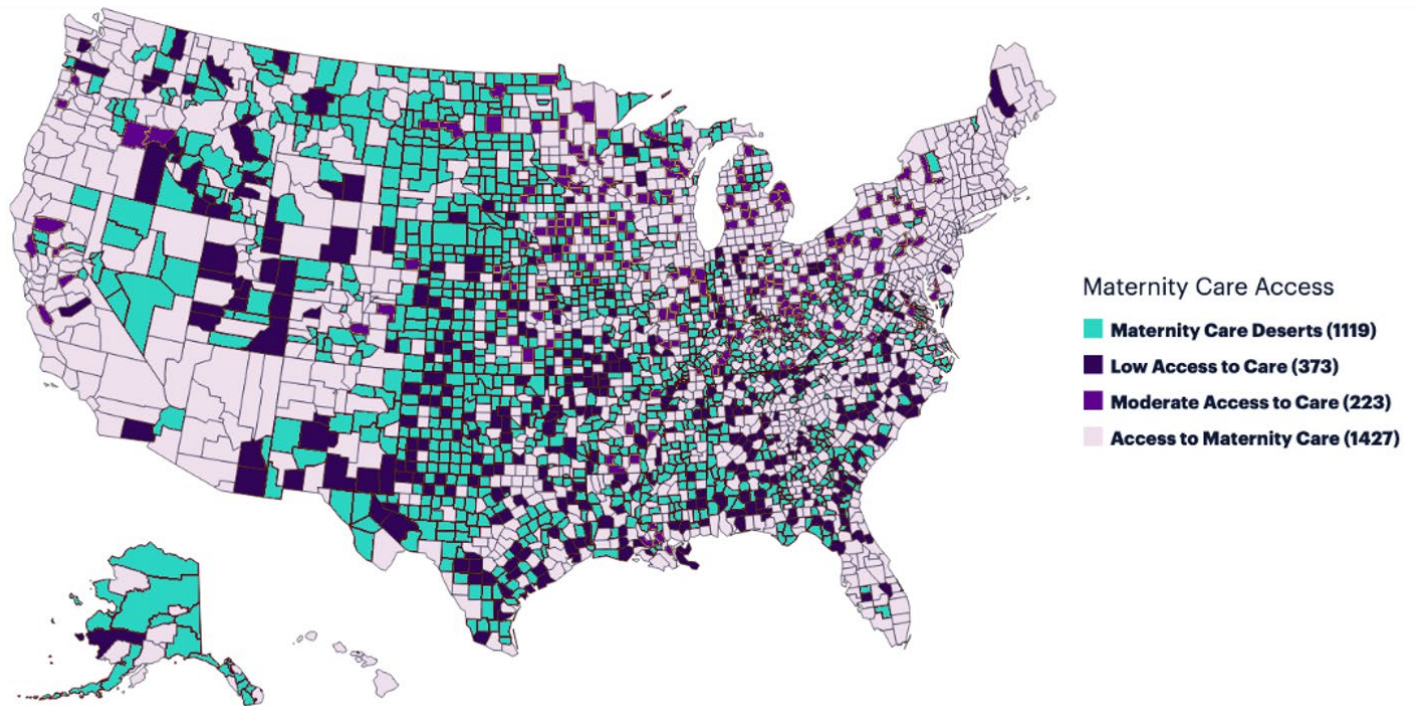
**Action 4.5. Evaluate the impact of doulas and lactation support on service members and their families** through a demonstration project providing beneficiaries with doula and lactation services not typically covered under TRICARE.

**Action 4.6. Identify areas within primary care Health Professional Shortage Areas** with the highest need for maternity care health professionals and target National Health Service Corps placements for obstetricians and certified nurse midwives there.

# HOW ARE WE DOING?

Below we highlight data related to Goal 4. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should be focused to improve health outcomes related to the goal.

**Figure 1: Maternity Care Deserts in the United States, by County, 2020**



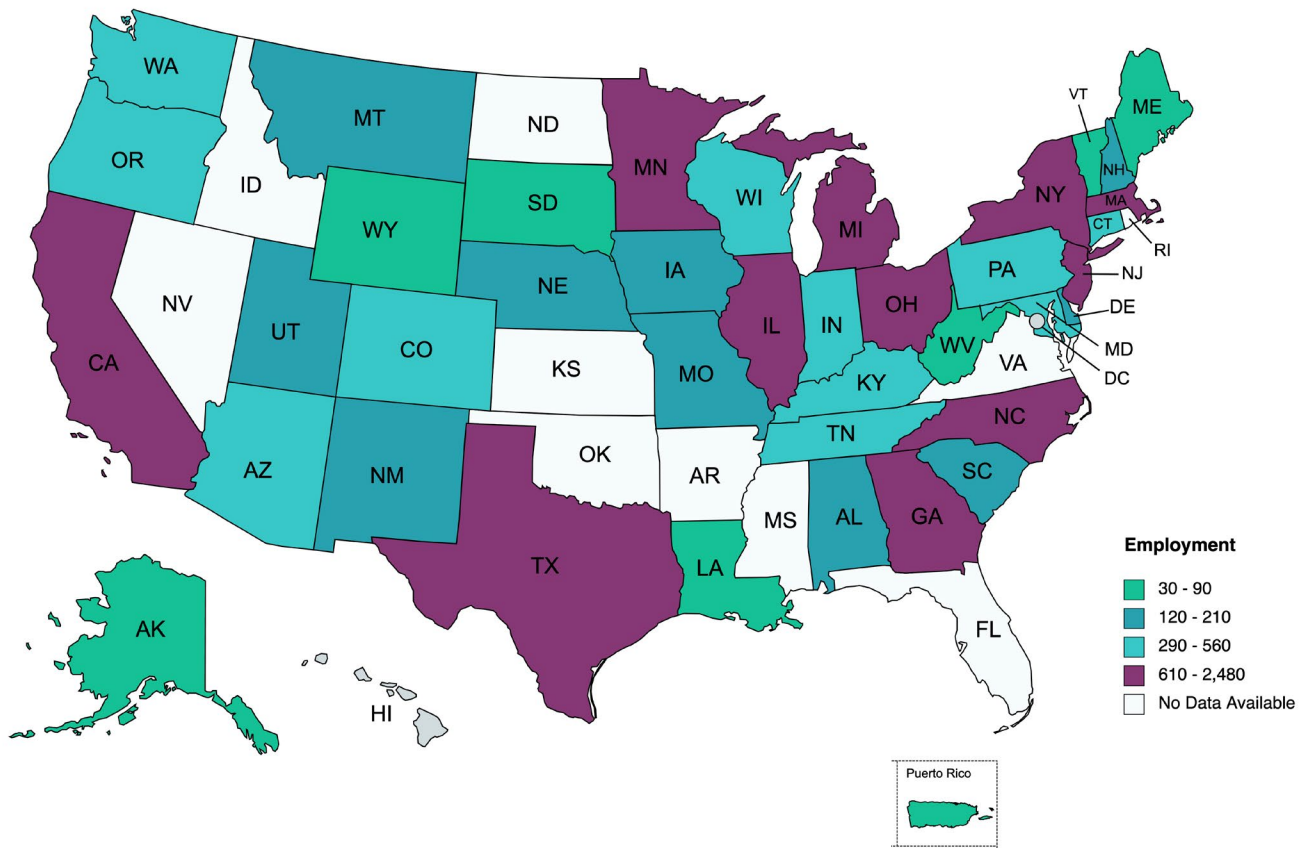
More than 2.2 million women of childbearing age in the US live in a maternity care desert and more than 36% of all counties in the US are designated maternity care deserts. Between 2020 and 2022, the number of counties declared maternity deserts increased by 5%.

Source: [US Health Resources & Services Administration, Area Health Resources Files, 2021](#)

## CALL TO ACTION

The care that midwives, doulas, lactation consultants, and CHWs provide to families improves equity and health outcomes and empowers parents. Health care leaders should remove barriers and enact policies that support the training, certification, and coverage of these health care practitioners—especially practitioners of color—and support their work in rural communities, reversing the trend of increasing maternity care deserts in US communities. Policies should also expand access to transformative care models such as freestanding birth centers, support the training of more family medicine and obstetric providers in underserved settings, and support funding to develop more opportunities in the workforce pipeline that would increase workforce diversity.

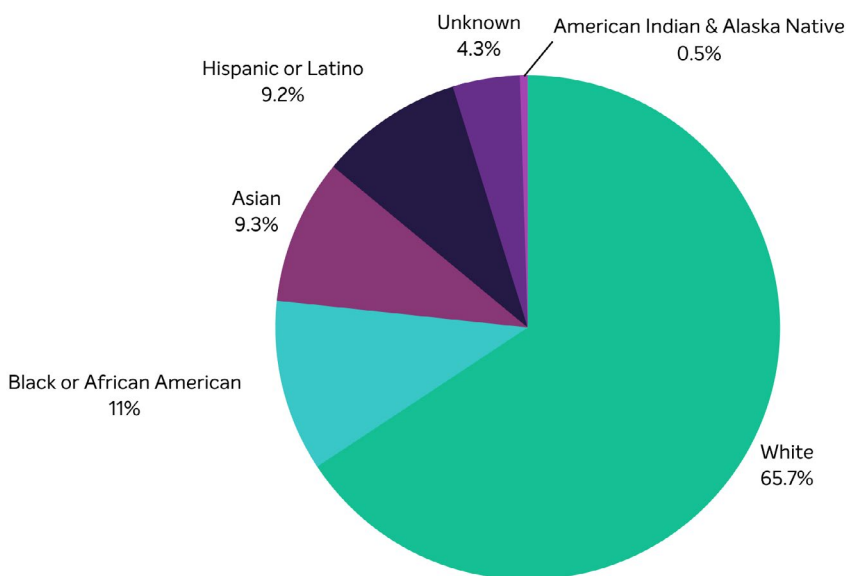
**Figure 2a: United States Employment of Obstetricians and Gynecologists by State, May 2022**



The number of practicing obstetricians/gynecologists varies geographically in the US, with some states having fewer than 90 obstetricians/gynecologists to serve the entire state.

**Source:** U.S. Bureau of Labor and Statistics. [Occupational Employment and Wage Statistics](#), 29-1218 Obstetricians and Gynecologists. 2022 May. Accessed September 5, 2023.

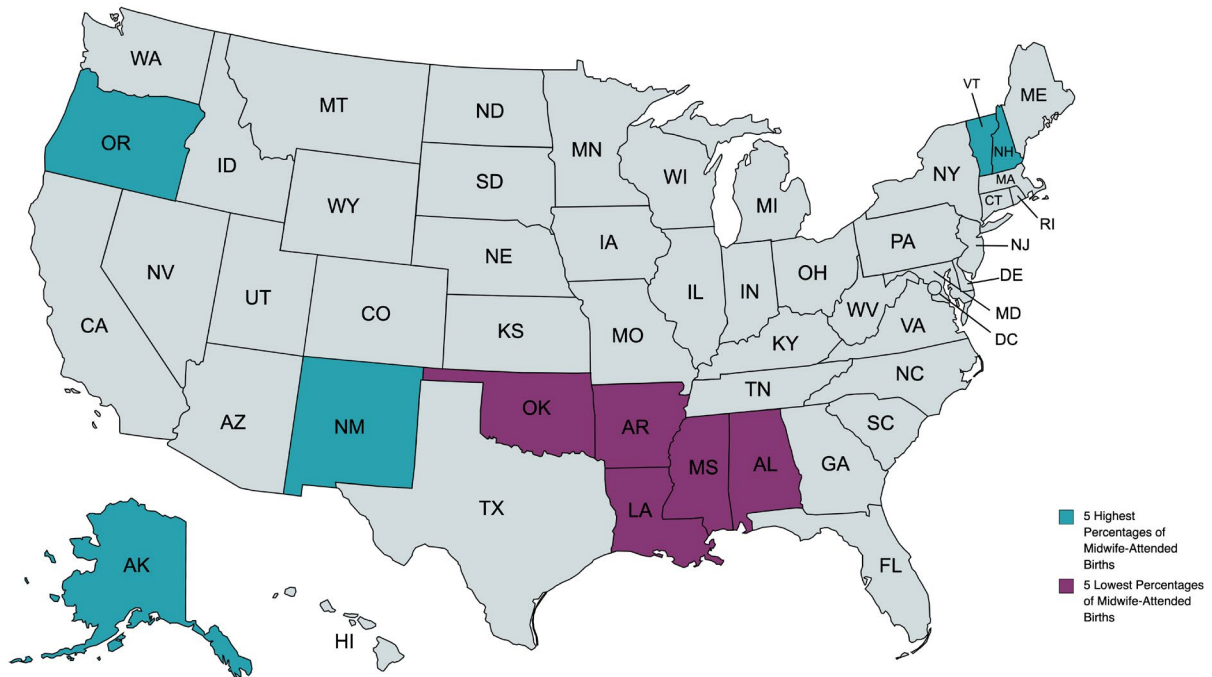
**Figure 2b: The Races and Ethnicities of Obstetricians/Gynecologists in the US Has Not Kept Pace with the Changing Diversity of the Country, 2021**



As of 2021, there were more than 23,000 obstetricians/gynecologists practicing in the US. Just over 85% self-identified as female, with an average age of 43 (data not shown). Over 65% of obstetricians/gynecologists self-identified as White, 11% as Black/African American, 9% as Asian, and 9% as Hispanic/Latino.

**Source:** Zippia. [Demographics of Obstetricians and Gynecologists in the United States, 2023](#). Last reviewed July 21, 2023. January 2021. Accessed September 5, 2023.

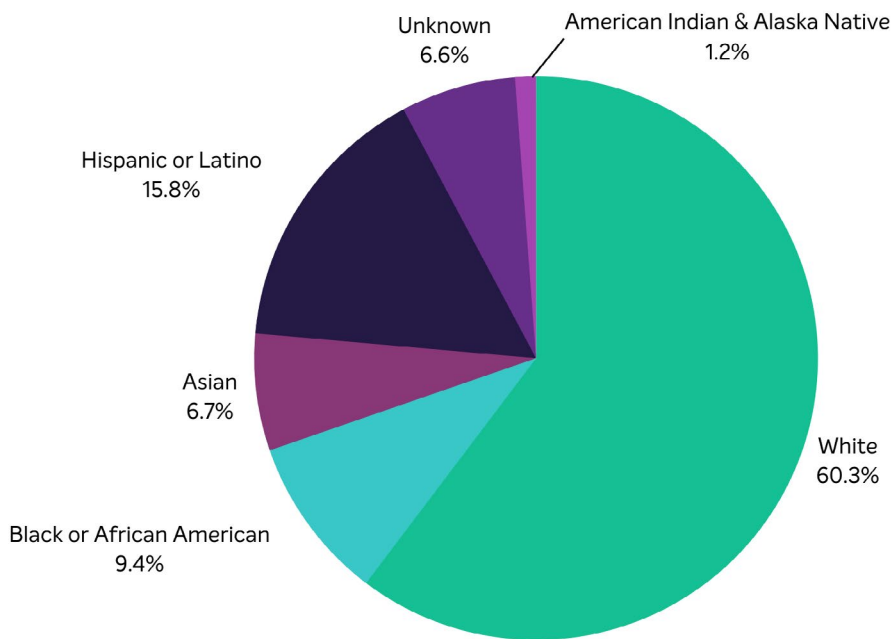
**Figure 3: States with the 5 Highest and 5 Lowest Percentages of Midwife-Attended Births, 2021**



Variation in the proportion of births attended by a midwife may be due to differences in how midwifery practice is regulated in each state, such as policies that may support midwives to practice independently and do not require physician supervision.

Source: Government Accountability Office. [Midwives: Information on Births, Workforce, and Midwifery Education](#). Report to Congressional Requesters. 2023.

**Figure 4: Race and Ethnicity of Doulas in the United States, 2023**



The majority of doulas in the US self-identify as female (data not shown) and self-identify as White (60%), Hispanic/Latina (16%), Black/African American (9%), and Asian (7%). The percentage of non-White doulas has steadily grown since 2010 (data not shown).

Source: Zippia. [Doula Demographics and Statistics in the US](#). Last reviewed July 21, 2023. Accessed September 5, 2023.

Note: There is no standard occupation code from the Bureau of Labor or from the Census, American Survey and the Occupation Employment and Wages and Statistics. Data shared here is likely an undercount and underrepresentation of the workforce. Click here for more information: <https://family-medicine.uw.edu/chws/wp-content/uploads/sites/5/2022/08/Doula-Workforce-RR-2022.08.22.pdf>



# STORY BEHIND THE DATA: FACTORS AFFECTING PROGRESS

There are numerous factors that influence the lack of maternal health care practitioners in US communities, several of which were exacerbated during the COVID-19 pandemic, such as burnout caused by increases in patient load, sleep deprivation, and emotional stress.<sup>3</sup> As noted above, the percentage of midwives in the US is significantly fewer than in other high-income countries, which limits access to critical maternal health services (see Figure 3). Midwives regularly cite opposition from hospitals, cumbersome licensing requirements, the cost of malpractice coverage, and insufficient reimbursement rates as reasons for midwives being less prevalent in the US than in any other peer nation.<sup>3</sup> Furthermore, a study found that a significant barrier for aspiring midwives of color was “structural and interpersonal racism.”<sup>24</sup>

Doulas can help to address racial disparities by providing culturally congruent care when integrated into the health care team, further highlighting the crucial need for a diverse workforce that is representative of the clients it serves (see Figure 4).<sup>3</sup> As noted above, improving access to doulas has been shown to improve maternal (and birth) outcomes; the presence of one-on-one support in the form of a doula is associated with improved patient satisfaction, a reduction in the rate of cesarean delivery, and a reduced risk of developing postpartum depression or postpartum anxiety.<sup>25,26</sup>

Efforts to increase birthing families’ access to doulas face similar challenges to midwives, including the lack of awareness of doula services among Medicaid beneficiaries (in states that provide coverage), high out-of-pocket cost for services, lack of coverage by insurers, insufficient reimbursement rates, and few pathways to training and certification.<sup>3</sup> Complex billing and low

reimbursement rates, even in states that have provided for doula coverage through Medicaid, also impede access. Similarly, birth centers face financial challenges associated with maternity payment models and inadequate Medicaid reimbursement.<sup>23</sup>

Access to advanced practice nurses (APNs) is another important part of facilitating improvements in maternal health care. APNs are specialists with an understanding of the educational components needed for maternity care and an ability to connect locally with birthing people to support perinatal health. Their training includes awareness of expertise that is crucial to families during this period, as well as skills needed to be partners in comprehensive care teams to better serve birthing families. This training specifically focuses on engaging in collaborative health care systems to achieve the best outcomes for families. In addition, APNs are in a unique position to connect with their clients on a personal level while providing leadership and advocating to other health care professionals on behalf of their families.<sup>27</sup>

While the use of professionals such as APNs, midwives, and doulas can have a positive impact on providing culturally appropriate care, there is a need to diversify the workforce and create pipeline programs and opportunities to increase representation of people of color in the perinatal workforce.

# WHAT CAN BE DONE TO ADDRESS THE ISSUE?

The [White House Blueprint](#) identifies actionable steps to address Goal 4. In addition, experts from the maternal and child health field have identified innovative, evidence-informed strategies from several databases and national repositories.

## Maternal and Child Health (MCH) Innovations

*MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub](#) (AMCHP), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the MCH field; the [Robert Wood Johnson Foundation's What Works for Health](#) (RWJ) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.*

- [American College of Nurse-Midwives](#). ACNM is the professional association that represents certified nurse midwives and certified midwives in the US.
- [Choices in Childbirth](#). This open-access resource is available for pregnant and postpartum people, in English and Spanish, and is offered online by [Every Mother Counts](#). The content contains video “chapters” with transcripts and downloadable worksheets. The goal of the program is to promote shared decision-making for individualized care planning during the perinatal and postpartum periods and to support birthing people building strong support systems.
- [Colorado Birth Equity Bill Package](#). The Birth Equity Bill Package in Colorado includes 3 components: (1) Protection of Pregnant People in the Perinatal Period (SB 193), which established basic human rights standards in perinatal care for all people, including those who are incarcerated; (2) Maternal Health Providers (SB 194), which aligned perinatal care data and systems for equity; and (3) Sunset Direct Entry Midwives (SB 101), a policy that continued the Direct-Entry Midwifery program. (AMCHP)
- [Expansion of Community-Based Doulas Through Medicaid Reimbursement](#). The New Jersey Department of Health awarded funding to support policy development to establish the [Doula Learning Collaborative](#), which provides training, workforce development, supervision support, mentorship, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the state. (AMCHP)
- [GROWTH with Doulas and Dads](#). An emerging practice based in Florida, this project provides pregnant women with the direct home visitation and doula support that promotes healthy births, bonding, and mother/child attachment. The program provides prenatal support services, health education, mentoring, hospital labor and delivery assistance, breastfeeding, and nutrition support. (AMCHP)
- [Lamaze International](#). A trusted birth leader for more than 60 years, Lamaze International provides information for families and health care providers on evidence-based childbirth edu-

cation and resources.

- [Midwife-Led Care in Hospital Settings](#). There is moderate scientific evidence to support interprofessional care within a hospital setting where both midwives and obstetricians deliver babies. (MCHbest)
- [National Network of Perinatal Quality Collaborative](#). NNPQC supports state or multistate perinatal quality collaboratives to implement and improve quality practices to improve maternal and infant health outcomes. NNPQC is housed at the National Institute for Children's Health Quality.
- [One-On-One Labor Support During Childbirth](#). There is emerging evidence for support programs that welcome doulas, nursing staff, lay birth assistants, or midwives who provide continuous support during low-risk labor and delivery. (MCHbest)
- [The Lived Experience Accessible Doula Program](#). A doula training program housed at the University of North Carolina School of Medicine seeks "to increase access and remove financial barriers to doula services for marginalized persons."

### **State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees**

The [State Maternal Health Innovations \(MHI\)](#) initiative, funded by [HRSA's MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations that address Goal 4 from the MHI cohorts (2019–2024):

- [Arizona](#). Recent legislation in Arizona seeks to increase the use of doulas in the maternal health workforce as support for birthing people. Arizona also is working to offer opportunities for reimbursement through Medicaid.
- [Iowa](#). In Iowa, the MHI program will implement the first nurse midwifery program in the state in fall 2023.
- [Montana](#). The Montana Obstetrics Maternal Support initiative is implementing and training Indigenous doulas to support the maternal health of their rural and frontier Indigenous populations.
- [North Carolina](#). The North Carolina MHI program is supporting the integration of doulas and CHWs to support maternal health in rural areas of the state.
- [Oklahoma](#). In Oklahoma, the MHI program is seeking legislative support to provide reimbursement for doula care from both private and public health insurance.

### **Resources from the [MCH Evidence Center's Digital Library](#)**

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers, and more with seminal and historic resources. The following may support Goal 4.

- Association of Maternal and Child Health Programs. [Amplifying Birthworker Models of Care: June 2022 Global Health Webinar](#). Global Health Workgroup. 2022.
- Strauss N. [Maximizing Midwifery to Achieve High-value Maternity Care in New York](#). Choices in Childbirth and Every Mother Counts. 2018.
- Bey A, et al. [Advancing Birth Justice: Community-based Doula Models as a Standard of Care for Ending Racial Disparities](#). Ancient Song Doula Services, Village Birth International, and Every Mother Counts. 2019.

## Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit [maternalhealthlearning.org/Blueprint](https://maternalhealthlearning.org/Blueprint) for more details.

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The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit

<https://maternalhealthlearning.org/connect>.

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