Health Impact Review of SB 6172
Concerning birth doulas
(2024 Legislative Session)

February 2, 2024

Staff contact:
Miranda Calmjoy (she/they)
Phone: (360) 819-0750
Email: Miranda.Calmjoy@sboh.wa.gov

Full review
The full Health Impact Review report is available at:
https://sboh.wa.gov/sites/default/files/2024-02/HIR-2024-08-SB6172_0.pdf

Acknowledgements
We would like to thank the key informants who provided consultation and technical support during this Health Impact Review.

Contents

Executive Summary
SB 6172, Concerning birth doulas (2024 Legislative Session)

Evidence indicates that SB 6172 may increase barriers to accessing doula care for some people, which would likely worsen health outcomes for birthing people and their infants and increase inequities.

SB 6172 may also lead to Washington State Department of Health (DOH) conducting rulemaking which may increase awareness of culturally congruent care requirements among some doulas. There is unclear evidence how provisions may impact some doulas seeking state certification and pregnant, birthing, and postpartum people in Washington State.

BILL INFORMATION

Sponsors: Senators Nobles, Randall, Dhingra, Frame, Hasegawa, Kuderer, Lovelett, Nguyen, Saldaña, Shewmake, Trudeau, Wilson, C.

Summary of Bill:

- Defines "culturally congruent care" and requires birth doulas[a] seeking state certification to provide proof of knowledge related to culturally congruent care for state certification[b].
- Clarifies that birth doulas provide support to birthing persons "from the date of confirmed conception."
- Removes the Secretary of Health's ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and caps fees allowable after July 1, 2030, subject to appropriations.

HEALTH IMPACT REVIEW

Summary of Findings:
This Health Impact Review found the following evidence for SB 6172:

Pathway 1: Confirmed conception

---

[a] There are multiple types of doulas who provide support to people and families at different stages of life (e.g. birth doula, bereavement doula) (personal communications, January 2024). This report focuses on birth doulas as defined in RCW 18.47.010 and uses the term doula when referring to a "nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth, and the postpartum period."[18]

[b] Doulas noted distinctions between "credentialing", "certification", and "state certification" (personal communications, January 2024). Credentialing is broader than certification and state certification, and may include certification, training, experience, etc. (personal communications, January 2024). Doulas of color noted that outside organizations have appropriated (i.e., taken without permission) cultural practices or traditional knowledge from Black, Indigenous, and People of Color communities and monetized that information for trainings and certification programs (personal communications, January 2024). Doulas of color recommended use of the term "credentialing" to refer to general requirements for birth doulas (personal communications, January 2024). This report uses "state certification" when discussing specific provisions of SB 6172 and current Washington State laws (RCW) and rules and regulations (WAC) specific to the state's birth doula certification program.

- **Informed assumption** that clarifying that birth doulas provide support to birthing persons "from the date of confirmed conception" may increase barriers to accessing doula care for some people. This assumption is based on information from key informants.
- **Very strong evidence** that increasing barriers to accessing doula care would likely worsen health outcomes for birthing people and their infants.
- **Very strong evidence** that worsening health outcomes for birthing people and their infants would worsen inequities.

Pathway 2: Rulemaking

- **Informed assumption** that defining culturally congruent care and requiring birth doulas to provide proof of knowledge related to culturally congruent care for state certification may result in the Washington State Department of Health (DOH) conducting rulemaking. This assumption is based on information from key informants and bill and law language.
- **Informed assumption** that removing the Secretary of Health's ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and capping allowable fees after July 1, 2030, may result in DOH conducting rulemaking. This assumption is based on information from key informants and bill and law language.
- **Informed assumption** that DOH conducting rulemaking may increase awareness of culturally congruent care requirements among some doulas. This assumption is based on information from key informants.
- **Unclear evidence** how increased awareness of culturally congruent care requirements among some doulas may impact pregnant, birthing, and postpartum people in Washington State.
- **Unclear evidence** how DOH conducting rulemaking may impact some doulas seeking state certification.
- "Additional Considerations" includes potential impacts of Washington State Medicaid program (Apple Health)[c] reimbursement for doula care.

---

[c] Apple Health is the Washington State Medicaid program. In this report, the use of Medicaid will be retained to refer to the federal Medicaid program or to research related to national or other state Medicaid programs.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review "health disparities" have been defined as differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.025). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social determinants (access to healthcare, economic stability, racism, etc.). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of Senate Bill 6172 (SB 6172).

Staff analyzed the content of SB 6172 and created a logic model visually depicting the pathways between bill provisions, social determinants, and health outcomes and equity. The logic model reflects the pathways with the greatest amount and strongest quality of evidence. The logic model is presented both in text and through a flowchart (Figure 1).

We conducted an objective review of published literature for each step in the logic model pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. The annotated references are only a representation of the evidence and provide examples of current research. In some cases, only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question and are referenced multiple times.

We consulted with people who have content and context expertise about the provisions and potential impacts of the bill. The primary intent of key informant interviews is to ensure staff interpret the bill correctly, accurately portray the pathway to health and equity, and understand different viewpoints, challenges, and impacts of the bill. We spoke with 21 key informant interviewees, including: 10 doulas and doula organization staff; 8 state agency staff; and 3 people with research and policy expertise in doula care.

We evaluated evidence using set criteria and determined a strength-of-evidence for each step in the pathways. The logic model includes information on the strength-of-evidence. The strength-of-evidence is summarized as:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may have less robust study design or execution. There is consensus between data sources and types.

- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include viewpoints from multiple types of informants. There is consensus among the majority of informants.
- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence was primarily descriptive in nature and unable to assess association or has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was completed during Legislative Session and was subject to the 10-day turnaround required in law. This review was subject to time constraints, which influenced the scope of work for this review.

Analysis of SB 6172 and the Scientific Evidence

Summary of relevant background information

Birth in the U.S.

- Birth traditions and birth workers have existed since time immemorial.[1]
- In the 1800's, the medical model of birthing began to emerge in western cultures.[2] In the medical model, pregnancy is viewed as a medical condition that needs hospital-based interventions to assure appropriate care.[2]
- By the 1900's, birth workers attended only about half of all births in the U.S. where physicians attended the other half.[2]
    - Birth workers generally continued to attend births in rural areas.[2]
- Black midwives and midwives of color were primary providers of childbirth care for people of color and people with low-incomes through the early 1900's.[3] Community support during birth has a long tradition within Black, Indigenous, and People of Color communities.[4] In Southern states, Black midwives, known as "granny midwives" or Grand Midwives,[4] "attended up to 75% of births until the 1940's. A combination of laws, educational restrictions, and campaigns against the profession led to the dismantling of their practice."[2] With the medicalization of childbirth, "Black midwives came under particularly intense scrutiny and became the targets of efforts to regulate and professionalize their field […] formal nurse-midwife training [and] an increase in supervision and licensing requirements altered the field of midwifery, largely at the exclusion (often intentional) of Black midwives. To this day, midwives are disproportionately white."[3]
- Indigenous birthing people have traditionally delivered babies at home with support from local midwives and family members and "knowledge about birthing infants was transmitted intergenerationally."[5] The medicalization of childbirth has also had a "profoundly negative impact on Indigenous [people's] birthing experiences."[5]
    - Indigenous birth doulas differ from "mainstream doula care providers because [Indigenous] care is grounded in culture and spirituality and recognizes the sacredness of women as life-givers […]."[5]
    - Indigenous doulas shared that they have a particularly close connection with the pregnant, birthing, and postpartum people they serve and often identify as an "auntie" and refer to clients as "relatives" (personal communication, Hummingbird Indigenous Family Services [Hummingbird], January 2024). Indigenous pregnant, birthing, and postpartum people generally want to engage in relationships with people who make them feel safe, seen, and connected, and culture is an important part of the relationship between Indigenous doulas and the families they serve (personal communication, Hummingbird, January 2024).
- While the medical model is the predominant model used in the U.S. today, the use of birth workers and doula care has increased in the U.S. since the 1960's and 1970's.[1]

- The U.S. is currently experiencing a mortality crisis among pregnant, birthing, and postpartum people. The U.S. has the highest maternal[d] mortality rate of any developed country.[6]
    - Systemic racism in U.S. healthcare systems contributes to high maternal mortality rates for birthing people of color and presents a public health crisis.[1,7,8] Maternal mortality rates among Black and Indigenous people are 2 to 3 times higher than among white people.[9] The U.S. White House Blueprint for Addressing the Maternal Health Crisis explains, "[s]ystemic barriers, together with a failure to recognize, respect, and listen to patients of color, has meant that Black and American Indian/Alaska Native […] women, regardless of income or education, experience a greater share of these grave outcomes [i.e., maternal morbidity and mortality], as do rural women."[6]
    - Washington State Department of Health's (DOH) 2019 and 2023 Maternal Mortality Review Panel (MMRP) reports to the Legislature examined maternal deaths between 2014 to 2020.[8,10] The 2023 MMRP report stated that 80% of pregnancy-related deaths in Washington were preventable.[10] The report named racism and bias as a key contributor to maternal mortality.[10]

Doulas

- Birth doulas[e] are "nonclinical birth workers trained to provide continuous physical, emotional, and informational support to [birthing people] in the prenatal, birth, and postpartum periods."[6]
    - Birth doulas are not midwives. Midwives provide medical care, and midwifery requirements are outlined in Chapter 18.50 RCW.[11]
- In the U.S., doula care has been primarily paid for out-of-pocket by individual clients as insurance coverage is limited.[12]
- In 2021, Rhode Island became the first state to pass legislation requiring private health insurance plans to provide doula care benefits.[13]
    - Rhode Island is the only state to require both public (i.e., Medicaid) and private health insurance coverage for doula care.[3]
- In 2022, the federal administration released the "White House Blueprint for Addressing the Maternal Health Crisis."[6] The intent of the Blueprint was to outline specific actions the federal government will take to improve perinatal health and advance equity.[6] Among 5 priorities for action, the Blueprint included a priority to expand and diversify the

---

[d] This Health Impact Review recognizes that "[d]ata and research often assume cisgender identities and may not systematically account for people who are transgender and non-binary. The language used in this [review] attempts to be as inclusive as possible while acknowledging that the data we are citing uses gender labels that we cannot change without misrepresenting the data."[50]

[e] There are multiple types of doulas who provide support to people and families at different stages of life (e.g. birth doula, bereavement doula) (personal communications, January 2024). This report focuses on birth doulas as defined in RCW 18.47.010 and uses the term doula when referring to a "nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth, and the postpartum period."[18]

perinatal workforce, including by incorporating "community-based workers (such as doulas) into the [perinatal] care system," and expand access to doulas.[6]

- In 2023, UnitedHealthcare launched a pilot program to provide comprehensive doula support to eligible members (pregnant and postpartum Medicaid enrollees) in 5 states, including Washington.[14]
- As of January 2024, 12 states and the District of Columbia (DC) actively reimburse doulas with Medicaid funding.[15] Of those, 11 states and DC developed and implemented a credentialing process.[15]
  - Doula care is not currently reimbursable by the Washington State Medicaid program (Apple Health)[f] (personal communication, Washington State Health Care Authority [HCA], January 2024).
  - ESSB 6168 (2020 Legislative Session), section 211 (32) required HCA to reimburse for doula care, consult with stakeholders, and develop methods to secure approval from the Centers for Medicare and Medicaid (CMS) for reimbursement.[16] In 2020, HCA published a report to the Legislature that included recommendations for doula reimbursement.[16] Due to funding and budget limitations, it is unknown when doula reimbursement may be implemented in Washington State (personal communications, January 2024).
- As doulas are considered nonclinical providers,

> [D]oulas 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) […] 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.[3]

Washington State law

- In 2022, the Legislature passed Engrossed Substitute House Bill 1881 (Chapter 217, Laws of 2022) creating a new credentialed health profession for birth doulas (Chapter 18.47 RCW).[17]
  - RCW 18.47.010 defines a "birth doula" to mean a person who "is a nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth and the postpartum period [i.e., the 12-month period beginning on the last day of the pregnancy]."[18] Birth doulas "advocate for and support birthing people and families to self-advocate by helping them to know their rights and make informed decisions. Birth doulas do not provide medical care."[18]
  - Under RCW 18.47.020, a birth doula may voluntarily apply for state certification[g] through DOH.[19]

---

[f] Apple Health is the Washington State Medicaid program. In this report, the use of Medicaid will be retained to refer to the federal Medicaid program or to research related to national or other state Medicaid programs.

[g] Doulas noted distinctions between "credentialing", "certification", and "state certification" (personal communications, January 2024). Credentialing is broader than certification and state certification, and may include certification, training, experience, etc. (personal communications, January 2024). Doulas of color noted that outside

        - Nothing in state law prohibits a person from practicing as a birth doula without obtaining a certification.[20] Doulas are the first credentialed profession in Washington State for which state certification is voluntary (personal communication, HCA, January 2024).
    - RCW 18.47.030 details competency-based requirements for birth doula state certification and requires that DOH, in collaboration with community partners who advance equitable access to improve perinatal outcomes and care through holistic services for Black and Brown communities, adopt rules to create competency-based requirements that a birth doula must meet to obtain state certification.[21] Applicants are required to:
        - Demonstrate successful completion of training and education programs approved by the Secretary of Health; and
        - Submit proof of successful completion of culturally congruent ancestral practices, training, and education that the secretary must review and determine whether the training and education meet the competency-based requirements.[21]
- Chapter 246-835 WAC details DOH requirements for birth doula state certification.[22] The rules governing state certification became effective October 1, 2023.[22] DOH began accepting paper applications in October 2023 and online applications in January 2024 (personal communications, January 2024).
    - There are 3 pathways to obtain birth doula certification in Washington State, including a training program pathway (WAC 246-835-020), an ancestral or legacy pathway (WAC 246-835-022), and an out of state pathway (WAC 246-835-040).[23]
    - WAC 246-835-005 states a person "who meets the certification requirements of [Chapter 246-835 WAC] and chapter 18.47 RCW is considered a 'state-certified birth doula'."[22]
    - WAC 246-835-010 defines "culturally congruent care" as "the care and respect towards families to uphold their cultural practices around birth as the duty of the doula regardless of their identity, as well as assisting families in accessing other doulas from the same background and community as them."[22]
    - WAC 246-835-990 details birth doula fees and renewal cycle.[22] According to rule, a birth doula must renew their state certification every 2 years on the practitioner's birthday.[22] Nonrefundable fees to be charged include application for initial state certification ($190), state certification renewal ($190), late renewal penalty ($95), expired certificate reissuance ($95), duplicate certificate ($10), and verification of state certification ($25).[22]

---

organizations have appropriated (i.e., taken without permission) cultural practices or traditional knowledge from Black, Indigenous, and People of Color communities and monetized that information for trainings and certification programs (personal communications, January 2024). Doulas of color recommended use of the term "credentialing" to refer to general requirements for birth doulas (personal communications, January 2024). This report uses "state certification" when discussing specific provisions of SB 6172 and current Washington State laws (RCW) and rules and regulations (WAC) specific to the state's birth doula certification program.

        - RCW 43.70.250 states that the cost of professional, occupational, or business licensing programs administered by DOH must be self-supporting.[24] Therefore, DOH must collect sufficient revenue through fees to fund the cost of administering professional licensing and certification programs (personal communication, DOH, January 2024). However, the statute prohibits DOH from imposing a fee for those seeking certification as a certified peer specialist trainee (July 1, 2025, through July 1, 2030) and limits fees to no more than $100 for a person seeking certification as a certified peer specialist[24] so as not to create a barrier for people pursuing the certification (personal communication, DOH, January 2024).
        - DOH received General Fund State funding for the birth doula state certification program costs for July 1, 2023, through June 30, 2025 (Fiscal Years 2024 and 2025).[25] DOH is waiving all fees listed in WAC 246-835-990 until July 1, 2025.[25]
- The Uniform Disciplinary Act (Chapter 18.130 RCW) governs the issuance and denial of certifications and the discipline of health professions, including state-certified birth doulas.[26]
- In 2015, the Governor's Interagency Council on Health Disparities (Council) convened the "Adverse Birth Outcomes Disparities Advisory Committee," which included doula organizations.[27] As part of the 2015 State Action Plan Update, the Council recommended Apple Health reimbursement for doula care.[27]
- In 2018, the Washington State Legislature passed the Reproductive Parity Act (Chapter 119, Laws of 2018). Among other provisions, the law directed the Council to conduct a literature review on disparities in access to reproductive healthcare and to provide recommendations for reducing or eliminating inequities.[28] On January 1, 2019, the Council submitted its "Literature Review on Inequities in Reproductive Health Access" to the Governor and appropriate legislative committees.[28]

Summary of SB 6172

- Defines "culturally congruent care" and requires birth doulas seeking state certification to provide proof of knowledge related to culturally congruent care for state certification.
    - States that culturally congruent care means "a duty to learn respect for and uphold a birth doula's client's cultural practices around birth regardless of the birth doula's identity" and "includes a birth doula's duty to use community resources and networks to help families access other doulas from the same background, religion, culture, and community as them."
- Clarifies that birth doulas provide support to birthing persons "from the date of confirmed conception."
- Removes the Secretary of Health's ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and caps fees allowable after July 1, 2030, subject to appropriations.

Health impact of SB 6172

Evidence indicates that SB 6172 may increase barriers to accessing doula care for some people, which would likely worsen health outcomes for birthing people and their infants and increase inequities.

SB 6172 may also lead to Washington State Department of Health (DOH) conducting rulemaking, which may increase awareness of culturally congruent care requirements among some doulas. There is unclear evidence how provisions may impact some doulas seeking state certification and pregnant, birthing, and postpartum people in Washington State.

Pathway to health impacts

The potential pathways leading from SB 6172 to health and equity are depicted in Figure 1. We made the informed assumption that clarifying that birth doulas provide support to birthing persons "from the date of confirmed conception" may increase barriers to accessing doula care for some people. This assumption is based on information from key informants. There is very strong evidence that increasing barriers to accessing doula care would likely worsen health outcomes for birthing people and their infants.[4,6,29,30] There is very strong evidence that worsening health outcomes for birthing people and their infants would worsen inequities.[1,4,5,7,9,14,30-34]

We made the informed assumptions that defining culturally congruent care and requiring birth doulas to provide proof of knowledge related to culturally congruent care for state certification and removing the Secretary of Health's ability to impose a fee for state certification, examination, or renewal for those seeking the birth doula certification between July 1, 2025, and July 1, 2030, and capping allowable fees after July 1, 2030, may result in DOH conducting rulemaking. These assumptions are based on information from key informants and bill and law language. We made the informed assumption that DOH conducting rulemaking may result in increased awareness of culturally congruent care requirements among some doulas. This assumption is based on information from key informants. There is unclear evidence how increased awareness of culturally congruent care requirements among some doulas may impact pregnant, birthing, and postpartum people in Washington State. There is unclear evidence how DOH conducting rulemaking may impact some doulas seeking state certification.

Scope

Due to time limitations, we only researched the most linear connections between provisions of the bill and health and equity and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- Non-birth doulas. There are a wide range of types of doulas who provide care, including comfort, delirium, hospice, end of life, death, and palliative care doulas.[35] This HIR did not analyze impacts associated with non-birth doulas.
- Additional proposals related to birth doula care and the doula workforce. Doulas and state agencies in Washington State are designing proposals related to Apple Health reimbursement for doula care and a doula hub referral system (personal communications, January 2024). This HIR analyzes provisions of SB 6172 and did not analyze impacts associated with additional proposals.

Magnitude of impact

SB 6172 has the potential to affect doulas as well as pregnant, birthing, and postpartum people in Washington State.

Doulas

There is no comprehensive public or private database on the doula workforce in the U.S.[12] Data on the doula workforce are not available through the U.S. Bureau of Labor Statistics Standard Occupational Classification (SOC) Code database.[36] National Provider Identifier (NPI) records are available for some[h] doulas working in the U.S. and in Washington State.[37] There are currently 515 people with NPIs associated with "doula" in Washington State.[37] A survey[i] of 201 birth doulas who provide care in Washington State was conducted between November 2019 to January 2020.[38] The survey found that 29.1% of 172 respondents use an NPI for their birth doula work, 54.7% do not have an NPI, and 16.3% do not know what an NPI is.[38]

Data suggest that over 80% of doulas in the U.S. are white.[6] In a survey of 201 doulas providing care in Washington State, the majority of survey respondents were female (96.6%) and between the ages of 21 and 59 years.[38] The respondents identified as white only (67.4%); multiracial or multiethnic (11.8%); Black or African American only (7.6%); Hispanic, Latino, or Spanish only (4.2%); and African only (3.5%).[38] All respondents who identified as African only also identified as Somali.[38] Less than 15% of survey respondents had worked with Tribes or Tribal Nations.[38] The results show that 13% of survey respondents spoke 2 or more languages.[38] Among survey respondents, 60.3% identified as straight (heterosexual), 15.9% identified as bisexual, and 8% identified as queer.[38] The majority (70%) of survey respondents reported using public assistance at some point in their life, and 48.6% reported that they had given birth while enrolled in Medicaid.[38]

The majority of survey respondents reported working in King, Pierce, and Snohomish counties.[38] Over half of Washington State counties had less than 5 doulas providing care in that area.[38] Almost half of respondents reported that they were volunteers or worked on a pro bono basis.[38]

The majority of survey respondents (almost 97%) had received formal training to become a doula, and 41.1% had obtained certification.[38] Most doulas received certification through DONA International (57.1%) or Pacific Association of Labor Support (PALS) Doulas (16.7%).[38] As of January 24, 2024, there were 5 Washington State-certified doulas in Washington State who received formal certification through DOH (personal communication, DOH, January 2024).

Pregnant, birthing, and postpartum people

In 2020 (the most recent DOH data available), there were 1,494,885 people of childbearing age (defined by DOH as aged 15 through 44 years) and 99,613 pregnancies among

---

[h] These data are subject to limitations. The NPI taxonomy code for doula care was introduced in 2009. The code may be used for billing and insurance reimbursement. Doulas may be but are not required to be registered in the NPI database. Therefore, some, but not all practicing doulas are in this database.

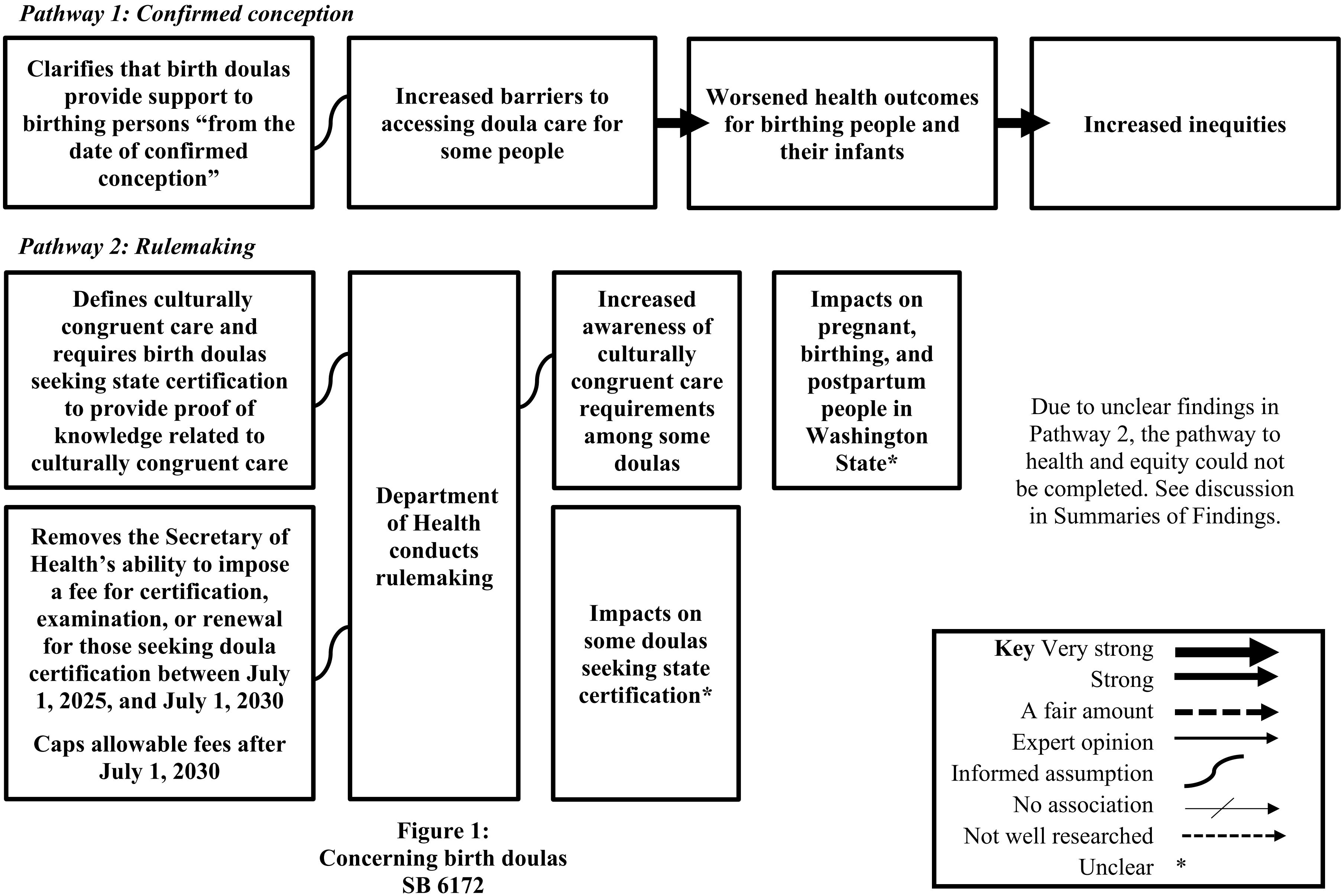
[i] These data are subject to limitations. Surveys were sent to 773 doulas in Washington State who were registered on Doulamatch.net, a web platform designed to connect people seeking doulas to doulas in their area. The survey was also distributed through several doula organizations in Washington State.

Washingtonians.[39] Data also show that in 2021, there were 83,899 live births in Washington State.[39] Data from the U.S. Census Bureau show the estimated fertility rate (calculated as births per year for every 1,000 women aged 15 through 44 years) in Washington State in 2021 was 54.2 per 1,000 women aged 15 through 44 years.[40]

According to DOH data, in 2022, 72.0% of people giving birth received prenatal care starting in the first trimester of pregnancy.[39] National data suggest that only about 6% of people who give birth receive doula care.[6] Since there is limited insurance coverage for doula care, "access to [doula] services is largely limited to families with higher incomes who can afford to pay for such services out-of-pocket."[3] Research shows that approximately 40% or more of birthing people are unaware of doula care and the services and support doulas can provide.[41]

Overall, SB 6172 has the potential to affect doulas as well as pregnant, birthing, and postpartum people in Washington State.

Logic Model



Due to unclear findings in Pathway 2, the pathway to health and equity could not be completed. See discussion in Summaries of Findings.

Figure 1:
Concerning birth doulas
SB 6172

Summaries of Findings

Pathway 1: Confirmed conception

Would clarifying that birth doulas provide support to birthing persons from the date of confirmed conception increase barriers to accessing doula care?
We have made the informed assumption that clarifying that birth doulas provide support to birthing persons "from the date of confirmed conception" may increase barriers to accessing doula care for some people. This informed assumption is based on information from key informants.

Under current law (RCW 18.47.010) birth doulas provide "physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth and the postpartum period [i.e., the 12-month period beginning on the last day of the pregnancy]."[18] If passed, SB 6172 would amend RCW 18.47.010 to state that birth doulas provide support to people during pregnancy "from the date of confirmed conception." Washington State Department of Health (DOH) staff stated that scope-of-practice topics (e.g., clarifying that birth doulas provide support from the date of confirmed conception) may not be addressed in rulemaking (personal communication, DOH, January 2024). However, if discussions with community indicated a need, this language could be further defined or clarified in rulemaking (personal communication, DOH, January 2024).

Previously, the Medicaid program required that a person receive confirmation of pregnancy from a medical provider to determine eligibility for Medicaid (personal communication, Washington State Health Care Authority [HCA], January 2024). This previous Medicaid requirement is no longer in place, and people may self-attest to their pregnancy and their due date when applying for Apple Health[j] coverage (personal communication, HCA, January 2024). However, some states that provide Medicaid reimbursement for doula care have specified that care may begin "from the date of confirmed conception" as part of their reimbursement requirements (e.g., New Jersey, Virginia).[42,43]

In addition, staff representing HCA shared that since RCW 18.47.010 states that birth doulas provide care "during pregnancy", there is no legal or practical need to include language specifying that care may begin from the date of confirmed conception (personal communication, HCA, January 2024). Key informants stated mixed interpretations of the meaning of the phrase "confirmed conception" (personal communications, January 2024). Some key informants shared concerns that this language could lead to requirements for people to provide proof of pregnancy through clinical or health worker-led pregnancy testing before being able to access doula care (personal communications, January 2024). For example, healthcare providers, facilities, people who may refer pregnant people to doula care, doulas, and pregnant people may interpret the meaning of "confirmed conception" differently. Requiring patients to provide health worker-led proof of pregnancy may result in delays in and barriers to accessing doula care and additional costs to the patient (personal communication, HCA, January 2024).

---

[j] Apple Health is the Washington State Medicaid program. In this report, the use of Medicaid will be retained to refer to the federal Medicaid program or to research related to national or other state Medicaid programs.

A randomized controlled trial with community health workers found that provision of a pregnancy test by community health workers can increase use of antenatal care services and contraception (since a negative pregnancy test may be necessary before beginning some forms of contraception).[44] Similarly, as navigators, doulas may be positioned to help people access pregnancy testing and subsequent care. However, research shows that approximately 40% or more of birthing people are unaware of doula care and the support doulas can provide.[41] Key informants noted that referrals to doula care are often word of mouth (personal communications, January 2024). Therefore, if "from the date of confirmed conception" is interpreted to mean that a person needs to receive a clinical or health worker-led pregnancy test before they can access doula care, the clarifying language may affect whether or when people (e.g., social service providers, public health nurses, community members) refer pregnant people to doula care (personal communications, January 2024).

In 2021, the World Health Organization (WHO) published a recommendation to "[make] self-testing for pregnancy available as an additional option to health worker-led testing for pregnancy, for [people] seeking pregnancy testing."[44] The WHO recommendation was informed by a systematic review and meta-analysis that examined the effectiveness of self-testing for pregnancy versus health worker-led testing as well as the values and preferences of people seeking pregnancy testing.[44] Studies have shown that self-testing for pregnancy is as effective as health worker-led pregnancy testing.[44] Research has also shown that people prefer self-testing for pregnancy due to the timeliness of results, convenience, confidentiality, privacy, cost, and accuracy.[44] Researchers stated that "[e]nsuring universal access to pregnancy self-testing may encourage more [people] to seek early antenatal care, which is a critical opportunity for health workers to deliver care and support during pregnancy, thus contributing to better health outcomes for women, newborn[s], and children."[44]

Moreover, evidence suggests that people may experience barriers to accessing reproductive healthcare. A 2019 literature review on inequities in reproductive health access identified 45 unique barriers to accessing reproductive healthcare in Washington State, including economic, structural, and social barriers.[28] Many barriers may impact access to preventive care services (e.g., pregnancy testing or prenatal care), including insurance status; distance to healthcare services, travel time, and transportation; work, school, or childcare limitations; lack of a consistent primary care provider or place to receive care; limited language access and lack of culturally and linguistically appropriate services; provider availability; experiences of violence; experiences of reproductive and pregnancy coercion; fear, perception, or experience of bias, discrimination, and/or stigmatization; lack of social support; people's attitudes and beliefs; historical trauma and medical mistrust; lack of actual or perceived confidentiality/privacy; and many additional barriers.[28] As health system navigators, doulas may help to reduce barriers to care.[1,3,7,9,31,32,41]

Therefore, since key informants suggested that some people may interpret the phrase "from the date of confirmed conception" to mean that a person may need a clinical or health-worker led pregnancy test in order to access doula care, and since some people experience barriers accessing reproductive healthcare, we have made the informed assumption that clarifying that birth doulas provide support to birthing persons "from the date of confirmed conception" may increase barriers to accessing doula care for some people.

Would increasing barriers to accessing doula care for some people worsen health outcomes for birthing people and their infants?
There is very strong evidence that increasing barriers to accessing doula care would likely worsen health outcomes for birthing people and their infants. The U.S. is currently experiencing a mortality crisis among pregnant, birthing, and postpartum people. The U.S. has the highest maternal[k] mortality rate of any developed country.[6]

It is well-documented that accessing doula care is associated with improved health outcomes for birthing people and their infants.[45] A 2017 systematic review of 27 clinical trials conducted in 17 different countries concluded that "continuous support during labour [e.g., from a doula] may improve outcomes for women and infants."[29]

Evidence shows that access to community-based doulas is associated with improved health outcomes for the birthing person, including increased spontaneous vaginal birth and reduced cesarean sections, health complications, instrumental vaginal birth, preterm birth and premature deliveries, length of labor, epidural use, and anxiety and stress.[4,6,29,30] For example, a study with 298 women enrolled in Medicaid who received doula care found a 52.9% decrease in the risk of cesarean section and a 57.5% decrease in rates of postpartum depression and anxiety compared to people without supportive care.[30] Doula guidance also resulted in increased confidence and autonomy of the birthing person during labor and higher rates of emotional satisfaction with the birthing experience.[29,30] Two studies found people with doula support were less likely to develop symptoms of postpartum depression.[29] Research has also shown that doula support is associated with increased breastfeeding initiation and continuation.[4,30]

Evidence has also shown improved health outcomes for infants, including reduced health complications, low 5-minute Apgar score (used to assess the health of a newborn), and risk of low birth weight and mortality.[29,30] One study also found that doula guidance was associated with increased car seat use.[30]

Since it is well-documented that accessing doula care is associated with improved health outcomes for the birthing person and their infants, there is very strong evidence that increasing barriers to accessing doula care would likely worsen health outcomes for birthing people and their infants.

Would worsened health outcomes increase inequities?
There is very strong evidence that worsening health outcomes for birthing people and their infants would worsen inequities. Many researchers have noted that access to doula care may help reduce birth-related health inequities, including inequities due to racism and by income.[1,4,5,7,9,14,30-34,46]

---

[k] This Health Impact Review recognizes that "[d]ata and research often assume cisgender identities and may not systematically account for people who are transgender and non-binary. The language used in this [review] attempts to be as inclusive as possible while acknowledging that the data we are citing uses gender labels that we cannot change without misrepresenting the data."[50]

National data suggest that only about 6% of people who give birth receive doula care,[6] as access to doula care is largely limited to people who can pay for these services out-of-pocket.[3,32] Available evidence suggests that people in Black, Indigenous, People of Color communities,[2-10,30,32,47-53] people with low-incomes,[3,8,10,30,32,54-68] immigrants,[30,57,69-80] and people living in rural communities[32,45,81-83] generally have lower access to doula care, lower access to healthcare, and worse perinatal health outcomes.

Inequities are not inherent to a person's identity. Rather, inequities are influenced by social determinants that systematically marginalize groups due to their identity. For example, perinatal health outcomes are not inherent to a person's race/ethnicity. Rather, they are influenced by social determinants of health like racism, which contributes to inequities like socioeconomic status, access to healthcare, and interactions with medical professionals.[48,49]

Intersectionality, or the understanding that multiple systems of oppression interact in the lives of people with multiple marginalized identities,[84] impacts the need, access, quality, and outcomes of reproductive health services.[85] People of color, immigrants, and people living in rural communities are more likely to have low-incomes and lack health insurance.[54,77,86] Furthermore, in Washington State, these communities also experience worse perinatal health outcomes, including perinatal and postpartum depression.[10]

As health system navigators, doulas may help to reduce barriers to healthcare.[1,3,7,9,31,32,41] The U.S. Department of Health and Human Services (HHS) has stated:

> Doulas can function as navigators and advocates for expecting parents as they engage with various clinical providers involved in their care […] and they can function as consistent points of contact and trusted sources of information in their local communities – which can be particularly valuable for populations that experience increased barriers to accessing clinical services.[32]

Moreover, many researchers have noted that access to doula care may help to reduce birth-related health inequities.[1,4,5,7,9,14,30-34] Researchers have suggested that doulas can "mitigate health disparities in groups at risk due to racial and socioeconomic stigmas via their roles as intermediaries between pregnant [people] and healthcare staff."[30] For example, researchers analyzed survey data from 1,977 women who gave birth at a California hospital between September 1 and December 15, 2016, to determine the association between doula support and respective care, which was defined as communication of information, being afforded respect in voicing concerns, and being involved in the decision-making process.[33] They found that the odds of respectful care was 40% higher among birthing people supported by a doula compared to birthing people without doula support, with greater impacts for Black birthing people, Asian/Pacific Islander birthing people, and birthing people enrolled in Medicaid.[33]

In addition, in 2019, researchers conducted a survey of 129 healthcare providers (e.g., physicians, certified nurse-midwives, nurses) at 2 hospitals in San Francisco, California, that partner with a doula organization to provide care.[34] Researchers found that 70% of providers agreed that community-based doulas can help address implicit bias and discrimination and 80.5% agreed that community-based doulas can help reduce inequities.[34] In subsequent interviews with 28 providers at 6 hospitals, providers reported that the presence of a doula increased their sense of personal responsibility to patients which "at times, mitigated racism and implicit bias in clinical settings."[34] The authors concluded that, "[d]oulas may be critical for birthing people who are most likely to experience mistreatment due to racism and other dimensions of oppression."[34]

Due to racism

People of color have less access to doula care due to historic and current systems of oppression, medicalization of childbirth, and limited insurance coverage for doula care, among additional factors,[2-4,32,47] and doulas often serve white, cis-gendered, higher-income people.[12] Research has also suggested that Black women are less likely to be aware of or knowledgeable about doula care compared to white women (37% versus 87%, respectively).[32] Black birthing people are also almost twice as likely to have a birth with late or no prenatal care compared to white women (9% versus 5% respectively).[50] Systemic racism results in differential access to resources, services, and opportunities, including access to healthcare, by race.[4,32,53]

It is well-documented that racism contributes to perinatal morbidity and mortality.[48-50] Racial inequities in perinatal health outcomes are rooted in systemic racism, sexism, and classism.[4] Systemic racism in U.S. healthcare systems contributes to high maternal mortality rates for birthing people of color and presents a public health crisis.[1,7,32] Black birthing people have higher rates of pregnancy-related mortality, preterm births, low-birthweight births, morbidity (e.g., preeclampsia, admission to intensive care unit during delivery), postpartum depression, poor experience of perinatal care, and lower rates of breastfeeding compared to white birthing people.[4,50] Maternal mortality rates among Black and Indigenous people are 2 to 3 times higher than among white people.[9,51,52] Of all 50 states, Washington State had the lowest infant mortality rate among non-Hispanic Black infants (5.97 deaths per 1,000 births compared to the U.S. national average of 10.46 deaths per 1,000 births).[52] However, the "Black infant mortality rate [is] higher than the [w]hite rate in every state."[52] The U.S. White House Blueprint for Addressing the Maternal Health Crisis explains:

> Systemic barriers, together with a failure to recognize, respect, and listen to patients of color, has meant that Black and American Indian/Alaska Native […] women, regardless of income or education, experience a greater share of these grave outcomes [i.e., maternal morbidity and mortality], as do rural women.[6]

Doula care may mitigate impacts of racism.[1,4,7,9,10,32,34,41,47] Researchers have stated that community-based doula care ensures "racially and culturally congruent emotional, physical, and informational support is available for those most at risk for experiencing structural racism and bias in health care."[4] A 2023 randomized control trial found that racially/culturally congruent doula care reduced cesarean births by 12% and increased exclusive breastfeeding at hospital delivery by 11.5% among Black, non-Hispanic birthing people.[4] The authors stated that this was the first study to examine the impact of racially/culturally congruent doula care on perinatal health outcomes.[4] They concluded that racially/culturally congruent doula care, 1) "addresses historical injustices rooted in the systematic elimination of Black birth workers in the [U.S.] by recognizing the experience and expertise of Black birthing people and their communities"[4]; 2) "helps birthing people connect with resources that reduce economic and social barriers to health"[4]; and 3) "reduces [inequities] in cesarean birth and breastfeeding outcomes between Black birthing people and those of other races/ethnicities."[4]

Due to settler colonialism

Impacts of settler colonialism and the medicalization of childbirth has had a "profoundly negative impact on Indigenous [people's] birthing experiences."[5] Key informants stated that the impacts of settler colonialism are best understood by Indigenous doulas and Indigenous doulas are best suited to serve Indigenous pregnant, birthing, and postpartum clients (often referred to as relatives by Indigenous doulas) (personal communication, Hummingbird, January 2024). For example, Indigenous doulas stated that white doulas operating within a standard doula model can unintentionally cause harm to Indigenous clients or families due to a lack of understanding of culture and the impacts of settler colonialism and systemic racism (personal communication, Hummingbird, January 2024). Further, Indigenous doulas highlighted that higher income is not a protective factor against health inequities for Native people (personal communication, Hummingbird, January 2024).

Inequities in perinatal health are intertwined with and "as a result of the trauma and inequities inflicted by colonization."[5] American Indian and Alaska Native birthing people were 6.6 times more likely to die from a pregnancy-related cause compared to white birthing people (maternal mortality ratio of 53 deaths per 100,000 live births compared to 8 deaths per 100,000 live births, respectively).[8]

In an article presenting information from qualitative interviews with Indigenous doulas in Canada, the study authors noted that "[o]ften doulas are the only source of culturally competent care for expectant Indigenous [people] during childbirth."[5] Indigenous doulas may or may not have a cultural background that matches the birthing person, especially in urban areas where "it is more difficult to have nation-specific traditional teachings."[5] However, Indigenous doulas center culture and spirituality in healthcare settings that often lack or have limited awareness and understanding of Indigenous traditions.[5] Indigenous doulas often have shared experiences with Indigenous birthing people and can help address factors such as discrimination and bias, "systemic racism, fear of medical and social services, and a long history of interactions with child and family services" among Indigenous communities.[5] The authors concluded that support from Indigenous doulas is essential to "counter systemic medical racism and socioeconomic barriers that Indigenous families disproportionately face" and to promote Indigenous birth sovereignty.[5]

By income

People with low-incomes also have less access to doula care. HHS has noted that "[a]ccess to doula [care] has been historically limited in the U.S., with greater utilization among higher-income individuals, since doula [care is] often not reimbursed by health coverage programs including most state Medicaid programs."[32] Since there is limited insurance coverage for doula care, "access to [doula care] is largely limited to families with higher incomes who can afford to pay for such services out-of-pocket."[3] This has contributed to doulas often serving people who are white, cis-gender, and have higher-incomes.[12] Medicaid provides health insurance coverage for more than 40% of all births in the U.S. and for more than 60% of all births among Black and American Indian and Alaska Native women.[68]

Evidence indicates that people of low socioeconomic status experience difficulty accessing healthcare.[54-67] Significant correlations exist between lower income and a number of reproductive health indicators. For example, findings from Washington's Maternal Mortality Review indicated that women enrolled in Apple Health coverage were disproportionately represented among all pregnancy-associated deaths.[10]

Research shows that doulas can help mitigate the harmful effects of classism and additional social determinants of health.[41] Among people with low-incomes, research found that doula guidance is associated with increased breastfeeding success, quicker lactogenesis, and continued breastfeeding 6 weeks after childbirth.[30] Additionally, the survey of 1,977 women in California found that, among birthing people enrolled in Medicaid, the odds of reporting respectful care was 80% higher among birthing people who had doula support compared to birthing people without doula support.[33]

By geography

There is significantly less availability of doula care in rural communities compared to urban communities.[45] A national survey of rural hospitals offering inpatient care for labor and delivery found that half of rural communities did not have doula care available.[45] For each hospital, the study authors calculated a Social Vulnerability Index score, which accounts for a combination of social and structural determinants of health (percentage of residents living below the Federal Poverty Level; percentage of people with a disability; percentage of people who speak English "less than well"; percentage of households lacking access to a vehicle, etc.).[45] Areas with a higher Social Vulnerability Index were considered more vulnerable.[45] The authors found that rural communities that were most vulnerable were significantly less likely to have doula care available compared to less vulnerable rural communities (33.3% versus 59.7%, respectively).[45] Researchers also found, "[r]esidents in the most socially vulnerable rural counties, many of whom are [Black, Indigenous, and People of Color] and thus at higher risk for poor birth outcomes, are significantly less likely to have access to evidence-based supports for [perinatal] and infant health", including access to doula care.[45]

People living in rural areas also have less access to healthcare in general and to obstetrics in particular.[32,81] People who live in rural areas face numerous access barriers, including transportation infrastructure, population distribution, and configuration of healthcare facilities.[82] Additional geographic factors associated with inequities in access are rural closures of family planning clinics,[87] increased travel time to clinics,[88] shortages of providers in rural areas,[89] increasing risk of malpractice litigation[90], and limited reproductive healthcare service availability due to health system directives.[91]

In 2020, 8 counties in Washington State (Columbia, Douglas, Ferry, Garfield, Lincoln, Pacific, Skamania, and Wahkiakum Counties) were classified as maternity care deserts, meaning there were no hospitals providing obstetric care, no birth centers, no obstetrician-gynecologists (OB/GYN), and no certified nurse midwives.[83] Additionally, 5 Washington counties (Adams, Franklin, Lewis, Mason, and Stevens Counties) were classified as having low access to maternity care services, meaning there was 1 hospital, or fewer, offering obstetric care and fewer than 60 obstetric care providers per 10,000 births, and the proportion of women without health insurance was 10% or greater.[83]

Evidence indicates that people living in rural communities are disadvantaged on multiple health and health-related measures[92-95] and experience worse perinatal health outcomes.[8,45] In Washington State, the pregnancy-related mortality ratio was higher for those living in rural areas (15 deaths per 100,000 live births) compared to those living in urban areas (11 deaths per 100,000 live births) from 2014 through 2016.[8]

By immigration status

Access to healthcare varies by immigration status, and individuals and communities experience different barriers to care based on immigration status, nativity, length of time in the U.S., and level of acculturation.[70-76] In general, immigrants are less likely to have health insurance (due to federal and state regulations and employment in jobs less likely to provide insurance), less likely to receive preventive care, and more likely to delay seeking health services.[70,73,77,78] Inequities in perinatal health outcomes by immigration status are connected to systemic racism and systems of oppression, discrimination and stigma, and lack of culturally and linguistically appropriate care among additional factors.[69] Immigrants are more likely to experience poor reproductive health outcomes, including unintended pregnancy, unintended birth, sexually transmitted infections, adverse birth outcomes, and longer durations of infertility than the general population.[57,69,70,73,79,80] People who are undocumented experience worse reproductive health outcomes than immigrants with legal status or the general population.[70]

Researchers conducted a 2022 systematic review examining perceptions and experiences of community-based doula programs for migrant and refugee birthing people in the U.S., Australia, England, and Sweden.[69] The authors concluded that community-based doula care may improve the responsiveness and experience of perinatal healthcare for migrant and refugee pregnant, birthing, and postpartum people.[69]

Researchers and key informants have also suggested additional groups that may experience lower access to doula care and worse birth outcomes, including, people in Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) communities, people experiencing incarceration, and people with limited English proficiency (personal communications, January 2024).[30,34,69,96] For example, SHB 2016 (Chapter 41, Laws of 2018) required Washington State Department of Corrections to make reasonable accommodations for midwifery and doula services to people who are pregnant or who have given birth in the last 6 weeks. However, the law has not been fully implemented and people experiencing incarceration do not have formal access to doula care in any Washington State prison (personal communication, Birth Beyond Bars, February 2024).

Therefore, since many pregnant, birthing, and postpartum people experience lower access to doula care, lower access to reproductive healthcare, and worse reproductive health outcomes, and since doulas may help alleviate these barriers and inequities, there is very strong evidence that worsening health outcomes for birthing people and their infants would worsen inequities.

Pathway 2: Rulemaking

Would defining culturally congruent care and requiring birth doulas to provide proof of knowledge related to culturally congruent care for state certification result in Washington State Department of Health (DOH) conducting rulemaking?

We have made the informed assumption that defining culturally congruent care and requiring birth doulas to provide proof of knowledge related to culturally congruent care for state certification may result in DOH conducting rulemaking. This informed assumption is based on information from key informants and bill and law language.

In 2022, the Washington State Legislature passed Engrossed Substitute House Bill 1881 (ESHB 1881) (Chapter 217, Laws of 2022) creating a new credentialed health profession for birth doulas (Chapter 18.47 RCW).[17] State law (RCW 18.47.010) defines a "birth doula" to mean a person who "is a nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth and the postpartum period [i.e., the 12-month period beginning on the last day of the pregnancy]."[18] Birth doulas "advocate for and support birthing people and families to self-advocate by helping them to know their rights and make informed decisions. Birth doulas do not provide medical care."[18] The law allows birth doulas to voluntarily apply for state certification from DOH.[19] Nothing in Washington State law prohibits a person from practicing as a birth doula without obtaining state certification.[20] It is the first credentialed profession in Washington State for which certification is voluntary (personal communication, HCA, January 2024).

DOH conducted rulemaking to establish the birth doula state certification and filed final rules on August 30, 2023.[22] Chapter 246-835 WAC details DOH requirements for birth doula state certification.[22] The rules became effective October 1, 2023, and DOH's Birth Doula Program began accepting paper applications for state certification in October 2023 and online applications in January 2024 (personal communications, January 2024). There are 3 pathways to obtain birth doula state certification in Washington State, including a training program pathway (WAC 246-835-020), an ancestral or legacy pathway (WAC 246-835-022), and an out of state pathway (WAC 246-835-040).[23] People applying to the training program pathway must complete DOH's formal application; provide proof of completion of certain educational requirements, including culturally congruent ancestral practices, training, and education; and provide verification from all states in which the applicant holds or has held a healthcare credential.[97] People applying to the ancestral program pathway must either provide a formal attestation stating that the applicant has completed training equivalent to what is required in WAC 246-835-020 or provide 3 written client testimonial letters or letters of recommendation that include certain key requirements per DOH guidance.[97] People applying to the out of state pathway must provide current doula certification from another U.S. state and, for applicants who have been certified in another U.S. state for at least 2 years, must show completion of 10 hours of continuing education within the 2-year period immediately preceding Washington State certification.[97]

WAC 246-835-010 currently defines "culturally congruent care" as "the care and respect towards families to uphold their cultural practices around birth as the duty of the doula regardless of their identity, as well as assisting families in accessing other doulas from the same background and community as them."[22] SB 6172 would add a new definition of "culturally congruent care" to law (Chapter 18.47 RCW) and would require birth doulas to provide proof of knowledge related to culturally congruent care for state certification. Specifically, culturally congruent care would be defined in law to mean “a duty to learn respect for and uphold a birth doula’s client’s cultural practices around birth regardless of the birth doula’s identity” and “includes a birth doula’s duty to use community resources and networks to help families access other doulas from the same background, religion, culture, and community as them.”

Staff from DOH noted that passage of SB 6172 would require DOH to conduct rulemaking to add the new requirement to rules (Chapter 246-835 WAC) (personal communication, DOH, January 2024). For example, proof of knowledge would involve applicants providing self-attestation that they have knowledge related to culturally congruent care required for state certification (personal communication, DOH, January 2024).

Therefore, we have made the informed assumption that defining culturally congruent care and requiring birth doulas to provide proof of knowledge related to culturally congruent care for state certification may result in DOH conducting rulemaking.

Would removing the Secretary of Health’s ability to impose a fee for state certification, examination, or renewal for those seeking doula certification between July 1, 2025, and July 1, 2030, and capping allowable fees after July 1, 2030, result in DOH conducting rulemaking?

We have made the informed assumption that removing the Secretary of Health’s ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and capping allowable fees after July 1, 2030, may result in DOH conducting rulemaking. This informed assumption is based on information from key informants and bill and law language.

Currently, WAC 246-835-990 details birth doula fees and renewal cycle for state certification.[22] According to rule, a birth doula must renew their state certification every 2 years on the practitioner’s birthday.[22] Nonrefundable fees to be charged include application for initial state certification ($190), state certification renewal ($190), late renewal penalty ($95), expired certificate reissuance ($95), duplicate certificate ($10), and verification of state certification ($25).[22] State law (RCW 43.70.250) requires that the cost of professional, occupational, or business licensing programs administered by DOH be self-supporting.[24] This means DOH must collect sufficient revenue through fees to fund the cost of administering professional licensing and certification programs (personal communication, DOH, January 2024). However, DOH is currently waiving all fees listed in WAC 246-835-990 until July 1, 2025.[25] DOH received General Fund State funding for the birth doula state certification program costs for July 1, 2023, through June 30, 2025 (Fiscal Years 2024 and 2025).[25] It is unknown whether such funding will be made available to the program in the future (personal communications, January 2024).

If passed, SB 6172 would remove the Secretary of Health’s ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and would cap allowable fees at $95 after July 1, 2030, subject to appropriations for this purpose. Eliminating state certification, examination, or renewal fees could reduce costs for birth doulas applying for or renewing state certification by up to $190 every 2 years until July 1, 2030, and up to $95 every 2 years after July 1, 2030. DOH staff noted that passage of SB 6172 would require that WAC 246-835-990 be amended, potentially several times to reflect applicable fees (personal communication, DOH, January 2024). Staff also noted DOH would explore all fees included in WAC 246-835-990 during rulemaking, but the fee amounts would be dependent on appropriations (personal communication, DOH, January 2024).

For context, additional Washington State professions currently have prohibition of fees for people seeking certification. RCW 43.70.250 prohibits DOH from imposing a fee for people seeking certification as a certified peer specialist trainee (July 1, 2025, through July 1, 2030) and limits fees to no more than $100 for a person seeking certification as a certified peer specialist.[24] Key informants noted that the limitations on fees for certified peer specialists and certified peer specialist trainees were established to avoid creating a barrier for those pursuing those certifications (personal communication, DOH, January 2024).

Overall, we have made the informed assumption that removing the Secretary of Health's ability to impose a fee for state certification, examination, or renewal for those seeking birth doula certification between July 1, 2025, and July 1, 2030, and capping allowable fees after July 1, 2030, may result in DOH conducting rulemaking.

Would DOH conducting rulemaking result in increased awareness of culturally congruent care requirements for state certification among some doulas?
We have made the informed assumption that DOH conducting rulemaking may result in increased awareness of culturally congruent care requirements for state certification among some doulas. This informed assumption is based on information from key informants.

Only doulas applying for state certification under Pathway A (Training Pathway) and Pathway C (Out of State Pathway) would be impacted by the revised definition and requirements related to culturally congruent care (personal communication, Doulas For All Coalition, January 2024). Applicants in Pathway B (Ancestral Pathway) would not be impacted since proof of completion in this Pathway is determined through either attestation of training substantially equivalent to the required training in WAC 246-835-020 or through 3 written client testimonial letters or letters of recommendation (personal communication, Doulas For All Coalition, January 2024).

It is unknown how long DOH rulemaking may take, should SB 6172 pass. After passage of ESHB 1881, initial paperwork regarding the intention to conduct rulemaking was published in July 2022, final rules were published in August 2023, and rules became effective October 2023.[98] Doulas may voluntarily apply for credentialing through DOH's state certification process between now and when final rules would become effective if SB 6172 passed. During this period, doulas applying for state certification may be held to the certification standards currently in place.

DOH staff stated that once updated rules became effective, applicants would be required to self-attest that they have proof of knowledge related to culturally congruent care (personal communication, DOH, January 2024). Application forms are not available in languages other than English unless an applicant requests a translated copy.[99] During the application process, applicants in Pathway A and Pathway C would need to read the new definition of culturally congruent care and consider whether they understand the definition, whether they possess that knowledge, and whether they would like to provide proof that they have the required knowledge.

Taken together, we have made the informed assumption that DOH conducting rulemaking may result in increased awareness of culturally congruent care requirements for state certification among some doulas.

Would increased awareness of culturally congruent care requirements for state certification among some doulas impact pregnant, birthing, and postpartum people in Washington State?

There is unclear evidence how increased awareness of culturally congruent care requirements for state certification among some doulas may impact pregnant, birthing, and postpartum people in Washington State. Key informants shared mixed information regarding what culturally congruent training and care currently looks like in Washington State. While some data and research indicate culturally congruent care may benefit the doula workforce and pregnant, birthing, and postpartum people,[4,100,101] self-attestation of proof of knowledge of culturally congruent care may not result in integration of culturally congruent care practices.

Key informants agreed and evidence indicates that pregnant, birthing, and postpartum people of marginalized identities, particularly people of color, face a wide range of barriers and challenges navigating western medical systems throughout their pregnancies.[1,7,9,41] Key informants generally stated that changing the definition of culturally congruent care and adding a new definition to WAC 246-835-010 may add clarity to expectations regarding doula competencies among doulas seeking credentialing through state certification (personal communications, January 2024). Key informants who were doulas also stated that changing the definition in law may lead to improved quality of care for pregnant, birthing, and postpartum people, as well as sustainability and longevity for the doula workforce (personal communications, January 2024). However, some key informants stated that Washington State doulas are currently providing culturally congruent care as defined in SB 6172 and that changing the definition in law simply adds legal clarity to match current competency expectations for doulas seeking state certification through DOH (personal communication, DOH, January 2024).

Workforce training and diversity

Research has stated that doulas "are acutely aware of the factors of obstetric violence and how to mitigate unnecessary interventions as well as helping their clients achieve the birth they are seeking."[1] Research also shows that doulas are positioned to provide advocacy and support against medical racism.[1,5,7] However, doula key informant interviewees stated there are discrepancies in the ways in which doulas are trained in and provide culturally congruent care (personal communications, January 2024).

Some training requirements in other states have included cultural or community-based training for doula credentialing.[68] For example, New Jersey requires doulas complete additional community competency training related to New Jersey-specific community-based resources.[68] As part of a 5 state case study, doulas also expressed the need for racial, ethnic, and linguistic congruence between doulas and people with Medicaid coverage.[68]

However, key informants who were doulas stated that trainings available to doulas vary in the quality and depth of information provided and there is a need for the doula workforce to have increased awareness of topics such as the history of birth workers since time immemorial, racism, colonialism, sexism, homophobia, transphobia, indigeneity, birth equity, intersectionality, and maternal and perinatal mortality, and for the workforce to recognize how these topics affect doula care provided to pregnant people and families (personal communications, January 2024). One researcher stated, "[b]y incorporating training topics such as advocacy, structural racism, and discrimination in care delivery, organizations can address the specific barriers underserved populations face."[9]

Doulas stated that most trainings available either do not include these topics at all or are presented in ways that center white dominant culture[1,102] (personal communications, January 2024). In listening sessions held by the U.S. Department of Labor's Women's Bureau (Women's Bureau), doulas noted:

> [T]rainings 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 [doulas] felt that certain large training and certification providers are not safe spaces for Black and queer doulas.[3]

Another researcher stated, "[m]ajor organizations have historically grounded their training in the experiences of [w]hite upper-class women, rarely including topics specific to the needs of underserved communities."[9] Key informants stated that white-led organizations host trainings facilitated by white instructors on these topics, but the trainings imitate, monetize, and are not as high-quality as people of color-created and -led trainings on these topics (personal communications, January 2024).

Doulas noted that general certification is associated with a white supremacy model (personal communications, January 2024). A study that examined both community-based organization (CBO) and mainstream (i.e., commercial training organizations and hospital-based doula employers) organization trainings found that CBO trainings often focused on racial and reproductive justice and health inequities, while mainstream organizations incorporated entrepreneurship and business skills into their programming.[9] For example, "one CBO started a training program for doulas who wanted to work with Native American communities and address the systemic challenges they faced, because doulas did not learn about communities' poverty and substance misuse in mainstream training programs."[9]

Unlike the standard doula model in which doulas support their clients in advocating for themselves, Indigenous doulas recognize it can be unsafe for Indigenous birthing people to advocate for themselves (personal communication, Hummingbird, January 2024). Indigenous doulas understand their role as protectors of the birthing space and are prepared to both empower their relatives (clients) and advocate for them as needed (personal communication, Hummingbird, January 2024).

---

[1] White dominant or white supremacist culture includes norms such as perfectionism, a sense of urgency, defensiveness and/or denial, quantity over quality, worship of the written word, the belief in one "right" way, paternalism, either/or binary thinking, power hoarding, fear of open conflict, individualism, progress defined as more, the right to profit, objectivity, and the right to comfort.[102]

Some doulas also stated that increases in culturally congruent training and care may lead to sustainability and longevity of the doula workforce (personal communications, January 2024). Doulas face various workforce-related challenges, including witnessing and experiencing discrimination, struggling with ineffective or inadequate payment models, experiencing burnout, and facing resistance when collaborating with other perinatal providers.[7,12,41] As part of 2 listening sessions with the Women's Bureau, doulas discussed challenges related to schedules, pay, benefits, interactions with medical providers, exposure to traumatic births, access to mental health services, and access to affordable, reliable, and quality childcare.[3] Doulas stated that doulas tend to practice doula care approximately 5 to 6 years (personal communications, January 2024). Further, doulas of color provide care to patients and families on a sliding scale or pro bono more often than their white doula counterparts in efforts to facilitate equitable access to care (personal communications, January 2024).

Doulas also stated that since most doula trainings currently available are not culturally congruent, doulas of marginalized and intersectional identities are generally not hearing and learning about their own backgrounds and cultural birth practices during these trainings (personal communications, January 2024). Doulas stated that there are positive benefits for marginalized doulas when they attend culturally congruent training. To explain, a qualitative study of 5 Black doulas and 2 program directors stated:

> Black doulas who obtain traditional doula training from the national accrediting organization may internalize and accept the status quo, never becoming aware of the importance of their identity in addressing the role of racism in the Black [perinatal] birth experience at its multiple levels. One doula acknowledged these limitations and remarked on how fortunate she felt to be aware of the inadequacy of national training, which led her to seek alternative training opportunities.[7]

Doulas stated that increased culturally congruent care and training may lead to doulas, particularly doulas of color, staying in the workforce for longer periods of time and having decreased levels of burnout (personal communications, January 2024).

Research shows that doulas also support "recruitment of Black doulas to meet the needs of women of color going through the birthing process."[1] Doulas stated that the majority of doulas in Washington State are white and may not be best suited to serve patients and families of color (personal communications, January 2024). Doulas also stated that the majority of doulas in Washington State are straight and cisgender and may not be best suited to serve patients in Lesbian, Gay, Bisexual, Trans, and Queer (LGBTQ+) communities (personal communications, January 2024). Further, the "White House Blueprint for Addressing the Maternal Health Crisis" stated:

> [D]iversity in the health care workforce can help address persistent racial and ethnic disparities in health care by improving patient experience, increasing patient satisfaction, and improving access to care for underserved patients. Some experts suggest that [inequities] in [perinatal] health outcomes could be reduced by increasing workforce diversity and having more culturally congruent [perinatal] care in the U.S., with health care providers of color helping to mitigate cultural barriers in the health care system.[6]

Doulas noted that when patients receive care from doula providers who share a similar background such as race, ethnicity, religious background, sexual orientation, gender identity, and additional dimensions of identity (i.e., "cultural concordance") quality of care increases (personal communications, January 2024). Indigenous doulas stated that white doulas are not able to provide culturally congruent care to Native families, regardless of trainings or certifications they may have (personal communication, Hummingbird, January 2024). Further, key informants shared that lived experience in Native cultures and communities is generally more valuable to clients than training and certification (personal communication, Hummingbird, January 2024).

Research has shown that "when patients and providers share the same race or ethnicity, patient perception of treatment decisions improves."[68] In 1 study, Black community-based doulas and doula program directors emphasized the importance of cultural concordance as integral to providing equitable care.[7] For example, the study found that white doulas are not able to provide the same level of care for Black patients that Black doulas can provide.[7] Doulas in research have noted that shared identity with clients is integral to providing equitable care.[7] One researcher stated, "[h]aving access to doulas who understand and have experienced the effects of systemic racism increases a pregnant person's trust and engagement in care and strengthens their agency in decision-making processes."[9] In addition:

> [A] qualitative study of community doulas and their work with immigrant women in Washington [S]tate explored the influences of cultural beliefs on doulas' ability to provide support and advocate for these individuals, both of which found that culture played a large part in both doulas' path to and practice of the profession.[41]

Evidence suggests a reciprocal relationship between doulas and patients of color, and doulas of color are particularly motivated and satisfied in working to support families of color.[31] In a qualitative study of 12 doulas of color, results showed "the underlying motivation for becoming a doula was related directly to a desire to support women from the doula's own racial, ethnic, and cultural community."[31] Doulas in the study also shared motivation and satisfaction in their work related to "perceiving birth work as a 'calling;' easing women's transitions to motherhood by 'holding space;' honoring the ritual and ceremony of childbirth; and providing culturally-competent support, often as the sole source of cultural knowledge during labor and delivery."[31]

Key informants stated that doulas serving Black and Indigenous clients should be aware of the Black and Indigenous perinatal health crisis, systems of racism and discrimination, and be prepared to speak to the client's and family's specific needs (personal communications, January 2024). Doulas shared, if doulas are not prepared to provide care specific to the client's and family's needs, they should be prepared to refer the client to doulas who can meet those needs (personal communications, January 2024).

Outcomes for patients and families

Research on culturally congruent care specific to doula care and impacts for pregnant, birthing, and postpartum people is still emerging. However, studies have defined culturally congruent care in different ways. Therefore, if SB 6172 were passed and the new definition was added, results may not be generalizable to Washington State.

A 2023 randomized control trial found that racially/culturally congruent doula care reduced cesarean births by 12% and increased exclusive breastfeeding at hospital delivery by 11.5% among Black, non-Hispanic birthing people.[4] The authors stated that this was the first study to examine the impact of racially/culturally congruent doula care on perinatal health outcomes.[4] They concluded that racially/culturally congruent doula care, 1) "addresses historical injustices rooted in the systematic elimination of Black birth workers in the [U.S.] by recognizing the experience and expertise of Black birthing people and their communities"[4]; 2) "helps birthing people connect with resources that reduce economic and social barriers to health"[4]; and 3) "reduces [inequities] in cesarean birth and breastfeeding outcomes between Black birthing people and those of other races/ethnicities."[4]

An analysis examined health outcomes associated with doula care of a non-profit organization that provided culturally congruent community-based doula care in Kansas City, Missouri (Uzazi Village).[100] Uzazi Village birth outcomes were compared to Kansas City's overall birth outcomes.[100] Among the 321 patient records studied, premature birth rates were 40% lower, low birthweight was 8.5% lower, and low Apgar scores (used to assess the health of a newborn) were 19% lower among Uzazi Village patients.[100]

A separate study evaluated the Mama Amaan Perinatal Care Model, a program that provides culturally congruent care to Somali refugee and immigrant households in South King County in Washington State.[101] The program evaluation found that the program increased awareness of perinatal health services, including doula care.[101] The researcher stated that participants received tools, resources, and strategies to advocate for themselves and their community.[101] The researcher also stated that participants reimagined a new framing of community congruence, "which included three core principles: 1) transformative mutual reciprocity; 2) constant cycle of flexibility, adaptability, and a little chaos; and 3) relational practice of listening, connecting, and building trust."[101]

Overall, doulas stated that integrating culturally congruent care into doula practice requires long-term commitment to continuing education and experience (personal communications, January 2024). For example, doulas recommended apprenticeship opportunities and continuous learning and integration of anti-racist training materials (personal communication, January 2024). One research study stated, "changing an organization from within and including a focus on health equity and racism take time and require continuing education for everyone involved."[9] While culturally congruent training and care may improve the doula workforce and quality of care, self-attestation of proof of knowledge of culturally congruent care may not result in integration of culturally congruent care practices. Taken together, there is unclear evidence how increased awareness of culturally congruent care requirements for state certification among some doulas may impact pregnant, birthing, and postpartum people in Washington State.

Would DOH conducting rulemaking impact some doulas seeking state certification?

There is unclear evidence how DOH conducting rulemaking may impact some doulas seeking state certification. Key informants shared historical information about previous DOH rulemaking specific to state certification of doulas, noted that fee-related provisions of SB 6172 are subject to appropriations, and discussed potential unintended consequences of certification (personal communications, January 2024). Research also shows potential unintended consequences associated with certification.[3,9,103] Lastly, the application process may pose barriers for some doulas.

DOH rulemaking after passage of ESHB 1881

Specific regulations to implement a law cannot be fully known or predicted before rulemaking is complete. Following the passage of ESHB 1881, coalitions, groups of doulas of color, and additional partners were engaged in the rulemaking process and provided recommendations to DOH (personal communications, January 2024). Key informants shared that at the end of the rulemaking process some, but not all, recommendations from doulas were included in rule (personal communications, January 2024). It is not possible to determine the exact regulations DOH may require in rule, should SB 6172 pass. Further, it is not possible to fully predict the impacts that rulemaking and future rule language will have on doulas seeking state certification.

Certification fees

Costs of fees create barriers for doulas pursuing credentialing (personal communications, January 2024). Key informants stated that any decreases in and waivers of fees for doula credentialing, including for state certification, would benefit the doula workforce (personal communications, January 2024). Since fee-specific provisions in SB 6172 are subject to appropriations, it is not possible to determine the exact fee-related rules that would be adopted if the bill became law. It is unknown how much doulas may be charged for fees associated with state certification if sufficient funding is not provided. Staff from DOH stated that the fee-specific provisions in SB 6172 (i.e., removal of the Secretary's authority to impose a fee for 5 years and subsequent fee cap of $95) are subject to appropriated funds (personal communication, DOH, January 2024). Additionally, if SB 6172 passed into law, doulas could apply for state certification between bill passage and when final rules would become effective. For example, rulemaking for ESHB 1881 took longer than a year.[98] If passed, doulas who apply for state certification while DOH conducts rulemaking may be held to the fee standards currently in law and fee amounts determined by available funding. Further, while some doulas seeking state certification may have some fees waived or reduced as a result of DOH's rulemaking process, it is not possible to determine the exact fees that would be required should SB 6172 pass.

Unintended consequences of certification

Washington State certification for doulas is voluntary, and key informants stated that there are currently 5 state-certified doulas in Washington State (personal communication, DOH, January 2024). Key informants stated they would not expect passage of SB 6172 to change the rate at which doulas apply for state certification, but they expect applications to gradually increase over time (personal communications, January 2024). Key informants also stated that Office of Customer Service Credentialing within DOH's Health Systems Quality Assurance division is currently backlogged due to limited staff and capacity, which is affecting many professions (personal communication, DOH, January 2024). DOH staff stated that if doula applications for state certification were to increase, applicants would likely experience long wait times before becoming formally state-certified (personal communication, DOH, January 2024).

Researchers have described additional unintended consequences associated with doula credentialing. In February 2023, the Women's Bureau held 2 listening sessions with doulas and doula organizations in Birmingham, Alabama, and Providence, Rhode Island, to understand how insurance reimbursement for doulas may impact job quality and professional barriers.[3] In these listening sessions, doulas discussed "the potential negative consequences of creating a structured pathway to becoming a doula or requiring specific certifications."[3] Among challenges to trainings and certifications, doulas noted that additional training or certification requirements create time and cost barriers.[3] Some doulas stated that "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."[3] The value of experience aligns with perspectives shared by doulas interviewed in a study analyzing the role of certification in legitimating doulas' alternative knowledge about childbirth.[103] Most doulas interviewed "indicated that experience mattered more to their clients than did certification, but doulas believed that [medical clinicians] valued certification more than clients did."[103]

Due to impacts of systemic racism and systems of oppression and medicalization that have limited the number of perinatal health providers of color, the Women's Bureau noted 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."[3] Similarly, an analysis to assess the benefits of professional certification for healthcare workers (i.e., personal care aides, medical transcriptionists, medical assistants, and community health workers) found that "[n]ot only are people of color less likely to have a certification, they also receive lower rewards [e.g., average weekly earnings] for certification."[104] The Women's Bureau concluded that:

> [U]nless 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 [care].[3]

To overcome barriers to training and certification, the Women's Bureau recommended:

> [I]ncluding 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 training; and subsidizing the cost of training and certification.[3]

Doula key informants also shared that since state certification applications opened in October 2023, at least 1 hospital in the Spokane area has denied doula support to a birthing person on grounds that the hospital only allows state-certified doulas to provide care (personal communication, Doulas For All Coalition, January 2024). Nothing in Chapter 18.47 RCW prohibits a person from practicing as a birth doula without obtaining state certification.[20] In addition to legal complications, hospitals denying patient access to doula care may lead to loss of revenue for doulas and increased negative health impacts for patients (personal communications, January 2024). Entities in other states have tried to license doulas or require that doulas be licensed, which is unnecessary, misleading, and inaccurate, as doulas are not licensed profession (personal communication, National Health Law Program, January 2024). These licensing efforts have created confusion for doulas, patients, and additional care providers (personal communication, National Health Law Program, January 2024).

Application process

People who apply for doula credentialing through DOH's state certification process may complete an application which includes self-attestation stating they have completed practices, training, and education in any areas listed in WAC 246-835-025. Although self-attestation is a relatively low-barrier application approach, doulas may still experience barriers during the application process. For example, application forms are not available in languages other than English unless an applicant requests a translated copy, online applicants must log in through the

SecureAccess Washington (SAW) security portal (which requires applicants create an account), and application questions include personal data questions that include civil and criminal legal history.[99] These application components may present barriers to doulas applying for state certification and/or may lead to some doulas opting not to apply for state certification.

Overall, historical rulemaking conducted by DOH specific to state certification of doulas, the lack of clarity regarding fees that may be required for state certification, potential unintended consequences associated with certification, and elements of the application process that may pose challenges for applicants result in unclear evidence how DOH conducting rulemaking may impact some doulas seeking state certification.

Additional considerations
Doula care is not currently reimbursable through Apple Health (personal communication, HCA, January 2024). ESSB 6168 (2020 Legislative Session), section 211 (32) required HCA to reimburse for doula care, consult with stakeholders, and develop methods to secure approval from the Centers for Medicare and Medicaid (CMS) for reimbursement.[16] In 2020, HCA published a report to the Legislature that included recommendations for doula reimbursement.[16] Due to funding and budget limitations, it is unknown when doula reimbursement may be implemented in Washington State (personal communications, January 2024).

Key informants shared that some doulas in Washington State are already working with clients enrolled in Apple Health (personal communications, January 2024). Because Apple Health does not provide reimbursement for doula care, doulas may offer care on a sliding scale or pro bono (personal communication, Doulas For All, January 2024). Were Apple Health to provide reimbursement to state-certified doulas, some doulas currently working with clients enrolled in Apple Health may seek state certification to secure reimbursement for care provided (personal communications, January 2024).

Key informants stated that more doulas may also be motivated to become state-certified if Apple Health provided reimbursement for doula care (personal communications, January 2024). Currently, doulas may choose to apply for credentialing through means other than DOH's state certification. For example, DONA International[105] and PALS provide certification for doulas (personal communications, January 2024). It is likely that doulas would be required to be state-certified to receive Apple Health reimbursement, and doulas with credentials from institutions other than DOH's state certification would likely not be eligible to receive reimbursement (personal communications, January 2024). Doulas becoming state-certified could lead to more doulas who are not connected to community working with more people of color and more people enrolled in Apple Health, which may lead to unintentional harm (personal communication, Hummingbird, January 2024).

Research has found potential positive outcomes as well as negative unintended consequences associated with Medicaid reimbursement for doula care.[46] As part of 2 listening sessions with doulas and doula organizations, the Women's Bureau found that the benefits of Medicaid and private insurance reimbursement included increased patient access to doulas, improved perinatal health outcomes, and improved job quality for doulas.[3] Doulas "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 [care]."[3] However, challenges included low reimbursement rates, structure of reimbursement, and training and certification requirements that "influence whether Medicaid reimbursement improves [doulas'] job quality or whether doulas choose to participate and take on the additional costs of participating" in reimbursement options.[3]

One study that included literature and policy reviews as well as 16 interviews with organizations involved in training, certifying, advocating for, and employing doulas, and key informants involved in state policy making stated that doulas recommend a "cautious approach to Medicaid reimbursement."[9] Participants were concerned that "Medicaid reimbursement would create a scope of practice that would not align with the needs of their doulas or communities and would push the expansion of doula [care] deeper into the hospital hierarchy without addressing the systemic racism embedded in it."[9] In addition, doulas may be hesitant to take on Medicaid clients because "reimbursement rates are low and paperwork is complicated."[9] Researchers also stated that reimbursement can be complicated because of conflicting certification requirements and difficulties in becoming enrolled providers with managed care organizations.[9]

The Medicaid and CHIP Payment and Access Commission (MACPAC) conducted key informant interviews with Medicaid officials, managed care organizations, doulas, and doula organizations in Florida, Minnesota, New Jersey, Oregon, and Rhode Island, which all provide reimbursement for doula care under Medicaid.[3] As part of these interviews:

> [S]ome doulas of color raised concerns that components of state-approved doula training and certification organizations are not community-based, not necessarily tailored to train doulas to meet the needs of historically marginalized communities, and may not train doulas to meet Medicaid beneficiaries' needs. This may hinder doulas from completing these trainings and enrolling as Medicaid providers. Doulas have advocated for more local and diverse training organizations to increase the cultural competency of doulas.[3]

For example, New Jersey requires doulas complete additional community competency training related to New Jersey-specific community-based resources.[3]

Doula care is not currently reimbursable through Apple Health. Should doula care become reimbursable through Apple Health, doula credentialing requirements would determine how doulas become Apple Health providers. Evidence indicates there may be both potential positive outcomes as well as negative unintended consequences associated with Apple Health reimbursement for doula care. Since passage of SB 6172 would not result in reimbursement through Apple Health, this pathway was not included in the Logic Model.

Annotated References

1. **Salinas Juan L., Salinas Manisha, Kahn Megan. Doulas, Racism, and Whiteness: How Birth Support Workers Process Advocacy towards Women of Color. *Societies.* 2022;12(1).**
Salinas, Salinas, and Kahn conducted 11 interviews with doulas in northeast Florida to examine how doulas come to terms with race, racism, and whiteness in maternal healthcare settings. The interview results show that doulas are positioned to provide advocacy and support against medical racism. The author wrote, "doulas' advocacy for maternal justice leads to an intersection with racial justice through their support of minority women clients". Doulas in the study stated a need for anti-racism training and "recruitment of Black doulas to meet the needs of women of color going through the birthing process." Doulas have the potential to prevent frequent medical interventions, high C-section rates, and trauma from negative birth experiences. The paper also cites prior research to state that doulas "are acutely aware of the factors of obstetric violence and how to mitigate unnecessary interventions as well as helping their clients achieve the birth they are seeking."

2. **A Brief History of Midwifery in America. Available at: https://www.ohsu.edu/womens-health/brief-history-midwifery-america. Accessed, 2024.**
Oregon Health & Science University published this webpage outlining the history of midwifery in the U.S. information on midwifery in the colonial era, the rise of obstetrical medicine, and the history and current practice of midwifery care are provided.

3. **Roux M. Issue Brief, Expanding and Diversifying the Doula Workforce: Challenges and Opportunities of Increasing Insurance Coverage. U.S. Department of Labor, Women's Bureau;2023.**
One goal of the "White House Blueprint for Addressing the Maternal Health Crisis" is to expand and diversify the perinatal workforce, including access to doulas. As part of this goal, the U.S. Department of Labor's (DOL) Women's Bureau conducted 2 listening sessions with doulas and doula servicing organizations in February 2023. One listening session occurred in Birmingham, Alabama and one in Providence, Rhode Island. Alabama does not require health insurance coverage for doula services; Rhode Island requires Medicaid and private insurance coverage for doula services. Rhode Island is the only state to require both public and private health insurance coverage for doula services. The intent of the listening sessions was "to identify job quality gaps for doulas, specifically with respect to state-by-state variations in insurance reimbursement." Listening session topics included the impact of health insurance coverage, job quality, professional barriers, ongoing challenges, and potential solutions. Doulas practicing in Alabama and Rhode Island expressed similar experiences with compensation, hours, training, and certification. Overall, DOL found that the benefits of Medicaid and private insurance reimbursement included increased patient access to doulas, improved maternal health outcomes, and improved job quality for doulas. However, challenges included reimbursement rates, structure of reimbursement, and training and certification requirements that "influence whether Medicaid reimbursement improves [doulas'] job quality or whether doulas choose to participate and take on the additional costs of participating" in reimbursement opportunities. Doulas also discussed challenges related to schedules, pay, benefits, interactions with medical providers, exposure to traumatic births, access to mental health services, and access to affordable, reliable,

and quality childcare. Doulas “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.” The report also noted that “[a]s 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) […] 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.” Coverage of doula services is an option Medicaid benefit. Since there is limited insurance coverage for doula services, “access to [doula] services is largely limited to families with higher incomes who can afford to pay for such services out-of-pocket.” Doulas acknowledged the importance of training and also discussed “the potential negative consequences of creating a structured pathway to becoming a doula or requiring specific certifications.” Among challenges to trainings and certifications, doulas noted that additional requirements create time and cost barriers. Some doulas stated that “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.” Doulas also noted 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.” The report discussed the impacts of systemic racism and systems of oppression and medicalization that have limited the number of maternal health providers of color, including Black and immigrant midwives. Black and immigrant midwives were primary providers of childbirth care for women of color and women with low-incomes through the early 1900s. With the medicalization of childbirth, “Black midwives came under particularly intense scrutiny and became the targets of efforts to regulate and professionalize their field […] 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. To this day, midwives are disproportionately white.” The Women’s Bureau noted 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.” The Women’s Bureau concluded that, “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 overcome barriers to training and certification, the Women’s Bureau recommended “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 training; and subsidizing the cost of training and certification.”

4. **Mottl-Santiago J., Dukhovny D., Cabral H., et al. Effectiveness of an Enhanced Community Doula Intervention in a Safety Net Setting: A Randomized Controlled Trial. *Health Equity.* 2023;7(1):466-476.**

Mottl-Santiago et al. conducted a randomized controlled trial to compare the impacts of standard maternity care versus standard maternity care plus community doula support on birth outcomes and health equity. The authors stated that community doula support may reduce maternal health inequities. The authors noted, "[w]hile community support during birth has a long tradition within communities of Black Indigenous and People of Color (BIPOC), the reframing of community doula support as a social intervention that reduces disparities in clinical outcomes is recent." The authors examined the impacts of doula support on cesarean birth, preterm birth, and breastfeeding outcomes. They also examined impacts by race/ethnicity. Study participants (n=367) had Medicaid coverage, were pregnant with their first child, had low-risk pregnancies, and were receiving care at an urban safety net hospital. Participants were randomly assigned to either standard maternity care (n=180) or the "Birth Sisters Best Beginnings for Babies" doula care intervention (n=187), which is a hospital-based doula program providing racially and ethnically diverse doula care. Of participants in the intervention group, 91% were matched with a doula who was racially congruent. Overall, the authors found no difference in cesarean section between groups and a trend toward increased breastfeeding initiation. There were no differences in other outcomes examined. When examining outcomes for Black participants, the authors found a 12% reduction in cesarean births and an 11.5% increase in exclusive breastfeeding among Black, non-Hispanic participants (both results were statistically non-significant). However, the authors noted that "this study is the first trial to examine the relationship between racially/culturally congruent doula support and maternal health outcomes." The authors stated that racially/culturally congruent doula support provided in this intervention "addresses historical injustices rooted in the systematic elimination of Black birth workers in the [U.S.] by recognizing the experience and expertise of Black birthing people and their communities […] helps birthing people connect with resources that reduce economic and social barriers to health […and] reduces [inequities] in cesarean birth and breastfeeding outcomes between Black birthing people and those of other races/ethnicities."

5. **Cidro J., Doenmez C., Sinclair S., et al. Putting them on a strong spiritual path: Indigenous doulas responding to the needs of Indigenous mothers and communities. *International Journal for Equity in Health.* 2021;20(189).**

Cidro et al. conducted 5 qualitative interviews with 5 Indigenous doula collectives in Canada. The authors noted that most of the research team is Indigenous and they used Indigenous research methods to inform the study design and execution. The authors explained that, "Indigenous doulas differ from […] mainstream doula care providers because the care is grounded in culture and spirituality and recognizes the sacredness of women as life-givers […]." The authors found that Indigenous doulas responded to community needs by providing harm reduction (i.e., both related to substance misuse and related to the healthcare system) and trauma-informed care; supporting cultural aspects of birthing and family; and navigating socioeconomic barriers (e.g., housing, food, transportation). Indigenous doulas may or may not have a cultural background that matches the birthing person, especially in urban areas where "it is more difficult to have nation-specific traditional teachings." However, Indigenous doulas center culture and spirituality in healthcare settings that often lack or have limited awareness and understanding of Indigenous traditions. Indigenous doulas often have shared experiences with Indigenous birthing people and can help address factors such as discrimination and bias, “systemic racism, fear of medical and social services, and a long history of interactions with child and family services” among Indigenous communities. The authors concluded that support from Indigenous doulas is essential to “counter systemic medical racism and socioeconomic barriers that Indigenous families disproportionately face.” They stated that, “[t]hrough building strong, trusting, and non-judgmental connections with [birthing people] and responding to community needs, Indigenous doulas play a critical role in countering medical racism in hospital settings and advancing the resurgence of Indigenous birthing sovereignty.” The authors noted that, while they spoke specifically with Indigenous doula collectives in Canada, the impacts of systemic racism in healthcare settings is generalizable.

6. **House The White. White House Blueprint for Addressing the Maternal Health Crisis.2022.**

In June 2022, the federal administration released the “White House Blueprint for Addressing the Maternal Health Crisis.” The report stated that the U.S. has the highest maternal mortality rate of any developed country and “[s]ystemic barriers, together with a failure to recognize, respect, and listen to patients of color, has meant that Black and American Indian/Alaska Native […] women, regardless of income or education, experience a greater share of these grave outcomes [i.e., maternal morbidity and mortality], as do rural women.” The intent of the blueprint is to lay out “specific actions that the federal government will take to improve maternal health […] underpinned by a continual focus on advancing equity.” The blueprint includes 5 priorities for action, including: 1) Increase access to and coverage of comprehensive, high-quality maternal health services, including behavioral health services; 2) Ensure people giving birth are heard and are decisionmakers in accountable systems of care; 3) Advance data collection, standardization, harmonization, transparency, and research; 4) Expand and diversify the perinatal workforce; and 5) Strengthen economic and social support for people before, during, and after pregnancy. Specifically, the goal to expand and diversify the perinatal workforce includes incorporating “community-based workers (such as doulas) into the maternal care system” by expanding access to doulas. The report defines doulas as “nonclinical birth workers trained to provide continuous physical, emotional, and informational support to women in the prenatal, birth, and postpartum periods.” Evidence shows that access to community-based doulas is associated with improved maternal health outcomes, including higher rates of emotional satisfaction with their birthing experience, lower rates of maternal and infant health complications, lower rates of preterm birth, and reduced odds of cesarean section. However, only about 6% of women who give birth receive doula care. The report identifies a number of barriers to expanding the doula workforce, including too few pathways to training and certification, poor coverage by insurers, and insufficient reimbursement rates. Notably, “[e]ven in states that have provided for doula coverage through Medicaid, complex billing and credentialing requirements and low reimbursement rates often also impede access to doulas, as they may influence the number of doulas available to provide their services.” Data suggest that over 80% of doulas are white. The report stated that, “diversity in the health care workforce can help address persistent racial and ethnic disparities in health care by improving patient experience, increasing patient satisfaction, and improving access to care for underserved patients. Some experts suggest that disparities in maternal health outcomes could be reduced by increasing workforce diversity and having more culturally congruent maternity care in the U.S., with health care providers of color helping to mitigate cultural barriers in the health care system.” The report also specifically identifies potential impacts of access to doula services for women of color, women who are incarcerated, and active duty military families.

7. **Thomas K., Quist S., Peprah S., et al. The Experiences of Black Community-Based Doulas as They Mitigate Systems of Racism: A Qualitative Study. *J Midwifery Womens Health.* 2023;68(4):466-472.**
Thomas et al. interviewed 5 Black community-based doulas and 2 program directors to explore motivations for becoming a doula, services provided, and challenges faced as a Black doula in perinatal settings. The study participants discussed structural, interpersonal, and internalized racism, and the researchers organized these data using the Levels of Racism framework by Dr. Camara Jones. For example, doulas' own experiences with racism leads to the ability to advocate for and support patients of color. Black doulas experience racism, microaggressions, and harassment from other care providers at the interpersonal level. In addition, marginalized communities who are often served by Black doulas are not able to compensate doulas at the same rate that white doulas are compensated. Programs that supplement Black doula workforce face challenges related to institutional racism due to a lack of funding, advocacy, and organizational support. The doulas in the study also discussed obstacles faced in sustaining and expanding programming. The doulas in the study also emphasized the importance of cultural concordance (shared identity with clients). The study participants named cultural concordance as integral to providing equitable care. For example, white doulas are not able to provide the same level of care for Black patients that Black doulas can provide. The authors conclude with recommendations to support Black doulas.

8. **Health Washington State Department of. Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016.Tumwater, Washington: Washington State Department of Health; October 2019 2019.**
Washington State law (RCW 70.54.450) created the state's Maternal Mortality Review Panel (the Panel) and requires that it submit a report to the Secretary of the Department of Health (DOH) and health committees of the Washington State Senate and House of Representatives. This 2019 report to the Legislature examines maternal deaths between 2014 and 2016 and includes data from the previously published (2017) report. Authors note, "the growing understanding of the complex role that behavioral health issues play in pregnancy led the Panel to examine maternal deaths from suicide and substance overdose for this report." The review was based on birth, hospitalization, and medical records, autopsies, and other available records. While Washington has historically tracked maternal mortality rates, "the most comprehensive review to date [in Washington] was conducted for deaths that occurred in 2014 through 2016." Overall, the Panel found "maternal mortality rates in Washington are not increasing like they are nationally." These maternal mortality reviews identified 100 pregnancy-associated deaths (i.e., "a death during pregnancy or within one year of the end of pregnancy from any cause") in 2014-2016. Of these, 30 deaths were determined by the Panel to be pregnancy-related (i.e., "death occurred during pregnancy or within the first year after pregnancy from a pregnancy complication, a chain of events initated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy"). For the period of 2014-2016, the state pregnancy-related death ratio was 11.2 deaths per 100,000 live births. Women 30 years older had the highest maternal mortality ratio. American Indian and Alaska Native (AI/AN) women experienced higher maternal mortality ratios (53 deaths per 100,000 live births) than any other race/ethnic group (Non-

Hispanic White: 8 deaths per 100,000 live births; Non-Hispanic Black: 9 deaths per 100,000 deaths; Asian or Native Hawaiian or other Pacific Islanders: 14 deaths per 100,000 live births; Hispanic: 17 deaths per 100,000; Multi racial: 19 deaths per 100,000 live births). "Women with private health insurance during or up to one year after pregnancy experienced the lowest pregnancy-related maternal mortality ratios [6 deaths per 100,000 live births] among all groups of insurance type." Those with unknown coverage experienced the highest pregnancy-related maternal mortality ratio (23 deaths per 100,000 live births), and those with Medicaid coverage had a pregnancy-related maternal mortality ratio of 18 deaths per 100,000 live births. The Panel found 69% of deaths from suicide reviewed were pregnancy-related; about half of the natural deaths were pregnancy-related; 13% of those due to accidental substance overdose were pregnancy-related; and none of the deaths due to other injuries were pregnancy-related. Data show "the leading underlying cause of death among pregnancy-related deaths (N=30) were behavioral health conditions, including suicide and overdose (30%, n=11), hemorrhage (20%, n=6) and hypertensive disorders in pregnancy (10%, n=3)." The Panel reported, "pregnancy-related deaths from behavioral health conditions consisted of suicide and accidental substance overdose from diagnoses of substance use disorder, and depression or other mental health conditions [...] Hemorrhage deaths were caused by cervical laceration, ectopic pregnancy, uterine rupture or other hemorrhage (not otherwise specified). Among the deaths due to hypertensive disorders in pregnancy the Panel identified preeclampsia, eclampsia, and HELLP syndrome (a life-threatening pregnancy complication usually considered to be a variation of preeclampsia that can lead to liver rupture or stroke.)" Reviews found, "more than one third of the pregnancy-related deaths occurred during pregnancy (20%) or within 24 hours of a delivery (17%). One third of the pregnancy related deaths (33%) occurred within 42 days after the end of pregnancy, and 30 percent occurred beyond 43 days after the end of pregnancy." While deaths due to hemorrhage and hypertensive disorders of pregnancy occurred on avergae within one and three days from the end of pregnancy, respectively, "deaths related to behavioral health conditions occurred on average 157 days after the end of pregnancy, with a range from zero to 344 days." Data show, all those who died from pregnancy-related causes had health insurance coverage during pregnancy and through the first year postpartum, and the majority of health insurance coverage was through Medicaid. "Among the six women who died while pregnant, five were covered by Medicaid and one had unknown health insurance coverage." Finally, the Panel concluded that 60% of the pregnancy-related deaths were preventable. The Panel categorized contributing factors (N=112) to pregnancy-related deaths as related to systems of care (39%), provider (25%), patient/family (25%), community (6%), or facility (4%) level. Factors identified as contributing to preventable pregnancy-related deaths include "access to health care services, gaps in continuity of care (especially postpartum), gaps in clinical skill and quality of care (including delays in diagnoses, treatment, referral, and transfer), and lack of care coordination at the provider, facility, and systems levels." The review found preventable pregnancy-related deaths from behavioral health conditions were impactedby contributing factors related to knowledge (100%); access/barriers to care (67%); mental health conditions (56%); care/case coordination or management (56%); continuity of care (56%); clinical skill/quality of care (44%); screening/assessment (44%); community outreach/resources (44%); communication (33%); and social support/isolation (22%). Panel recommended six actions to help prevent maternal deaths. See recommendations in the full report. Table 4 estimates the percentage of preventable pregnancy-related deaths that could have been impacted by each type of recommendation made by the Maternal Mortality Review Panel (2014-2016). As part of Priority

Recommendation 3, the Panel recommends, "the Health Care Authority (HCA) should make Maternity Support Services (MSS) available to all women who have Medicaid during pregnancy and through the first year after pregnancy." Additionally, the full Maternal Mortality Review Report provides additional information on pregnancy-associated deaths. Authors recommend interpretations of data presented should be made with caution stating, "while each death is a tragecy, the cohort of maternal deaths for 2014-2016 is relatively small, and slight changes could have resulted in very different percentages." Overall, "the Panel identified several contributing factors to deaths, including gaps in postpartum follow-up care and services, breaks in continuity of care and transfer of care to other providers, and lack of social support and support structures during the first year after pregnancy." Authors state, "these factors affected women who died from suicide and substance overdose, hypertension in pregnancy, and sepsis, as well as women who experienced fetal loss, and loss due to legal removal of an infant from its mother's care."

9. **Van Eijk M. S., Guenther G. A., Kett P. M., et al. Addressing Systemic Racism in Birth Doula Services to Reduce Health Inequities in the United States. *Health Equity.* 2022;6(1):98-105.**

Van Eijk et al. conducted literature and policy reviews and conducted 16 interviews with organizations involved in training, certifying, advocating for, and employing doulas, and informants involved in state policy making. The research was collected March to August 2020. The research examines organizational approaches to addressing racism that could reduce inequities in birth outcomes. The authors cite prior research highlighting that doula care leads to decreased maternal stress, lower rates of C-section, and increased satisfaction with the birth experience. Prior research also shows that "[h]aving access to doulas who understand and have experienced the effects of systemic racism increases a pregnant person's trust and engagement in care and strengthens their agency in decision-making processes." The researchers interviewed both mainstream organizations (n=6) and community-based organizations (CBOs) (n=5). Mainstream organization train, certify, and/or employ doulas to work mostly in hospital environments. CBOs are "rooted in underrepresented communities to work outside of the hospital-based system […]" Overall, study results show that training, recruitment, and funding of doula care varies, and there are specific opportunities to create systemic change. The researchers found that doula training and certification varies. Interviewees highlighted the importance of incorporating information on structural racism into training curriculum focused on maternal health. The two mainstream employer organizations in the study tended to hire doulas who were trained by mainstream organizations and worked primarily in hospital settings. These employers also had a preference for doulas who were certified. CBOs did not place as much emphasis on certification, compared to mainstream organizations. The CBOs in the study that trained and employed doulas offered a full training and offered additional instruction to doulas who had already completed training with a mainstream organization. CBO trainings often focused on racial and reproductive justice and health inequities, while mainstream organizations incorporated entrepreneurship and business skills into their programming. For example, "one CBO started a training program for doulas who wanted to work with Native American communities and address the systemic challenges they faced, because doulas did not learn about communities' poverty and substance misuse in mainstream training programs." Overall, all organization types discussed the importance of including content that addresses structural racism into training curricula. Results also show that CBOs employ doulas who are committed to serve, have lived experience, and a mindset toward racial and social justice and health equity. Hospital-based employers hire doulas who match the racial/ethnic background of the patients served and who would be a good fit for work in a hospital environment. Both types of organizations struggle to fund their programs. The participants identified the following three areas of systems level change: "the importance of addressing structural racism, changing the balance of power in decision making and policy making, and a cautious approach to Medicaid reimbursement." Participants were concerned that "Medicaid reimbursement would create a scope of practice that would not align with the needs of their doulas or communities and would push the expansion of doula services deeper into the hospital hierarchy without addressing the systemic racism embedded in it." In addition, doulas may be hesitant to take on Medicaid clients because "reimbursement rates are low and paperwork is complicated." Researchers have also stated that reimbursement can be complicated because of conflicting certification requirements and difficulties in becoming enrolled providers with managed care organizations. The researchers included study limitations and a call for future research on barriers and challenges faced by doulas in the U.S. healthcare system.

10. **Health Washington State Department of, Commission American Indian Health. Report to the Legislature Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2022 and American Indian Health Commission Addendum to the Washington State Department of Health's Maternal Mortality Review Panel Report to the Legislature "Tribal and Urban Indian Leadership Recommendations September 2022". February 2023 2023.**
This Report to the Legislature prepared by the Washington State Department of Health's (DOH) Prevention and Community Health Division details the findings of the state's Maternal Mortality Review Panel (the Panel) as well as recommendations to prevent pregnancy-related preventable deaths in the future. The Panel identified 224 pregnancy-associated deaths (i.e., deaths from any cause during pregnancy or within 1 year of the end of pregnancy) from 2014–2020, and of these the Panel identified 97 pregnancy-related deaths (i.e., due to pregnancy complication, a chain of events initiated by pregnancy, or aggravation of unrelated condition[s] by the physiological effects of pregnancy). Most pregnancy-related deaths occurred after the end of pregnancy, with 31% occurring 2–42 days after pregnancy (i.e., before the 6-week postpartum exam) and 31 percent occurring 43 days to one year after pregnancy. Moreover, the Panel found that 80% of pregnancy-related deaths in Washington were preventable. The Panel made 6 overarching priority recommendations: 1) undo racism and bias, 2) address mental health and substance use disorder, 3) enhance health care quality and access, 4) strengthen clinical care, 5) meet basic human needs, and 6) address and prevent violence. For example, within these priority recommendations there are recommendations to fund efforts to expand doula care and to connect pregnant and postpartum patients with doulas. Additionally, the Panel noted 2 key areas of focus to significantly improve perinatal care in Washington and reduce maternal mortality: 1) improve behavioral health care during the perinatal period and 2) ensure that all recommendations specifically benefit Black, Indigenous, and People of Color communities. The American Indian Health Commission (AIHC) for Washington State provided an addendum to DOH's report "Tribal and Urban Indian Leadership Recommendations September 2022." AIHC highlighted the Maternal Mortality Listening Sessions it hosted to address American Indian/Alaska Native maternal mortality disparities in Washington State. Leadership identified 2 top priority recommendations: "to reduce Native Maternal Mortality until the disparity is eliminated" and to ensure "access to health care through the continuum of pregnancy and postpartum for both mom

and dad". Additionally, AIHC notes that "[c]ulturally relevant services require that the importance of 'Seven Generation Principles' are understood and integrated into service planning and delivery," and "[r]elevant services also include a healing team [e.g., midwives, doulas, elders, and WIC providers] that is trusted by the Native Pregnant, Birthing, and Postpartum People." Furthermore, support and resources must be available for both parents and "be open to the fact that extended family [especially grandparents] are essential support for American Indian/Alaska Native Pregnant, Birthing, and Postpartum People." Leadership and Community participants also expressed a high level of concern about "the discrimination, racism, and stereotyping that the Native Pregnant, Birthing, and Postpartum people face, which cause high levels of stress and distrust in providers and the healthcare system overall." AICH highlighted significant evidence of the "negative effects of stress and toxic stress which pose developmental concerns for the baby, and emotional and physical health issues for parents and families." AICH recognized "[r]acism and discrimination are core elements in the formation of American society based on centuries old policies, structures, and institutions" and stated, "a substantive recommendation […] would be for the state to analyze and find ways to measure the harms caused by racism in health care systems to create momentum for change." Overall, Tribal and Urban Indian Leadership made 7 recommendations including but not limited to reducing Native Maternal Mortality until the disparity is eliminated; incorporating culturally appropriate engagement and building trust at a community level; improved and expanded access for culturally relevant services and resources throughout the continuum of pregnancy, birth, and postpartum for both parents; and funding, focus, and prioritization to support Tribal-led Workforce planning and development to successfully recruit, train and hire an AI/AN workforce to support the needs of Native pregnant, birthing, and postpartum people.

11. **Midwifery, Chapter 18.50 RCW.**
RCW 18.50 details definitions, requirements, application processes, etc. for the midwifery practice in Washington State.

12. **Guenther G., Kett, P., Skillman, S., Frogner, B. The Birth Doula Workforce in the U.S.: Rapid Response Brief. University of Washington Center for Health Workforce Statistics;2022.**
Guenther et al. published this research brief which highlights the birth doula workforce in the U.S. The authors highlight research gaps and opportunities. There is limited data available on the doula workforce. The researchers state, "[t]here is no comprehensive public or private database available on the doula workforce in the U.S. that could be used to describe the size, distribution, and characteristics of the doula workforce." Further, "The doula workforce is not identifiable in common federal data sources used to estimate workforce size and describe the health workforce broadly such as the Census, American Community Survey, and Occupation Employment and Wage Statistics." For additional context, "[t]hese data sources use a Standard Occupation Code (SOC) to estimate those currently working as doulas. In the Bureau of Labor Statistics, doulas fall under the category of 39-9099. Personal Care and Service Workers, All Other occupational code with butlers, house sitters, shoe shiners, and magnetic healers. It is not possible to determine the number of doulas that fall under this SOC compared to the other occupations in this category. Doulas that work within community-based organizations may also fall under 21-1094.00 Community Health Workers, but it is not possible to distinguish between doulas and other occupations that may fall under this category." The research brief states that in recent

years, there have been increases in the diversity of the doula workforce in the U.S. However, the doula workforce faces challenges with a lack of diversity in the field, witnessing and/or experiencing discrimination, struggling with ineffective or inadequate payment models, experiencing burnout, meeting resistance when collaborating with other perinatal providers, and feeling alienated from mainstream doula groups. Doulas also faced specific challenges from the COVID-19 pandemic, including miscommunication with hospitals, being deemed as "non-essential" workers. The researchers also stated that doulas have shared concerns with state policies that work to reimburse doula services under Medicaid plans. Concerns include "a lack of focus on racial equity, prohibitive training and certification requirements, as well as a potential emphasis on hospital care which could move attention away from local, community-based perinatal services." Due to systemic inequities, pregnant people of color face worse birth outcomes than white peers. For example, people of color, particularly Black and Indigenous people experience higher maternal mortality rates. There are research gaps in exploring systemic issues that underly differences. Regarding payment for services, doula care has historically primarily been paid for out-of-pocket and insurance coverage is limited. This has contributed to doulas often serving white, cis-gendered higher-income people. The training available to doulas varies widely in topic and quality and is often either aimed toward doulas working in hospital settings or to doulas providing care in community settings. Many community-based doulas provide care on a sliding scale or free of charge to increase access to care. Certification for providing doula care is not currently a requirement. Certification takes time and money to complete. Doulas are typically employed by either a commercial or community-based organization. The researchers stated, "Often among [hospital-based organizations], there is a preference for hiring commercially trained and certified doulas for employment." Outside of formal employers, doulas are often hired independently by clients. The research brief also includes policies and programs intended to expand the doula workforce in the U.S. The researchers discuss Medicaid policy and practice implications for doula reimbursement. The research shows that Medicaid reimbursement can provide doulas with steady income and improve the affordability of care. Evidence shows that 43% of pregnancies in the U.S. are covered by Medicaid and people of color are disproportionately served by Medicaid. However, a study found that no state policies included a clear focus on improving racial equity nor guaranteed a living wage for doulas. Further challenges include low reimbursement rates, limitations on the number of billable appointments, and concern that reimbursement will move doula care away from community-based settings and toward hospital settings. Additional concerns are related to training and credentialing requirements, which cost time and money. The researcher recommends that state Medicaid programs "enable the CMS Preventive Services Rule to allow for state coverage of non-licensed care providers, which would permit doulas to provide their services independently of medical providers." The researchers also recommend awareness campaign efforts related to doula care and engaging doulas in the policy development process.

13. **Private Insurance Coverage of Doula Care: A Growing Movement to Expand Access. 2023; Available at: https://healthlaw.org/private-insurance-coverage-of-doula-care-a-growing-movement-to-expand-access-2/. Accessed 1/25/2024.**
This National Health Law Program webpage provided an overivew of private insurance coverage of doula care in the U.S. as of March 14, 2023. Rhode Island became the first state to pass legislation in 2021 requiring doula coverage in private insurance plans. "The law applies to all fully insured commercial plans offered by a Rhode Island licensed insurer and issued after July

1, 2022. [...] individuals are [...] guaranteed doula coverage if they purchase a plan through the Rhode Island health insurance exchange or receive coverage through a Rhode Island employer with less than [50] employees (excluding self-insured plans)," reported the National Health Law Program. Each plan is permitted to define its coverage. Several other states (California, Indiana, Massachusetts, Missouri, New York, and Virginia) are considering expanding private coverage of doula care either by requiring or encouraging health care cservice plans and insurers to cover this care. The program noted, "addressing racial disparities in maternal care, particularly among Black pregnant and postpartum people, requires action across income levels. A recent study found that maternal and infant health mortality rates remain disproportionately high even among wealthy Black families." At the time of publication, "most doula services are paid for out-of-pocket, with costs often reaching upwards of $1,500 per birth [...] costs pose a barrier for people with limited financial resources, leaving those who would most benefit from doula care without access." The program cited evidence that 6% of birthing people in 2015 reveived doula care, and many more report desiring but not having access to doula care.

14. **Doula care pilot program for Medicaid members. 2023; Available at: https://www.uhc.com/news-articles/community/doula-network. Accessed 1/24/2024.**
This UnitedHealthcare (UHC) webpage detailed a doula care pilot program for Medicaid members in 5 states, including Washington State. The partnership with The Doula Network provided, 5 doula care visits (4 perinatal visits plus labor support), in-person labor support at birthing location, phone or email support between visits, 24/7 on-call support from 37 weeks until birth, and social determinants of health screening and support. UHC stated, "[d]oulas have been found to improve clinical outcomes, especially for people of color. In addition, doulas may offer support as a patient advocate and familiar face in navigating a clinical environment that can be overwhelming. The pilot will match members with doulas of similar background, race, language, ethnicity, as much as possible."

15. **Doula Medicaid Project. 2024; Available at: https://healthlaw.org/doulamedicaidproject/. Accessed 1/24/2024.**
This National Health Law Program webpage documented information about the Doula Medicaid Project which "seeks to improve health outcomes for Medicaid enrollees by ensuring that all pregnant and postpartum people enrolled in Medicaid who want access to a doula will have one." The program tracks current state doula Medicaid efforts and compiled data about each state's and DC's efforts (e.g., enacted legislation, implementation). As of January 2024, 12 states (California, Florida, Maryland, Massachusetts, Michigan, Minnesota, Nevada, Oklahoma, Oregon, Rhodes Island, and Vermont) and DC had implemented and were actively reimbursing doula services on Medicaid plans. Of those, 11 states and DC developed and implemented a credentialing process. In Florida, each plan can determine credentialing procedures and how the benefits are rolled out. Another 11 states (Colorado, Connecticut, Delaware, Illinois, Louisiana, New Hampshire, New York, Ohio, Pennsylvania, Tennesee, and Utah) were in the process of implementing Medicaid doula benefits.

16. **Methods to secure doula reimbursement approval from CMS. In: Clinical Quality and Care Transformation WSHCA, ed2020.**
The Washington State Health Care Authority (HCA) published this report to the legislature to provide recommendations on how to reimburse for doula services for Washington Apple Health

(Medicaid). HCA and the Washington State Department of Health formed a workgroup to consult with stakeholders and make recommendations on how to reimburse for doula services in Washington. Doulas and doula partners were involved in discussions during the spring and summer of 2020. The workgroup examined the two primary options from the Centers for Medicare and Medicaid Services (CMS) for doula reimbursement: 1. Non-credentialed route where doulas would need to establish a relationship with a billing and supervising provider who would bill Apple Health on the behalf of the doula; or, 2. Credentialed route where doulas would need to be credentialed through DOH allowing them to bill Apple Health directly. Doula partners/stakeholders have shared with us their unified position to not pursue the noncredentialed route.

17. **Engrossed Substitute House Bill 1881 - Birth Doulas, Revised Code of Washington(2022).**
ESHB 1881 (Chatper 217, Laws of 2022) created a new credentialed health profession for birth doulas (Chapter 18.47 RCW).

18. **RCW 18.47.010 - Definitions., Revised Code of Washington(2022).**
RCW 18.47.010 defines terms relevant to the doula chapter of law (chapter 18.47 RCW) including the department, birth doula, postpartum period, and secretary.

19. **RCW 18.47.020 - Certification requirements., Revised Code of Washington(2022).**
RCW 18.47.020 details the voluntary certification that doulas may apply for thorugh the Washington State Department of Health.

20. **RCW 18.47.040 - Birth doula without certification—Permitted., Revised Code of Washington.**
RCW 18.47.040 states that nothing in the law prohibits a person from practicing as a birth doula without obtaining certification under this chapter.

21. **RCW 18.47.030 - Competency-based requirements—Administration—Fees., Revised Code of Washington(2022).**
This Washington State RCW details competency-based requirements, administration, and fees for state certification of birth doulas.

22. **Chapter 246-835 WAC - Birth Doula, Revised Code of Washington(2023).**
Chapter 246-835 WAC details the Washington State Department of Health's (DOH) rules and regulations implementing the state-certified doula program established in chapter 18.47 RCW.

23. **Frequently Asked Questions - Birth Doulas. 2023; Available at: https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/birth-doulas/frequently-asked-questions. Accessed 1/23/2024.**
This Department of Health webpage answers frequently asked questions regarding state-certification of birth doulas.

24. **RCW 43.70.250 - License fees for professions, occupations, and businesses., Revised Code of Washington(2023).**

RCW 43.70.250, License fees for professions, occupations, and businesses, (2023). Chapter 43.70 RCW pertains to the Washington State Department of Health (DOH). Under RCW 43.70.250, the cost of professional, occupational, or business licensing programs administered by DOH must be "fully borne by members of that profession, occupation, or business." The statute includes a provision which prohibits the Secretary of Health from imposing any certification, examination, or renewal fee upon a person seeking certification as a certified peer specialist trainee between July 1, 2025, and July 1, 2030, and limits fees to no more than $100 for any person seeking certification as a certified peer specialist.

25. **Health Washington State Department of. Birth Doula Notice Certification Fees. Tumwater, WA2023.**
This notice from the Washington State Department of Health (DOH) announced that DOH was waiving all fees listed in WAC 246-835-990 until July 1, 2025, as it received General Fund State dollars to fund the program in Fiscal Years 2024 and 2025.

26. **Chapter 18.130 RCW - Regulation of health professions - Uniform Disciplinary Act, Revised Code of Washington.**
Chapter 18.130 RCW, or the Uniform Disciplinary Act, is meant to "strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions and businesses by providing a uniform disciplinary act with standardized procedures for the licensure of health care professionals and the enforcement of laws the purpose of which is to assure the public of the adequacy of professional competence and conduct in the healing arts." All newly credentialed health and health-related professions come under the act.

27. **Disparities Governor's Interagency Council on Health. December 2015 Update State Action Plan to Eliminate Health Disparities.Tumwater, WA December 2015 2015.**
This report from the Governor's Interagency Council on Health Disparities (Council) to the Washington State Governor and the Legislature presented the Council's second set of recommendations to eliminate disparities in adverse birth outcomes. Specifically, the Council recommended "the Legislature should provide the Health Care Authority funding to provide Medicaid reimbursement for doulas..." The report cited evidence showing the benefits of doula care (e.g., decreased cesarean rates, improved breastfeeding rates, lower use of pain medications and vacuum extraction or use of forceps).

28. **Disparities Governor's Interagency Council on Health. Report to the Legislature: Literature Review on Inequities in Reproductive Health Access (Chapter 119, Laws of 2018).2019.**
In 2018, the Washington State Legislature passed the Reproductive Parity Act (Chapter 119, Laws of 2018). Among other provisions, the law directed the Governor's Interagency Council on Health Disparities (Council) to conduct a literature review on disparities in access to reproductive healthcare and to provide recommendations for reducing or eliminating inequities. On January 1, 2019, the Council submitted its “Literature Review on Inequities in Reproductive Health Access” to the Governor and appropriate legislative committees. The report included discussion of 45 unique barriers identified through a review of literature. Barriers were further grouped into three categories: Economic, Structural, or Social. The Council approved 14 recommendations included in the report, which were informed by the review of literature,

conversations with key informants, and reports authored by state agencies and community-based organizations. While not comprehensive, recommendations represent actions that would reduce disparities in accessing reproductive healthcare for multiple people and groups experiencing inequities in Washington State.

29. **Bohren M. A., Hofmeyr G. J., Sakala C., et al. Continuous support for women during childbirth. *Cochrane Database Syst Rev.* 2017;7(7):CD003766.**
In 2017, the Cochrane Collaborative conducted a systematic review related to continuous support for women during childbirth. Specifically, the Cochrane Collaborative evaluated "the effects, on women and their babies, of continuous, one-to-one intrapartum support compared with usual care, in any setting." One variable studied was the impact of having a person "present solely for the purpose of providing continuous support, e.g., a doula". The systematic review included evidence from 27 clinical trials conducted in 17 different countries, including 13 high-income settings. The review found that, "continuous support was most effective at reducing Caesarean birth, when the provider was present in a doula role […]" Overall, "continuous support during labour may improve outcomes for women and infants, including increased spontaneous vaginal birth, shorter duration of labour, and decreased caesarean birth, instrumental vaginal birth, use of any analgesia, use of regional analgesia, low 5-minute Apgar score, and negative feelings about childbirth experiences." Two trials also found women were less likely to develop symptoms of postpartum depression.

30. **Sobczak A. , Taylor L., Solomon S., et al. The Effects of Doulas on Maternal and Birth Outcomes: A Scoping Review. *Cureus.* 2023;15(5):e39451.**
Sobczak et al. conducted a scoping review to "synthesize the existing literature on how doulas might improve birth outcomes." The scoping review excluded systematic reviews and meta-analyses. Among additional inclusion criteria, the review included articles published between January 1, 2000 and December 31, 2021, written in English, peer-reviewed, conducted in more economically-developed countries, involving women without high risk pregnancies, and involving doula support. Sixteen articles met the inclusion criteria and were rated as "good quality" evidence. Overall, the authors found that doula guidance in perinatal care was associated with reduced cesarean sections, premature deliveries, length of labor, epidural use, and anxiety and stress for the birthing person and reduced risk of low birth weight and mortality in infants. Doula guidance also increased confidence and autonomy of the birthing person during labor. Among women with low-incomes, the authors also found that doula guidance was associated with increased breastfeeding success, quicker lactogenesis, and continued breastfeeding 6 weeks after childbirth. One study found that doula guidance was associated with increased carseat use. For example, a study with 298 women with Medicaid coverage who received doula care found a 52.9% decrease in the risk of cesarean section and a 57.5% decrease in rates of postpartum depression and anxiety compared to people without supportive care. The authors also cited previous research showing that women with low-incomes, women of color, and women with limited English proficiency experience worse birth outcomes. They stated that doulas can "mitigate health disparities in groups at risk due to racial and socioeconomic stigmas via their roles as intermediaries between pregnant [people] and healthcare staff." The authors noted that doulas help to provide emotional, tangible, informational, appraisal, and physical support during labor and childbirth.

31. **Hardeman R. R., Kozhimannil K. B. Motivations for Entering the Doula Profession: Perspectives From Women of Color.** ***J Midwifery Womens Health.*** **2016;61(6):773-780.**
Hardeman and Kozhimannil conducted semi-structured interviews with 12 newly-trained doulas of color in the Minneapolis, MN metropolitan area to explore motivation and satisfaction with doula work. The results of the interviews showed that the main underlying motivation for many to become a doula is related to a desire to support pregnant people from the doula's own racial, ethnic, and cultural community. Interview results also showed that reasons for motivation and satisfaction included: perceiving birth work as a "calling;" easing women's transitions to motherhood by "holding space;" honoring the ritual and ceremony of childbirth; and providing culturally-competent support, often as the sole source of cultural knowledge during labor and delivery. The authors recommend recruitment and retention of women of color as doulas to support broader efforts to reduce birth-related health inequities.

32. **Knocke K, Chappel A, Sugar S , et al. Issue Brief | Doula Care and Maternal Health: An Evidence Review. U.S. Department of Health and Human Services; 12/13/2022 2022.**
This 2022 Issue Brief from the U.S. Department of Health and Human Services (HHS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides a review of evidence specific to doula care and maternal health. Authors note that while the brief generally refers to women, the content is inclusive of every person giving birth, irrespective of gender identity or demographic background. It cites evidence that "Black and American Indian and Alaska Native women experience substantially higher rates of severe maternal morbidity and mortality than White women, irrespective of educational attainment" and that these differences in outcomes can be attributed to factors (e.g., inequities in housing, environmental conditions, economic opportunity, and access to healthcare) which are in large part "the result of inequitable policies due to discrimination – both structural and interpersonal." Evidence indicates that Medicaid covers over 40% of all births in the U.S. and 60% of all U.S. births among Black and American Indian and Alaska Native people. Thus, Medicaid is an important source of coverage for populations experiencing poor maternal health outcomes. Additionally, rural communities, where access to perinatal care is often limited, experience higher probability of severe maternal morbidity and mortality than those in urban areas. Doulas provide their clients education and emotional support, affirmation and advocacy, and assistance navigating health systems. As trusted members of the community, doulas are well positioned to address issues of discrimination and other drivers of health disparities by "bridging language and cultural gaps and serving as health navigators." Additionally, they often provide services tailored to the needs of the community they serve including prenatal and postpartum home visits, which reduce travel and logistic issues for clients; breastfeeding education and consultation; and referral and navigation support for additional needs like social services. These services may be especially important for Black and American Indian and Alaska Native women, "who have been historically marginalized in institutions both inside and outside of health care, and thus may face more barriers addressing services and experience far worse maternal health outcomes." The brief highlights research that doulas positively impact several maternal and infant health outcomes and experiences. For example, "[a] randomized control trial on doula home visit services found women who received doula services were more likely than women enrolled in case management to attend classes ahead of their delivery and practice infant safety measures, including back-sleeping for infants and appropriate car seat use." The brief also highlights challenges regarding

public and provider education and awareness of the doula workforce. For example, evidence indicates that awareness of doula services may vary by race. “One study found Black women were less likely to be aware of doula care services, with [37%] of Black women indicating they felt knowledgeable about doula care, compared to [87%] of [w]hite women,” stated HHS. Moreover, friction between clinical providers and doulas, or lack of respect for doulas by health care providers can limit the potential to improve patient experiences and clinical outcomes. The doula workforce also faces challenges obtaining payment from health insurance for services provided. Authors cited evidence that Many doulas operate as solo practitioners and lack the capacity and infrastructure to manage health plan contracting and billing requirements, generally requiring clients to pay out-of-pocket without using insurance. Furthermore, where Medicaid reimbursement is available for doula services, the level of payment, ease of enrolling in insurance arrangements, and administrative burden of getting paid may affect access and availability of doula services. Insurance coverage and adequate reimbursement of services are likely critical to establish doula care as a financially viable profession. Specific to training, HHS cites research that “[d]oulas can benefit from training on how maternal health experiences differ by race, ethnicity, and other factors, and combining this training with recruiting doulas in greater numbers from the communities they serve (sometimes referred to as community-based doulas) can contribute to the provision of culturally appropriate and trauma-informed care that can improve outcomes.” HHS details policy efforts to expand doula care (e.g., by CMS, Health Resources and Services Administration, Office of Minority Health, Department of Defense, Office of Personnel Management, and Department of Justice), particularly for Black and American Indian Alaska Native people who experience worse perinatal health outcomes, and notes it has the potential to reduce disparities in clinical outcomes and improve care experiences. HHS concluded, “If implemented with a focus on equitable access to doula services and coupled with other initiatives to improve maternal health, doula care can help address longstanding racial disparities in maternal health outcomes.”

33. **Mallick L. M., Thoma M. E., Shenassa E. D. The role of doulas in respectful care for communities of color and Medicaid recipients. *Birth.* 2022;49(4):823-832.**

Mallick et al. analyzed survey data from 1,977 women as part of the 2018 “Listening to Mothers in California Survey,” which is a representative survey of women aged 18 years and older who had a singleton birth at a California hospital between September 1 and December 15, 2016. Of respondents, 15.7% were supported by a doula. The survey included questions related to the experiences of the mother during prenatal, intrapartum, and postpartum periods. The authors used survey data to examine associations between doula support and respectful care, which was defined as communication of information, being afforded respect in voicing concerns, and being involved in the decision-making process. The authors noted that “racialized groups, low-income people, and people who receive Medicaid insurance in the [U.S.] experience mistreatment, discrimination, and disrespectful care more of then people with higher income or who identify as white.” They stated that doulas may be able to counter inequities by promoting respectful care. Overall, the authors found that the odds of respectful care was 40% higher among people supported by a doula compared to those without doula support. Specifically, Black birthing people, Asian/Pacific Islander birthing people, and birthing people on Medicaid experienced the greatest increased odds in respective care. Among birthing people with Medicaid coverage, the odds of reporting respectful care was 80% higher among birthing people who had doula support compared to those that did not (which was statistically significant).

34. **Reed R., Nguyen A., Armstead M., et al. "An extra layer of pressure to be my best self": Healthcare provider perspectives on how doulas foster accountability and bridge gaps in pregnancy-related care. *SSM - Qualitative Research in Health.* 2023;3(100259).**
Reed et al. conducted qualitative interviews with 28 physicians, certified nurse-midwives, and nurses at 6 hospitals in San Fransisco that partner with a doula organization to provide care. The intent of the interviews was to understand provider perceptions of doulas on perinatal care. As part of a 2019 survey of 129 providers at 2 hospitals, the researchers found that 70% of providers agreed that community-based doulas can help address implicit bias and discrimination and 80.5% agreed that community-based doulas can help reduce inequities. Sixty percent of providers stated that the presence of community-based doulas at a birth helps to foster trust. The researchers conducted qualitative interviews from November 2021 through April 2022. Overall, providers reported an increase in personal responsibility to patients in the presence of doulas, which "at times, mitigated racism and implicit bias in clinical settings." Providers also stated that doulas bridged gaps in care by providing continuous labor support. Overall, the authors reported that doula presence had a positive impact on healthcare providers' experience providing care and on their perception of patients' experience of care. The authors stated, "[d]oulas may be critical for birthing people who are most likely to experience mistreatment due to racism and other dimensions of oppression." The authors cited previous research showing that people of color experience higher rates of mistreatment in healthcare settings, and particularly in hospital settings. They noted that doulas "bear witness to disrespectful care during childbirth. Their presence can mitigate, but not eliminate, the impact of obstetric violence and racism." The authors also noted that providers indicated "that patients who do not speak English would most benefit from doula support."

35. **Lentz J. The Doula Model in American Health Care in the 21st Century: A Narrative Literature Review. *Journal of Hospice & Palliative Nursing.* 2023;25(1):18-23.**
Lentz published this narrative literature review outlining the doula model that has been used in the U.S. An overview of how doulas do their work is included in the review. The author concludes with a call for additional research on the doula workforce.

36. **Statistics U.S. Bureau of Labor. Occupational Employment and Wage Statistics. 2022.**
The U.S. Bureau of Labor Statistics publishes occupational employment and wage statistics. Data on the doula workforce is not available through the U.S. Bureau of Labor Statistics Standard Occupational Classification (SOC) Code database.

37. **Search NPI Records. U.S. Department of Health and Human Services.**
Centers for Medicare & Medicaid Services CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign unique identifiers to health care providers. The National Provider Indentifier (NPI) has been the standard identifier for all HIPAA-covered entities (health care providers) since May 23, 2007. Small health plans were required to obtain and use an NPI by May 23, 2008. NPI Registry Public Search is a free directory of all active NPI records. Records are available for some doulas working in the U.S. and in Washington State. There are currently 515 people with NPIs associated with "doula" in Washington State.

38. **Nguyen A. *A Survey of Birth Doulas: Medicaid Reimbursement in Washington State*: Health Services, University of Washington; 2020.**
Nguyen published this thesis as part of program requirements for a Master of Public Health degree program. Nguyen administered a web-based survey from November 2019 to January 2020 to gather demographic information about the doula workforce in Washington State, explore state Medicaid reimbursement for doula services, and examine how birth doulas do their work and receive compensation for that work. Surveys were sent to 773 doulas in Washington State who were registered on Doulamatch.net, a web platform designed to connect people seeking doulas to doulas in their area. The survey was also shared with several doula organizations. 201 survey responses were included in the analysis. The majority of survey respondents were female (96.6%) and between the ages of 21 and 59. The respondents identified as white only (67.4%), multiracial or multiethnic (11.8%), Black or African American only (7.6%), Hispanic, Latino, or Spanish only (4.2%) and African only (3.5%). All respondents who identified as African only also shared that they identified as Somali. Less than 15% of survey respondents have worked with Tribes or Tribal Nations. The results show that 13% of survey respondents spoke two or more languages. Among survey respondents, 60.3% identified as straight (heterosexual), 15.9% identified as bisexual, and 8% identified as queer. The majority (70%) of survey respondents reported using public assistance at some point in their life, and 48.6% reported that they had given birth while enrolled in Medicaid. The majority of survey respondents reported working in King, Pierce, and Snohomish counties. Over half of Washington State counties had less than 5 doulas providing care in that area. Almost half of respondents reported that they are volunteers or work on a pro bono basis. The majority of survey respondents (almost 97%) had received formal training to become a doula, and 41.1% had obtained certification. Most doulas received certification through DONA International (57.1%) or PALS Doulas (16.7%). The researcher includes specific recommendations regarding ways to best serve birthing people through Washington State Mediciad reimbursement. The researcher calls for diversification of the workforce, for the Washington State Health Care Authority (HCA) to explore pathways for trained, non-certified doulas to be reimbursed through Medicaid, for HCA consultation with community-based doula programs, and for HCA to explore additional billing options.

39. **Abortion and Pregnancy Data. In: Health WSDo, ed2022.**
The Washington State Department of Health (DOH) collects information on pregnancy in Washington State from birth certificates, fetal death certificates, and the abortion reporting system. Data from DOH show that in 2020 (the most recent data available), there were 1,494,885 people of childbearing age (aged 15 to 44 years) and 99,613 pregnancies among Washington State residents. Data also show that in 2021, there were 83,899 live births in Washington State. DOH data show that in 2022, 72.0% of people giving birth received prenatal care starting in the first trimester of pregnancy.

40. **Data for Washington 2022; Available at: https://www.marchofdimes.org/peristats/data?reg=99&top=2&stop=1&lev=1&slev=4&obj=1&sreg=53. Accessed, 2024.**
March of Dimes publishes state level data on fertility rate. Fertility rates presented for 1990-1999 are calculated using Census 1990-based population estimates. Calculations for 2000-2009 use Census 2000-based population estimates. Calculations beginning in 2010 use Census 2010-based population estimates.

41. **Wint K., Elias T. I., Mendez G., et al. Experiences of Community Doulas Working with Low-Income, African American Mothers. *Health Equity.* 2019;3(1):109-116.**
Wint et al. conducted in-depth interviews with 10 doulas to explore the components of their services that might best serve low-income, Black people and explore how doulas impact birth experiences. Doulas were recruited from a local community doula program and through word of mouth. The researchers sorted results into the following themes: The influence of similarities of race, culture, and lived experience on doula care; how doulas often provide birthing persons with support and resources beyond birth; and how doulas recognize the institutional biases that exist in the health care system and try to mediate their effect on birthing persons. The researchers found that doulas can support birthing people to mitigate the harmful effects of racism, classism, and additional social determinants of health. The study found that racial concordance in concert with a similarity in life and cultural experience fosters a trusting relationship between patient and doula. The results also show that doulas provide additional supports and resources outside of traditional birth roles. For example, community doulas may provide transportation or go through their own children's clothing to give to birthing clients. Lastly, the study found that doulas recognize and navigate institutional biases in the hospital system. Doulas may step in and speak up on behalf of clients (e.g., suggesting a change of doctors, holding hospital staff accountable for their language and behavior, etc.). The study authors include limitations, and conclude the paper with recommendations for future work on "exploring the clinical impact of community doulas on various racial and socioeconomic populations, reducing barriers to access, and how to communicate doula benefits, with an emphasis on doulas work to mediate the effects of institutional biases."

42. **Department of Health & Human Services Center for Medicaid and CHIP Services. Title XIX State Plan Amendment (SPA), Transmittal #22-0020. 2022.**
The State Plan Amendment submitted by New Jersey includes information and requirements related to Medicaid reimbursement for doula care.

43. **Office of the Governor Commonwealth of Virginia. Doula Services. 2021.**
The State Plan Amendment submitted by Virginia includes information and requirements related to Medicaid reimbursement for doula care.

44. **Kennedy C.E., Yeh P.T., Gholbzouri K., Narasimhan M. Self-testing for pregnancy: A systematic review and meta-analysis. *British Medical Journal Open Access.* 2022;12(e054120).**
Kennedy et al. conducted a systematic review and meta-analysis evaluating the effectiveness of pregnancy self-testing and values and preferences of pregnancy testing for pregnant people and healthcare workers. The authors compared the effectiveness of urine self-testing for pregnancy versus health worker-led pregnancy testing. The authors identified 4 randomized control trials demonstrating that effectiveness of self-testing for pregnancy was no different than health worker-led testing. The authors identified 18 studies that used primary data collection (8 qualitative and 4 quantitative) that examined values and preferences related to self-testing for pregnancy. The majority of articles (12) followed people after receiving a medical abortion and 6 articles studied general pregnancy test users. Five studies were conducted in the U.S. Overall, the authors found that pregnancy self-testing was preferred due to the timeliness of results,

convenience, confidentiality, privacy, cost, and accuracy. Study participants also noted ability to access, informed decision-making, health decision-making, coercion, self-determination, and seeking redress. The authors concluded, “[b]ecause pregnancy self-testing is commonplace in many settings, it is perhaps unsurprising that not many studies have examined the comparative effectiveness of this intervention on home use versus facility-based access, except in specific circumstances like postabortion care and community health worker programmes.” The authors noted that, “[e]nsuring universal access to pregnancy self-testing may encourage more women and girls to seek early antenatal care, which is a critical opportunity for health workers to deliver care and support during pregnancy, thus contributing to better health outcomes for women, newborn[s], and children.” The authors stated that the systematic review was conducted to inform a guideline set by the World Health Organization (WHO). In 2021, WHO published a recommendation to “[make] self-testing for pregnancy available as an additional option to health worker-led testing for pregnancy, for [people] seeking pregnancy testing.”

45. **Ibrahim B.B., Interrante J.D., Fritz A.H., et al. Inequitites in Availability of Evidence-Based Birth Supports to Improve Perinatal Health for Socially Vulnerable Rural Residents. *Children.* 2022;9(1077).**
Ibrahim et al. conducted a national survey of 93 rural hospitals (32.6% response rate) offering inpatient care for labor and delivery in order to determine the availability of evidence-based support services to promote perinatal health in rural communities. About 36% of hospitals responding were located in the West. Survey questions asked about availability of evidence-based supports (including availability of birth doulas). For each rural hospital, the researchers calculated a Social Vulnerability Index using methods developed by Centers for Disease Control and Prevention (CDC), which includes consideration of 4 areas of social and structural determinants of health and health inequities (i.e., socioeconomic status, household composition and disability, minority status and language, and housing and transportation). Social Vulnerability Index scores “indicated higher social vulnerability for [rural counties with majority Black, Indigenous, People of Color populations], with a median score approximately twice that of the majority-[w]hite, non-Hispanic counties.” Overall, they found that rural communities had significantly less availability of certified lactation support, midwifery care, doula support, postpartum support groups, and childbirth education classes. About half of rural communities did not have doula care available, and communities that were most vulnerable were significantly less likely to have doula care available (33.3% of most vulnerable communities had doula care compared to 59.7% of less vulnerable communities). The researchers concluded, “[r]esidents in the most socially vulnerable rural counties, many of whom are [Black, Indigenous, People of Color] and thus at higher risk for poor birth outcomes, are significantly less likely to have access to evidence-based supports for maternal and infant health”, including access to doula care.

46. **Bey A., Brill, A., Porchia-Albert, C., Gradilla, M., Strauss, N. . Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. Ancient Song Doula Services, Village Birth International, Every Mother Counts;2019.**
Ancient Song Doula Services, Village Birth International, and Every Mother Counts published this report outlining New York State's Medicaid coverage plan pilot program, and included research on doula care and recommendations. The report states, "[e]xtensive, reliable research shows that doula care is a high-value model that improves childbirth outcomes, increases care

quality, and holds the potential to achieve cost savings." The report includes 7 recommendations: 1) Adjust reimbursement rates to ensure that doulas have the opportunity to earn a living wage; 2) Collaborate with and invest in community-based doula programs to ensure that doulas enrolled in Medicaid reimbursement programs are equipped to serve communities of color and low-income communities; 3) Support best practices through the pilot design, including ensuring adequate training, certification, supervision, mentorship and peer support to appropriately serve communities of color and low-income communities; 4) Develop a comprehensive approach to wellness and support by ensuring organizations or agencies are equipped with the structure, relationships, and processes in place to provide a coordinated network of referrals; 5) Provide funds to train and certify a diverse doula workforce, specifically from underserved rural and urban low-income communities, communities of color, and communities facing linguistic or cultural barriers. 6) Incorporate community engagement as an essential component to improve health equity, and 7) Take active steps to raise awareness about the benefits and availability of community-based doulas.

47. **Canales B. , Sloane E. . Addressing Racism in Medicine with Community-Based Doula Services for Black Mothers, a Narrative Review of the Literature and Historical Perspective. *Marshall Journal of Medicine.* 2023;9(4).**
Canales and Sloane conducted a literature review to assess the effect of doulas on decreasing the discrepancy between mortality rates of Black and white birthing people. Additionally, they conducted a historical review to "examine how the history of racism in obstetrics and gynecology may continue to impact patient care and outcomes today." Two non-fiction books were referenced for the historical background, Medical Bondage: Race, Gender, and the Origins of American Gynecology by Diedre Cooper Owens and Birthing a Slave: Motherhood and Medicine in the Antebellum South by Marie Jenkins Schwartz. The article highlighted, "Many advancements in early obstetrics and gynecology were made through oppression and experimentation on enslaved Black women without their consent" with "the sole purpose of persevering enslaved women and their offspring to perpetuate a population of bonded laborers." Authors acknowledge that "Black women […] played a fundamental role in furthering medical knowledge and often paid the ultimate price." Experiments and abuses during the time of slavery contribute to both the dread and mistrust of physicians by Black patients and the perpetuation of stereotypes in the medical industry about Black patients (e.g., pain tolerance). Furthermore, "inequities and biases still exist in the care of Black women today." Researchers used the NIH PubMed database for their search and reviewed a variety of review articles and original articles. Researchers cited evidence that "Black women experience maternal mortality rates 2.9 times higher than non-Hispanic white women" and detail contributing factors, including chronic health issues, lack of access to quality health care, implicit bias, and structural racism. Moreover, adverse birth outcomes for Black women are seen across the socioeconomic spectrum, including for more educated wealthy Black women compared to less educated and lower-income white women. They cite evidence that experiences of racism and disrespect during pregnancy contributes to adverse birth outcomes experienced by many pregnant women of color, including premature birth, maternal morbidity and mortality, and increased risk of death for infants in the first 100 days of life. Literature shows continuous labor support and doula care improve outcomes for women and infants. Authors cite evidence that "Black women who use doulas report that doulas help them understand and feel seen and heard by medical providers during their prenatal appointments." By building trust with their clients, doulas "can facilitate a

more trusting relationships between the patient and the medical provider, making patients more likely to trust and follow their provider's recommendations." A study in Brooklyn found that "doula services can aid in addressing birth disparities among higher-risk groups, including women of color and those who [have low income]." Authors also note challenges including that the population of doulas in the U.S. (60% white, 15.18% Hispanic or Latinx, and 9.8% Black) does "not accurately reflect the population of expectant [people] who might gain the most from doula support." They recommend actions that insurance providers and states should take to improve access to doula services, particularly for high-risk birthing people.

48. **Prather Cynthia, Fuller Taleria R., Marshall Khiya J., IV William L. Jeffries. The Impact of Racism on the Sexual and Reproductive Health of African American Women. *Journal of Womens Health (Larchmt).* 2016;25(7):664-671.**
Prather et al. use the socioecological model to describe racism and its effect on African American women's sexual and reproductive health. Authors examine the historical context of racism (e.g., medical experimentation) as well as institutional racism (society), personally mediated racism (neighborhood/community), and internalized racism (family/interpersonal supports and individual). Authors concluded, "[i]n both historical and contemporary contexts, race-based mistreatment has been shown to place African American women at increased risk for HIV/STIs, pregnancy-related complications, and early mortality."

49. **Taylor J. Promoting better maternal health outcomes by closing the Medicaid postpartum coverage gap. The Century Foundation**
The Commonwealth Fund;2020.
This report from the Century Foundation and Commonwealth Fund discuss inequities due to racism in maternal morbidity and mortality. The report states that, "because so many women of color are covered by Medicaid, and because many maternal deaths and health complications occur within one year after giving birth, extending postpartum coverage to at least one year is an essential tool to reduce maternal mortality, eliminate racial and ethnic health disparities, and advance health equity." The Century Foundation and Commonwealth Fund conducted key informant interviews in Illinois, New Jersey, and South Carolina with Medicaid directors, researchers, physicians, local elected officials, community-based health care workers, and individuals with pregnancy-related Medicaid coverage to understand the impact of Medicaid loss after 60 days postpartum.

50. **Hill L., Artiga S., Ranji U. Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Kaiser Family Foundation;2022.**
This report from the Kaiser Family Foundation (KFF) summarizes data related to maternal mortality and perinatal health outcomes. KFF analyzed publicly available, federal data sources from the Centers for Disease Control and Statistics (CDC) and U.S. Government Accountability Office (GAO). Data show that Black and American Indian and Alaska Native birthing people have higher rates of mortality, preterm births, and low-birthweight births compared to white women. Black birthing people are also almost twice as likely to have a birth with late or no prenatal care compared to White women (9% versus 5% respectively). Black birthing people also experience higher risk for maternal morbidity, including preeclampsia and admission to the intensive care unit during delivery. Recent data also suggest that mental health conditions and cardiovascular conditions are leading causes of pregnancy-related death. Inequities have

increased during the COVID-19 pandemic. The report noted that, "[e]ven controlling for insurance status, income, age, and severity of conditions, people of color are less likely to receive routine medical procedures and experience a lower quality of care." The report also included a data footnote about gendered language.

51. **Services U.S. Department of Health and Human. The Surgeon General's Call to Action to Improve Maternal Health.2020.**
In conjunction with U.S. Department of Health and Human Services' Action Plan to Improve Maternal Health in America, the U.S. Surgeon General issued a Call to Action to Improve Maternal Health.

52. **Declercq E., Shah N. Five Questions Raised by the New 2022 Birth Data. *Health Affairs Forefront.* 2024.**
This January 29, 2024 commentary in Health Affairs summarizes perinatal health data trends from the National Center for Health Statistics from 2022 (which is the most current data and newly released). They noted that, "despite considerable advocacy and proposals from policymakers to address racial and geographic inequities in birth outcomes […] wide inequities persist on key health outcomes." Black birthing people continue to experience the highest maternal and infant mortality, with maternal and infant mortality rates about 2.5 times higher among Black birthing people than white birthing people. In 2022, 49.5 Black birthing people per 100,000 births died compared to 19.0 white birthing people. Of all 50 states, Washington State had the lowest infant mortality rate among non-Hispanic Blacks (5.97 deaths per 1,000 births compared to the U.S. national average of 10.46 deaths per 1,000 births). However, the "Black infant mortality rate [is] higher than the [w]hite rate in every state." The commentary noted that perinatal health inequities are likely to increase as a result of state actions in the wake of the Dobbs decision. Specifically, "[r]estrictions in access to abortion and comprehensive reproductive care—at the same time that maternal safety continues to be in jeopardy—will continue to exacerbate [inequities]." Data also show that, in 2022, the proportion of births to non-Hispanic white people dropped to 50.2% and "preliminary 2023 data suggest that the [U.S.] is poised to have a majority of non-[w]hite births this year." The authors stated that these data suggest that "[i]n addition to addressing mistreatment at the root [of perinatal health inequities] and ensuring provider are trained to provide culturally humble care, there is a need to diversify the maternity care workforce and improve concordance with the populations they serve."

53. **Alhusen J. L., Bower K. M., Epstein E., Sharps P. Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. *J Midwifery Womens Health.* 2016;61(6):707-720.**
Alhusen et al. conducted an integrative review of literature published from 2009 to 2015 examining the relationship between racial discrimination and adverse birth outcomes. Fifteen studies met the inclusion criteria (4 qualitative, descriptive studies; 11 quantitative studies - 8 convenience samples, 3 population-based studies using quota sampling and stratified sampling), and articles were assessed using the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) 2009 framework. The majority of studies were conducted to assess the relationship between racial discrimination and adverse birth outcomes in African Americans. Three studies discussed experiences of institutionalized racism in both accessing and receiving prenatal care, and two studies examined racial discrimination during prenatal care and racial

discrimination as a barrier to accessing prenatal care. African American women in one qualitative study described experiencing both interpersonal level (e.g., racial slurs directed at them) and institutionalized racism during prenatal care (e.g., differential treatment based on receipt of public assistance). One study reviewed used a biological marker to examine the effects of race and racial discrimination. Results indicate that at every point, African American women exhibited higher antibody titers than white women ($P<.001$). "The effect was most pronounced among African American women who reported experiencing higher levels of racial discrimination in the first and second trimesters ($P=.03$ and $P=.04$, respectively), supporting a role that chronic stress is related to this association." Authors conclude there is a significant need for the development and testing of interventions addressing racial discrimination at the provider level (i.e., students and professionals). They recommend interventions adapt a community-based participatory research framework to establish mutually respectful relationships grounded in learning, shared responsibilities, and capacity building. Additionally, relationship-based services like home visiting may be beneficial for individuals who experienced delayed access to prenatal care.

54. **Gynecologists The American College of Obstetricians and. Committee Opinion: Access to Contraception.2015.**
In this brief, the American College of Obstetricans and Gynecologists (ACOG), Committee on Health Care for Underserved Women summarizes barriers to accesssing contraceptive care and presents recommendations to improve access. In general, ACOG recognizes that barriers to contraceptives include lack of knowledge and misperceptions by individuals, lack of knowledge about the risks and benefits of contraceptives by providers, restrictive legal rulings and legislation, costs and insurance coverage, religious and ethical beliefs, appopriate payment and reimbursement for clinician services, and unnecessary medical practices. ACOG states that the unintended pregnancy rate for low-income women is five times the rate for women in the highest income bracket. They state that low-income women are less likely to be insured, and that federal programs like Title X and Medicaid are underfunded and cannot provide coverage for all women. Specific to increasing access for low-income women, ACOG recommends continued funding for the federal TItle X family planning program and Medicaid family planning services.

55. **Bahn K, Kugler A, Mahoney M, et al. Linking Reproductive Health Care Access to Labor Market Opportunities for Women. Center for American Progress;2017.**
This Center for American Progress report examines the relationships between economic status and reproductive health. The report concludes that, "women's economic empowerment, as measured by women's labor force participation, earnings, and mobility, is correlated with stronger measures of upholding reproductive rights and health care access." They found that states with better access to reproductive health care also have the greatest economic opportunity for women. Low-income women face barriers due to lack of insurance and restrictive state laws that have economic implications (e.g. requirements that women have multiple doctors offices or unnecessary waiting period before recieving an abortion result in additional costs for travel, child care, missed work, etc.). These barriers "affect those who already have the least resources and face the most barriers to recieving medical care, exacerbating economic inequality." While income is a barrier to accessing reproductive heatlh care, recieving reproductive health care also impacts a women's future economic opportunities. For example, access to contraception and abortion "has serious economic consequences for women, in both immediate costs as well as

long-term effects on economic stability and progress." This suggests that the relationship between socioeconomic status and access to reproductrive health care is cumulative and cyclic.

56. **Akinyemiju T. F., Soliman A. S., Yassine M., et al. Healthcare access and mammography screening in Michigan: a multilevel cross-sectional study.** ***International Journal for Equity in Health.*** **2012;11(16).**
Socioeconomic status and access to healthcare may contribute to disparities in use of available mammography screening. Women of lower socioeconomic status and women living in neighborhoods of lower socioeconomic status are less likely to have mammography screening. Akinyemiju et al. analyzed data from the 2008 Michigan Sepcial Cancer Behavioral Risk Factor Survey (modeled after the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance Survey) with women aged 40 or older to determine risk factors, family history, screening behaviors, and cancer knowledge. Access to health care was measured by health insurance status, having a usual place of care, and having a usual healthcare provider. Socioeconomic status was measured at the individual and county levels based on measures of affluence, disadvantage, and immigration. Overall, Their analysis found that having no usual source of care reduced the likelihood of receiving a mammogram by 54% (OR= 0.46, 95% CI= 0.21-0.99), having no healthcare provider reduced the likelihood of recieving a mammogram by 68% (OR= 0.32, 95% CI= 0.15-0.69), and having no health insurance reduced the likelihood of recieving a mammogram by 73% (OR= 0.27, CI= 0.14-0.54). None of the county level factors (including county level socioeconomic status) were significant. The authors concluded that the primary barriers to mammography screening were lack of health insurance and not having a usual healthcare provider.

57. **Dehlendorf C., Rodriguez M. I., Levy K., et al. Disparities in family planning.** ***American Journal of Obestrics & Gynecology.*** **2010;202(3):214-220.**
Dehlendorf et al. provide a descriptive summary of reproductive health disparities by race/ethnicity and socioeconomic status, and the barriers women of color and women of low socioeconomic status experience in accessing family planning services. They present background information that minority women and those with lower socioeconomic status are more likely to experience poor reprodutive health outcomes, including unintended pregnancy, unintended births, abortions, and teen pregnancies. They also state that low socioeconomic status has also been associated with earlier initiation of sexual intercourse, and adolescent pregancy and childbirth, and state that "undesired or mistimed pregnancies...significantly impact the course of a woman's life, and disparities in the ability to plan pregnancies as desired can contribute to the cycle of disadvantage experienced by vulnerable populations." Delendorf et al. present the barriers to accessing family planning services using a framework developed by Kilbourne 2006 to examine barriers related to patient preferences and behaviors, health care system factors, and provider-related factors. Patient preferences and behaviors include barriers such as health literacy; education level; culturally-based myths and misinformation; historical trauma and discrimination; cultural and familial differences in communication, attitudes, and practices related to reproductive health; and culturally and linguistically appropriate care and services. Health care system factors include, changes in federal and state legislation and funding (including Title X, Medicaid expansion and the Hyde Amendment), insurance status, insurance coverage of contraception, and cost of care (e.g. abortions). Dehlendorf et al. also state that "immigrants often face unique challenges accessing family planning services due to language

and insurance coverage barriers." Immigrants also face barriers due to legislative changes and the Personal Responsiblity and Work Opportunity Act of 1996 which, "restricted legal immigrants' access to publically financed health care for their first 5 years of residence." Dehlendorf et al. explain that immigrants are only elgible for "Emergency Medicaid" which only covers acute illnesses and obestric deliverty, not preventive services like contraception. Provider-related barriers to care include provider biases and discrimination. Dehlendorf et al. also present five potential solutions to reduce disparities in access to care: 1. Provide universal converage for contraceptive methods (similar to the Family PACT program in California); 2. Provide public funding for abortion services; 3. Increase training related to abortions in obstetrics and gynecology and family medicine residency programs; 4. Provide information about birth control options in ways that are culturally and linguistically appopriate; and 5. Train providers to provide quality and patient-centered family planning care to all women.

58. **Henry K.A., Sherman R., Farber S., et al. The joint effects of census tract poverty and geographic access on late-stage breast cancer diagnosis in 10 US states. *Health and Place.* 2013;21:110-121.**

Henry et. al. evaluated the impact of poverty and geographic access to mammography on stage of breast cancer diagnosis. They cite previous research showing disparities in breast cancer stage at diagnosis by race and ethnicity, insurance status, income, education, and neighborhood conditions (area socioeconomic status and residential segregation). They state that access to mammography screening plays a role in early detection of breast cancer, and assumed that late-stage diagnosis of breast cancer could be indicative of disparate access to mammography services. The authors noted that stage at diagnosis is an imperfect measure of access to mammography facilities, but use this indicator due to data availability. Using state cancer registry data, Henry et. al. evaluated breast cancer data for 161,619 women aged 40 or older from 10 states (Arkansas, California, Idaho, Iowa, Kentucky, New Hampshire, New Jersey, New York, North Carolina, and Oregon). They examined the relationship between stage at breast cancer diagnosis, geographic accessibility (measured by relationships between distance from a mamography facility location and road travel times), rural/urban residence, and census tract poverty. Overall, they found that, "stage differed significantly by age, race/ethnicity, insurance, census tract poverty, rural/urban residence, travel time to the nearest mammography facility, geographic access based on our derived access score, and state." They found a direct relationship between poverty and late-state breast cancer diagnosis, such that the odds of being diagnosed with late-stage breast cancer is 1.3 times (95% Cl= 1.26-1.34) greater in census tracts with poverty rates >20% than the odds of being diagnosed in census tracts with poverty rates <5%. They authors also found that, "after adjusting the models for census tract poverty, there was no evidence that geographic access measures were associated with late-stage diagnosis of breast cancer." They suggest that, "specific interventions, such as the introduction of mobile mammography units or new permanent facilities in rural areas may have reduced travel time to mammography facilities to a level that improves any historical disparities among rural versus urban women." Poverty remained a significant, independent predictor of late-stage diagnosis. Similarly, the authors state that increased odds of late-stage breast cancer diagnosis in high poverty areas are the same for all women regardless of geographic accessibility. Therefore, the authors concluded that women in high poverty areas and women without health insurance were at greatest risk of being diagnosed at a late stage of breast cancer.

59. **Zimmerman M. S. Information Poverty and Reproductive Healthcare: Assessing the Reasons for Inequity between Income Groups. *Social Work in Public Health.* 2017;32(3):210-221.**
Zimmerman provided a summary of the literature examining the relationship between socioeconomic status and access to reproductive health care services. Her literature review identified barriers including, women's attitudes and beliefs; knowledge of services; lack of social support; transportation; clinic environment; existing laws and legislation; cost of care; insurance status; communication with healthcare workers; gender inequality; and intimate partner violence. She states that, "it is commonly known that in the United States women who are of low-income do not access reproductive healthcare services to the same advantage as women who are of higher income." She also cites previous research suggesting that income is a greater predictor of access to healthcare than race, and that low-income women were less likely to access reproductive care than higher-income women. As part of this study, Zimmerman completed 15 in-depth interviews with women of various socioeconomic status to determine barriers to accessing reproductive healthcare services and information. She conducted semi-structured interviews with women in North Carolina to learn about how women seek reproductive healthcare, their experiences, and barriers to accessing care. Ten of the interviews were completed with women with an income below 200% of the federal poverty limit. She took extensive notes during the interview process, coded and analyzed all responses, and presented results by theme, following best practices for qualitative research. Despite use of best practices, this study has three main limitations, including small sample size, low generalizability, and the use of general or theoretical questions, rather than asking specifically about personal experience. Based on her in-depth interviews, she concluded that the primary barriers low-income women face in accessing reproductive health care include: clinical staff attitudes, knowledge of care available, cost of care, and lack of insurance. Zimmerman offers two solutions to address these barriers: 1. Work with social workers to increase awareness of and education about available healthcare and services within communities: 2. Train medical providers to positively engage with patients to improve understanding.

60. **Phillippi J. C., Myers C. R., Schorn M. N. Facilitators of prenatal care access in rural Appalachia. *Women and Birth.* 2014;27(4):e28-35.**
Philippi et al. completed 29 qualitative interviews with pregnant women recieving prenatal care at a birth center in rural Applachia to determine what factors facilitate access to care. The authors concluded that, "women were willing to overcome barriers to access care that met their needs." The identified a number of barriers to acessing prenatal care, including insurance status, cost of care (e.g. Private insurance had more out-of-pocket expenses than Medicaid), service availablity (e.g. women valued being able to choose the type of prenatal care they wanted), provider availability (e.g. 20% of counties in Tennessee do not have any prenatal care provider, 39% of counties in Tennessee have provider shortages, study participants went to the only birth center in a 50 mile radius), competing priorities (e.g. other children and childcare needs, housing), transportation, work schedules, and social support. They suggest that factors that increase access include insurance (e.g. Medicaid eligibility provided greater access), patient-centered care (e.g. personalized, compassionate, not rushed, willing to answer questions), and welcoming clinic environments (e.g. minimal wait times, family-friendly). The authors align their findings with the Healthy People 2020 report that describes access as "a three step process, including: gaining

entry into the health care system, accessing a place where needed services are provided, and finding a provider with whom the individual can communicate and trust."

61. **Quality Agency for Healthcare Research and. 2016 National Healthcare Quality and Disparities Report.Rockville, MD: U.S. Department of Health and Human Services;2017.**
The National Healthcare Quality and Disparities Report is mandated by Congress and has been published every year since 2003. The intent of the report is to summarize the quality of healthcare recieved by people in the United States, and to identify disparities in care and access to care by priority populations. It evalutes quality of healthcare in six core areas: person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability. The report uses four main measures for access to care: having health insurance, having a usual source of care, encoutering difficulties when seeking care, and recieving care as soon as wanted. Over time, the report has found disparities in access to care based on race and ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. The 2016 report concluded that, while disparities in health insurance status decreased since 2014, about 70% of care affordability measures have not changed since 2010 and disparities in care persisted for poor and uninsured populations in all priority areas. The report stated, "poor people experienced worse access to care compared with high income people for all access measures except one" and "more than half of measures show that poor and low-income households have worse care than high-income households." Further, the report concluded that "significant disparities continue for poor people compared with high-income people who report they were unable to get or were delayed in getting need medical care due to financial or insurance reasons."

62. **Ethics Committee of the American Society for Reproductive Medicine. Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion. *Fertil Steril.* 2015;104(5):1104-1110.**
The Ethics Committee of the American Society for Reproductive Medicine summarized disparities in accessing fertility treatments in the U.S. The Committee reports that approximately 11% of women and 9.4% of men of reproductive age experience difficulty with fertility, but only 38% of women experiencing fertility problems use infertility services and only 24% of the need for assisted reproductive technology (ART) is being met. They found that disparities in accessing infertility service and ART exist due to race, ethnicity, geography, and socioeconomic status. However, "economic factors are the chief contributors to disparities in access to effective treatment." Barriers include differential counseling and referrals from providers (e.g. based on assumptions about an individual's or couple's socioeconomic status, whether a person deserves to be a parent or can raise a child, marital status, and sexual orientation/gender identity), lack of health insurance coverage (e.g. the Affordable Care Act does not include infertility care as an esssential health benefit, public insurance (including Medicaid) does not cover ART), cost of care (e.g. in vitro fertilization costs can exceed $19.000 out-of-pocket), transportation costs, ability to take time off from work, distance from clinics or providers (e.g. 16 states had 5 or fewer IVF providers, with most providers centered in areas of high median income), fear of stigmatization (e.g. aversion to being labeled as "infertile"), limited English proficiency, cultural or religious beliefs, lack of service availablity at relgiously-affilited hospitals and clinics, and lack of federal policy and restrictive state policies (e.g. some states provide mandated insurance coverage, other states require a 2-year wait period). The Ethics Committee also proposed

recommendations to reduce these disparities, including increasing insurance coverage (e.g. state mandated insurance coverage has been shown to increase the use of fertility services threefold), reducing the cost of treatment, increasing partnerships between providers and non-profit organizations that can reduce costs for patients, improving provider awareness of treatment disparities, training providers in cultural competency, improving referrals to providers and institutions that can provide ART, improving data collection (e.g. race and ethnicity are only captured 65% of the time according to data from the Society for Assisted Reproductive Technology Clinic Outcomes Reporing System), and improving public education to increase understanding about prevention, signs, and treatment of infertility.

63. **Todd Ana, Stuifbergen Alexa. Breast Cancer Screening Barriers and Disability. *Rehabilitation Nursing.* 2012;37(2):74-79.**
Authors Todd and Stuifbergen (2012) review and summarize the barriers to breast cancer screening for women with disabilities. The following categories emerged: finances, environment, physical limitations, health care providers' attitudes and lack of knowledge, and psychosocial issues. Financial: with 41% of women with disabilities living at or below the national poverty line, financial barriers are particularly salient. Lack of insurance coverage and cost were cited by many studies as barriers to receiving mammograms (yet post-ACA research may yield different results due to differences in coverage). Environmental: transportation-related barriers included unreliable or limited public transportation (especially for women in rural areas and those for whom fatigue is a barrier to daily activities), needing to schedule ahead for transportation, and relying on family members for transporation. Equipment also posed a barrier to many, especially those who cannot stand to use standard mammography equipment. Physical: those with more severe disabilities, especially motor impairments, were less likely than those without disability to receive a mammogram (13% versus 44%). Providers: many providers treat women with disabilities in a condescending manner, ignore routine female screening needs, and fail to recommend mammograms. Women with disabilities are less satisfied with their care and thus more likely to delay or forgo care in the future. Psychosocial: women with disabilities are more likely to have depression than those without disabilities (30% versus 8%), and women who are depressed are less likely to receive mammograms.

64. **Drew J. A., Short S. E. Disability and Pap smear receipt among U.S. Women, 2000 and 2005. *Perspect Sex Reprod Health.* 2010;42(4):258-266.**
Drew and Short (2010) analyzed data from the National Health Interview Surveys in order to determine the relationship between disability and Pap tests. The authors selected data from the 2000 and 2005 National Health Interview Surveys. The NHIS is an annual household survey conducted in person by interviewers from the US Census Bureau. This analysis included a total of 9,661 women aged 21-64. Disability was defined in four categories: 1) mobility; 2) sensory, mental, cognitive, or social; 3) a combination of the two; and 4) physical limitations unrelated to mobility. Eighteen percent of participants reported having one or more disability, and most were mobility limitations. The findings were conflicting in this study. Those with disabilities were only 60% as likely to have a Pap test as those without disabilities. Women with both mobility and sensory/mental/cognitive/social limitations had lower rates of Pap tests than those with only mobility limitations. Having a disability, however, was positively associated with receiving recommendation for a Pap test from a physician (1.2 times as likely as those without disability). Yet disabled women who did receive a recommendation only had a 50% chance of actually

receiving a Pap test. Of those who did not receive a Pap test, women with disabilities more frequently cited cost or lack of insurance as the reason compared to those who did not have a disability (31% vs 13%). The authors discuss previous research indicating that Pap test recommendation is the strongest factor in Pap test receipt, and disabled women are less likely to receive a recommendation. Yet this analysis reveals that Pap test recommendations are relatively high among disabled women although screening rates remain low.

65. **Goin D., Long S.K. Health Care Access and Cost Barriers for Adults with Physical or Mental Health Issues: Evidence of Significant Gaps as the ACA Marketplace Opened their Doors.Health Reform Monitoring Survey. The Urban Institute;2014.**
This report by The Urban Institutute summarizes data from the 2013 Health Reform Monitoring Survey related to barriers to care for adults with physical and mental health issues after the implementation of the Affordable Care Act (ACA). They cite evidence that, in 2012, approximately 35.9% of U.S. adults aged 18-64 reported that their physical health and 38.5% reported that their mental health was not good for one or more days in the last month. The report concludes that adults with physical and mental health issues face more barriers to accessing health care, even with insurance, than their healthier counterparts. They drew three conclcusions: 1. Adults with health problems reported difficulties accessing and affording health care. For adults with mental health problems, 50.8% reported trouble affording health care, compared to 37.8% of adults with no health issues. 2. Adults with health issues that also had low socioeconomic status had a harder time obtaining care. 3. Adults with health issues experienced barriers in accessing care, regardless of insurance status. For example, 29.8% of uninsured adults and 29.9% of insured adults with health issues reported difficulty accessing care; 80% of uninsured adults and 60% of insured adults with health issues reported difficulty affording care. These numbers are all significantly higher than adults without health issues.

66. **Sutter M. B., Gopman S., Leeman L. Patient-centered Care to Address Barriers for Pregnant Women with Opioid Dependence. *Obstet Gynecol Clin North Am.* 2017;44(1):95-107.**
Sutter et al. summarize literature addressing substance use during pregnancy. Estimates suggest that, between 2013 and 2014, approximately 5.3% of pregnant women used illicit drugs during prengancy, and 2% using drugs other than marijuana. These estimates likely under-report substance use by pregnant women, and drug use during pregnancy can have negative pregnancy, birth, and maternal health outcomes. Women with substance use disorders encounter many barriers to seeking prenatal care services, including unstable housing, low soecioeconomic status, job insecurity, competing financial priorities, transportation, experiences of violence (intimate partner violence), lack of social support, difficulty enrolling in Medicaid, low health literacy, mental health issues, stigma (from society and health care providers), lack of provider training (related to screening, recognition, or treatment of substance use disorders), lack of confidentiality, incarceration and/or recidivism, and fear of criminal justice involvement (including removal of children and incarceration). Homelessness during pregnancy is associated with lack of prenatal care and substance use, and is considered a contributing factor to high-risk pregnancies. The authors note, "homeless women have 2.9 times increased risk of having a preterm birth, 6.9 times for birth weight less than 2000 [grams], and 3.3 times for newborn small for gestational age" and that these odds increase more for homeless pregnant women who also

have substance use disorders. The authors recommend implementing programs that are multlidisciplinary, harm-reduction focused, and trauma-informed.

67. **Baumgartner J.C., Collins S.R., Radley D.C., Hayes S.L. . How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care.Data Brief. The Commonwealth Fund;2020.**
This January 2020 Data Brief from The Commonwealth Fund examined the Patient Protection and Affordable Care Act's (ACA) affect on disparities in access to health care among Black, Hispanic, and white adults using data from the federal American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) for the years 2013-2018. Researchers compared differences in the share of Black, Hispanic, and white adults who are uninsured (ages 19 to 64 years); differences in the share who went without care because of cost in the past 12 months (ages 18 to 64); and differences in the share with a usual source of care (ages 18 to 64). Authors found the ACA's coverage expansions reduced "racial disparities in access to health care since 2013, but progress has stalled and, in some cases, eroded since 2016." Specifically, "[t]he gap between Black and white adult uninsured rates dropped by 4.1 percentage points, while the difference between Hispanic and white uninsured rates fell 9.4 points." Although disparities narrowed in both states that expanded Medicaid eligiblity under the ACA and those that did not, all three groups had better overall access to care in expansion states (n=31) than nonexpansion states (n=19). "Coverage disparities in expansion states narrowed the most over the period, even though the disparities were smaller to begin with. The black–white coverage gap in those states dropped from 8.4 percentage points to 3.7 points, while the difference between Hispanic and white uninsured rates fell from 23.2 points to 12.7 points." Authors note that congressional inaction (i.e., no federal legislation since 2010 to enhance or reinforce the ACA) as well as recent legislation and executive actions (e.g., reductions in funding for outreach ane enrollment assistance for those eligible for the marketplace or Medicaid coverage) have negatively affected Americans' coverage and access to care. Finally, "Hispanic adults also experience much larger disparities, in part because undocumented immigrants can't qualify for marketplace coverage, receive subsidies, or enroll in Medicaid." Authors list actions policymakers can take to further reduce racial/ethnic differences in health care access that persist.

68. **(MACPAC) Medicaid and CHIP Payment and Access Commission. Issue Brief, Doulas in Medicaid: Case Study Findings.2023.**
The Medicaid and CHIP Payment and Access Commission (MACPAC) is a federal, non-partisan, legislative branch agency that advises Congress, U.S. Department of Health and Human Services (HHS), and states on issues related to Medicaid and the Children's Health Insurance Program. In November 2023, MACPAC published an issue brief related to Medicaid reimbursement for doulas. They noted that Medicaid provides health insurance coverage for more than 40% of all births in the U.S. and for more than 60% of all births among Black and American Indian and Alaska Native women. MACPAC conducted case studies, including reviewing documents and conducting key informant interviews, in 5 states (i.e., Florida, Minnesota, New Jersey, Oregon, and Rhode Island) that provide reimbursement for doula services under Medicaid. Key informant interviews were conducted with Medicaid officials, managed care organizations, doulas, and doula organizations in each state as well as federal officials, maternal health experts, birth justice advocates, doulas, and doula organizations. Among additional topics, the report discusses "approaches and challenges of designing and

implementing doula coverage, including benefit design, training and credentialing requirements, payment, utilization of the service, and workforce issues." MACPAC stated that, "[s]tates can specify the training and skills doulas must have to be qualified as Medicaid providers." As part of key informant interviews, "some doulas of color raised concerns that components of state-approved doula training and certification organizations are not community-based, not necessarily tailored to train doulas to meet the needs of historically marginalized communities, and may not train doulas to meet Medicaid beneficiaries needs. This may hinder doulas from completing these trainings and enrolling as Medicaid providers. Doulas have advocated for more local and diverse training organizations to increase the cultural competency of doulas." For example, New Jersey requires doulas complete additional community competency training related to New Jersey-specific community-based resources. Doulas also expressed the need for racial, ethnic, and linguistic congruency between doulas and Medicaid beneficiaries. MACPAC cited prior research showing that "when patients and providers share the same race or ethnicity, for example, patient perception of treatment decisions improves."

69. **Khaw S. M., Zahroh R. I., O'Rourke K., et al. Community-based doulas for migrant and refugee women: a mixed-method systematic review and narrative synthesis. *BMJ Glob Health.* 2022;7(7).**
Khaw et al. conducted a systematic review of 18 articles published through January 2022 that examined perceptions and experiences of community-based doula programs for migrant and refugee birthing people in the U.S., Australia, England, and Sweden. Six out of 12 (50%) studies were from the U.S. The authors noted that this was the first review to explore the impacts of community-based doula support for migrant and refugee women specifically. The authors concluded that community-based doula care may improve the responsiveness and experience of perinatal healthcare for migrant and refugee pregnant, birthing, and postpartum people.

70. **Munro K., Jarvis C., Munoz M., et al. Undocumented pregnant women: What does the literature tell us? *Journal of Immigrant and Minority Health.* 2013;15:281-291.**
Munro et al. completed a literature review of 23 articles published between 1987 and 2010 evaluating access to prenatal and obstetric health services for undocumented pregnant migrants. The authors define migrants as, "individuals who...choose to leave their home countries and establish themselves either permanently or temporarily in another country." Based on their review, the authors found that pregnant undocument migrants were more likely to be young, unmarried, engaged in low-income domestic work, and have unintended pregnancies. They were also less likely to access prenatal care than documented migrant women and women in the general population. Reasons for not seeking care were related to lack of legal residency status, lack of health insurance, cost of care, fear of deportation, and confusion about healthcare policies. The authors did not consider strength of study design or quality of research as inclusion criteria for the literature review. In addition, articles included research completed in the United States, Canada, and Europe. Therefore, articles may be of varying quality and lower generalizability.

71. **Thiel de Bocanegra H., Carter-Pokras O., Ingleby J. D., et al. Addressing refugee health through evidence-based policies: a case study. *Annals of Epidemiology.* 2018;28(6):411-419.**

The American College of Epidemiology convened an international workgroup of experts in refugee health, epidemiology, policy, and program administration from the United States, Canada, and the European Union to examine literature published between 1999 and 2016 related to examples and challenges of providing health services to refugees. They organized their results by eight key lessons learned for epidemiologists: 1. Definitions for "refugee" and "asylum seeker" vary. 2. Efficent systems are needed to idenify health needs and begin integration into the health system upon arrival at port of entry. This should include questions about pregnancy, pregnancy intention, contraception needs, and chronic diseases. US federal policy only requires documentation of pregnancy status, and states can require more comprehensive assessments of reproductive health needs. 3. Data sources need to be linked in order to allow for ongoing monitoring of refugee health indicators, and data about refugee status should be collected consistently and in additional sources. 4. A "health in all policies" approach is needed to ensure health-promoting environments for refugees and asylum seekers. 5. Refugees and asylum seekers must have equitable access to health services. The authors cite evidence showing that migrants often lack information about how to navigate the health care system and do not recieve culturally appropriate care. 6. Health services for refugees and asylum seekers must be integrated into the existing health care system and be culturally appropriate. 7. Initiatives to improve access to care need to be evaluated. 8. Epidemiologists need training to engage with policymakers and the public.

72. **Hacker K., Anies M., Folb B. L., Zallman L. Barriers to health care for undocumented immigrants: a literature review.** ***Risk Management and Healthcare Policy.*** **2015;8:175-183.**
Hacker et al. completed a literature review of 66 articles published in the 10 years prior to this review to examine barriers to accessing health care for undocumented immigrants, and identifying strategies to address these barriers. Articles in the review included research from multiple countries, including the United States. Policy barriers to accessing health care included health insurance laws and documentation requirements to get services. Health system barriers included constraints related to work conflicts and transporation, constraints related to lack of translation services and culturally competent care, discriminantion in the clinic environment, and complex paperwork or registration systems to receive care. Individual level barriers included fear of deportation, stigma, shame about seeking services, lack of social capital, lack of financial capital to pay for services, limited health literacy or knowledge about the health care system, limited English proficiency, and cultural differences. Overall, the largest barrier identified through the review was "national policies excluding undocumented immigrants from receiving health care" with the majority of policies restricting access to health insurance. The authors state, "because insurance was generally required for affordable care or required to recieve services at all, these laws effectively barred access to care [for undocumented immigrants]." The authors identified five catetories of recommendations: 1. Change policies; 2. Extend insurance options; 3. Expand the safety net; 4. Train providers; 5. Educate undocumented immigrants on navigating the health care system. Specific to changing policy, recommendations include expanding health care access regardless of immigration or citizenship status, giving full rights to health care for all immigrants, and delaying deportation until care is completed. Recommendations related to insurance included allowing all immigrants access to a state funded health plan, providing insurance to all workers regardless of immigration status, providing a limited insurance option to preventive care or by disease, and offering sliding-scale payment systems. Safety net

recommendations included expanding the capcity of clinics (e.g. federally qualified health centers, public hospitals, community health centers, state and local public health clinics) to provide care to immigrants through additional state support, and providing health education in alternative settings (e.g. faith-based organizations). Training recommendations included educating providers to understand the specific medical needs of immigrant communities, to use interpretation services, and to understand immigration laws. Health literacy recommendations included educating immigrants about the health care system and their right to health care as well as connecting immigrants with "culturally appopriate navigators in health care environments" to help navigate services. The authors note that an important limitation is that, "many of the recommendations we have identified in the reviewed articles have not been tested so it is difficult to ascertain whether or not they would be deemed successful."

73. **Mehta P. K., Saia K., Mody D., et al. Learning from UJAMBO: Perspectives on Gynecologic Care in African Immigrant and Refugee Women in Boston, Massachusetts. *Journal of Immigrant Minority Health.* 2018;20(2):380-387.**
Mehta et al. analyzed results from 6 focus groups completed with 31 Congolese and Somali female immigrants in Boston, Massachussetts to understand access to and use of gynecological services. They identifed a number of barriers to accessing reproductive health care, including fear of stigma (that seeking care means sexual promiscuity), concerns about privacy and sexual modesty, fear of discrimination, prior experiences with sexual trauma or violence, lack of providers who understand female circumcision/genital cutting, lack of partner support, lack of financial resources and cost of care, lack of insurance, attitudes and beliefs (including cultural beliefs about when to see a doctor and what constituted pain/discomfort), and environmental constraints (e.g. transportation, cultural limitations on mobility, lack of childcare). Recommendations to improve access include training providers in culturally humble communication and culturally-appropriate and trauma informed care, including understanding of female circumcision/genital cutting; providing health education about preventive care in community-based and religious settings; and developing peer support programs to reduce social stigma.

74. **Perez-Escamilla R., Garcia J., Song D. Health Care Access Among Hispanic Immigrants: ¿Alguien esta escuchando? [Is anybody listening?]. *NAPA Bulletin.* 2010;34(1):47-67.**
Perez-Escamilla et al. completed a systematic literature review of 77 articles related to health care access for Hispanic immigrants in the United States. Major barriers to accessing health care included lack of health insurance, stigma, fear of deportation, and low English proficiency. For adolescents, parental citizenship and immigration status has also been identified as a barrier to accessing health care, even for children who are U.S. citizens. Eleven articles examined barriers to accessing women's health care. In addition to general barriers, the review found additional barriers specific to access of women's health services like mammography and prental care, including: lack of culturally competent services (including outreach practices), low self-efficacy, lack of social support, and mobility. The authors also note that, "deeply rooted cultural beliefs about the origin of health and disease within the context of limited access to health insurance may be associated with more prevalent use of traditional healing...as alternative means to access care." Studies have found that language differences, differences in cultural beliefs about health, and percieved discrimination may limited access to health care in the U.S. Based on their reivew,

the authors note that "programs relying heavily on community health workers, also known as promotoras, have improved health care access."

75. **International Wellshare. Providing Culturally Appropriate Reproductive Health and Family Planning Services to Somali Immigrants and Refugees: A reference guide.2009.**
Wellshare International is a non-profit organization based in Minneapolis, Minnesota that operates community health programs and works to design, implement, and evaluate health projects in the United States and abroad. In 2004, they started the Somali Child Spacing Program to provide culturally sensitive reproductive health information and resources to health care providers and Somali immigrants. As part of this report, Wellshare International documents barriers that Somali immigrants experience in accessing health care in the United States and recommendations to address these barriers. They identify a number of provider-centered and environmental barriers to accessing health care. Provider-centered barriers included cultural, religious, and social beliefs and practices; language access; confidentiality (especially with interpreters); lack of understanding about female circumcision; mistreatment and lack of respect from clinic staff and receptionists; and lack of providers who understand Somali culture. Environmental barriers included lack of knowledge about where to go for services, lack of knowledge about insurance, transportation, childcare, inconvenient clinic hours, lack of information in primary language, low health literacy, and lack of financial resources and social capital. The report also outlined organizational and structural recommendations to reduce these barriers. Organizational level recommendations include diversifying organizational leadership to reflect Somali practitioners, engaging community leaders as advisors, employing community health workers to work as cultural liaisons, and educating clinic staff and providers on cross-cultural communication. Structural recommendations included developing culturally and linguistically appropriate materials, expanding clinic hours, providing quality interpreter services, providing comprehensive services on-site (reducing the need for off-site referrals), allowing clinic staff and providers to attend culturally competentcy trainings, matching client and provider genders, and allowing extra time during appointments for questions and explanations.

76. **Wojnar D. M. Perinatal experiences of Somali couples in the United States.** ***J Obstet Gynecol Neonatal Nurs.*** **2015;44(3):358-369.**
Wojnar completed a literature review and conducted interviews with 48 Somali immigrants (26 women and 22 men) who had arrived in the United States within the past five years to understand their experience with perinatal care (care during and after birth). The review of literature cited past research that identified barriers to Somali immigrants accessing reproductive health care, including lack of transportation, limited access to interpretation services, lack of provider understanding of female genital cutting/circumcision, fear of Western medicine and procedures (e.g. cesarean section). All interviewees lived in the Pacific Northwest and had at least one child born in the United States. He found that access to perinatal care was complicated by lanaguage access, cultural beliefs and preferences (e.g. family size), fear of discrimination or bias, distrust of medical providers and practices, misinformation, limited access to resources, and exclusion of husbands from prenatal education and care. Recommendations to improve access include offering prenatal education in a culturally appopriate setting (ie. separate classes for men and women), training providers in culturally-appropriate care, and training providers in the care of patients with female genital cutting/circumcision.

77. **Association National Family Planning & Reproductive Health. Policy Brief--Title X: Helping Ensure Access to High-Quality Care.2015.**
Title X of the Public Health Service Act was enacted in 1970 and is known as the "national family planning progarm." It is the only federal funding source for family planning services in the United States, and provides "high-quality family planning services and related preventive health care to low-income and uninsured individuals who may otherwise lack access to health care." Funding provides care for both men and women regardless of ability to pay, insurance status, or immigration status. Approximately 70% of Title X patients have incomes below 100% of the Federal Poverty Level and 63% are uninsured. This policy brief outlines service by socioeconomic status, insurance status, race and ethnicty, and geography. It states that women, women of color, immigrant women, and women living in rural or frontier areas are less likely to have health insurance. An estimated 40% of women of reproductive age with low-incomes lacked health insurance. Of all women without health insurance, 39% are immigrants due to "policies and regulations restricting access to public and private health insurance as well as the overrepresentation of immigrants in jobs unlikely to provide health insurance."

78. **Hasstedt K., Desai S., Ansari-Thomas Z. Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States. Guttmacher Institute;2018.**
In this report, the Guttmacher Institute summarize evidence related to immigrant women's access to reproductive health care. They conducted a rapid literature review of 24 published articles and grey literature since 2011. They found that "existing research suggests immigration status influences women's sexual and reproductive health coverage, care, and outcomes." The authors highlight two main findings: 1) "A smaller proportion of immigrant women-- including both undocumented and those lawfully present-- have health insurance coverage and are less likely to use sexual and reproductive health services, compared with U.S.-born women." The report cites data from 2016 that 34% of noncitizen immigrant women of reproductive age in the U.S. were uninsured, compared to 9% of U.S.-born women. 2) "Among immigrant women who do obtain contraceptive care, they are signficantly more likely than their U.S.-born counterparts to visit publicly funded family planning centers." They cite data that 41% of immigrant women who obtained contraceptive coverage used safety-net family planning centers, compared to 25% of U.S.-born women. Approximately 70% of immigrant women reported safety-net providres as their usual source of care. The authors recommend improving access to reproductive health care for immigrant women by expanding insurance eligiblity, providing additional support to health care safety net providers, and supporting community health workers.

79. **Hasstedt K. Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants. *Guttmacher Policy Review.* 2013;16(1):2-8.**
Hasstedt outlines curent and historic federal legislation restricting immigrants' access to health insurance and health care in the United States. The 1996 Personal Responsiblity and Work Opportunity Reconciliation Act states that individuals who immigrated to the United States after 1996 are ineligible for Medicaid or the Children's Health Insurance Program (CHIP) for the first five years they have "lawful status," effectively creating a "five year ban" on federally-funded health insurance. The act does specify that Medicaid will provide emergency coverage, including costs related to labor and delivery, regardless of immigration status. Also, in 2002 and 2013, the federal government issued exceptions to the law that allow states waive the 5 year ban and

provide Medicaid and CHIP coverage to immigrant pregnant women and children. Washington State currently offers coverage to lawfully residing children and pregnant women without the 5-year wait period, and to all pregnant women regardless of their immigration status. While the Affordable Care Act (ACA) does not address the five-year-ban, it does enable lawful immigrants to purchase and recieve subsidies for private health insurance through the exchanges. Undocumented immigrants remain ineligible under the ACA to purchase private insurance, and grantees under the Deferred Action for Childhood Arrivals (DACA) program are ineligble for public and private health insurance. DACA grantees and undocumented immigrants are only eligible for Medicaid in states that do not use federal dollars to fund their Medicaid program and provide coverage regardless of immigration status, or for priviate insurance coverage obtained outside the exchanges. In addition, "immigrants are overrepresented in low-wage jobs that are unlikely to offere employer-sponsored health coverage." As a result, approximately 45% of noncitizen immigrant women of reproductive age are uninsured, compared to 24% of naturalized immigrants, and 18% of U.S. born women. The author concludes that current policies greatly hinder immigrants to access health insurance and health care.

80. **Ho J. R., Hoffman J. R., Aghajanova L., et al. Demographic analysis of a low resource, socioculturally diverse urban community presenting for infertility care in a United States public hospital. *Contracept Reprod Med.* 2017;2:17.**
Ho et al. summarized the literature about access to infertility care. They stated that only 24% of the demand for assisted reproductive technogies are met in the United States and that geography, income, insurance status, language and cultural barriers, and beaurocracy within the public health system all create barriers to accessessing infertility care. As part of this study, Ho et al. also recurited women who were presenting for infertility treatment at a public, county-based, low resource clinic and at a a high resource infertility clinic in San Francisco. They surveyed 87 patients and collected information related to English proficiency, parity, ethnicity, immigrant status, income level, and education level. They compared these demographics with length of infertility and infertility diagnosis to determine if there were differences by subgroup. Length of infertility served as a proxy for difficulty in accessing health services. Patients at the low-resource clinic were more likley to speak a langauge other than English, to have immigrated to the United States, to have a lower annual income, amd to have less than a college degree as compare to patients at the high resource clinic. They found that, "after controlling for age at the initiation of pregnancy attempt, lower education level, lower income, and immigrant status were significantly correlated with a longer duration of infertility." For example, the authors found that, "[patients] reporting an income [greater than or equal to] $100,000 presented to clinic approximately 6 months earlier than those with an income [less than] $100,000 ([beta]= -6.2, p= 0.04)." They also found that, "women with insufficient income to pay for [assisted reproductive technologies] services experience an insurmountable gap in access to care." They note that infertility treatments are excluded from coverage under the Affordable Care Act, and that most county, state, and federal public health programs do not cover basic infertility services. The authors state, "in the US, price is a barrier that separates those that are able to pay for standard of care treatment vs those that must accept substandard or no care in many cases." In addition to cost of care, the authors also point out that provider bias and implicit assumptions about income, patient ability to navigate the health care system, and low health literacy may also serve as barriers to recieving care.

81. **Women Committee on Health Care for Underserved. Committee Opinion 586: Health Disparities in Rural Women. Washington, DC: American College of Obstetricians and Gynecologists; 2014 (reaffirmed in 2016).**
Rural women have poorer health outcomes and more limited access to health care as compared to urban women. Health care providers, particularly in women's health, are limited in many rural areas. The heterogeneity of rural areas in the U.S. result in there being various problems depending on the specific region and state. It is important for health care professionals to have awareness about health disparities for rural women and advocate for its reduction.

82. **Delamater Paul L, Messina Joseph P, Shortridge Ashton M, Grady Sue C. Measuring geographic access to health care: raster and network-based methods. *International Journal of Health Geographics.* 2012;11(15).**
Geographic inequalities to health care can be caused by facility configuration, population distribution, and transportation infrastructure. Although recent studies on this issue have used traditional Euclidean measures of distance, this study used travel distance or time instead. These different underlying data models are one explanation for the differences in raster-based and network-based studies' findings.

83. **Brigance C. , Lucas R. , Jones E. , et al. Nowhere to Go: Maternity Care Deserts Across the U.S.Report No. 3. March of Dimes;2022.**
This 2022 Report from the March of Dimes is an update of the 2020 report and aims to increase education and raise awareness of maternity care deserts.

84. **University of California, Davis. LGBTQIA Resource Center Glossary. Available at. Accessed, 2018.**
This Glossary has been collectively built and collected by the staff members of the University of California, Davis' LGBTQIA+ Resource Center since the early 2000s. The terms and definitions included in the glossary are always evolving and changing and often mean different things to different people. They are provided as a starting point for discussion and understanding.

85. **Kozhimannil K. B., Hardeman R. R., Henning-Smith C. Maternity care access, quality, and outcomes: A systems-level perspective on research, clinical, and policy needs. *Seminars in Perinatology.* 2017;41(6):367-374.**
Kozhimannil, et al. found that rural residents, low-income individuals, and people of color have less access to maternity care in the United States, including access to prenatal care, labor and delivery care, emergency obsetric care, and postpartum care. Factors such as health care financing, health care delivery and organization, and the policy context contribute to access to reproductive health services. The authors state that ,"multiple other factors- and the intersection of these factors- affect need for, access to, quality, and outcomes of maternity care. These factors include clinical conditions, health insurance coverage, geographic location (rural or urban), and sociodemographic characteristics including race and ethnicity."

86. **Yen W. Washington State Health Services Research Project: Statewide Uninsured Rate Remained Unchanged from 2018 to 2019.Research Brief. Washington State Office of Financial Management, Health Care Research Center; December 2020 2020.**

In this Research Brief, Washington State Office of Financial Management (OFM) describes trends in health coverage through 2019. Overall, Washington State's uninsured rate remained constant from 2018 to 2019 at approximately 6.1% uninsured. In addition, "no population group experienced a statistically signficant change in its uninsured rate between 2018 to 2019." OFM provides uninsured rates by age, sex, race/ethncity, and family income. The uninsured rates for the three lowest income groups remained approximately four times higher than the highest income group. However, based on weekly estimates of uninsured rates during the COVID-19 pandemic, OFM estimated that the uninsured rate for 2020 is likely to be higher. OFM estimates suggest that the uninsured rate doubled in May 2020 compared to before the pandemic. As of December 2020, the rate has returned to pre-pandemic levels largely due to the increase in enrollment in Medicaid and, to a lesser degree, in Qualified Health Plans on the Exchange.

87. **Sobel Laurie, Rosenzweig Caroline, Salganicoff Alina. Proposed Changes to Title X: Implications for Women and Family Planning Providers. Henry J. Kaiser Family foundation; June 2018 2018.**
This Kaiser Family Foundation issue brief provides an overview of the changes to regulations for the federal Title X family planning program proposed by the Trump Administration. Authors highlight that the proposed regulations would: 1) block the availability of federal funds to family planning providers that also offer abortion services; 2) end counseling and referrals to abortion services by Title X providers; 3) eliminate current requirements that Title X sites offer a broad range of medically approved family planning methods and non-directive pregnancy option counseling (e.g., prenatal care, delivery, adoption, and abortion; and 4) direct new funds to faith-based and other organizations that promote fertility awareness and abstinence as methods of family planning.

88. **Rayburn W. F., Richards M. E., Elwell E. C. Drive times to hospitals with perinatal care in the United States. *Obstet Gynecol.* 2012;119(3):611-616.**
"Access to care is an important issue in health care reform. This study evaluated access to inpatient obstetric care by determining the percentage of women of reproductive age living within a 30-minute or a 60-minute drive to the closest hospital with perinatal services. As defined by the 2007 American Hospital Association survey, perinatal centers were level I (uncomplicated obstetric and nursery care), level II (limited complicated care), or level III (full complement of care). The study used geographic information system mapping software to determine drive times from the census block group centroid to the closest perinatal center. In the United States, 2,606 hospitals offered some level of perinatal care for the 49.8 million reproductive-aged women. There was variation in access to perinatal centers within a 30-minute drive depending on the level of care: 87.5% of the population had access within a 30-minute drive to any center, 78.6% to a level II or III center, and 60.8% to a level III center. Access within a 60-minute drive also varied by level of care: 97.3% had access to any center; 93.1% to a level II or III center; and 80.1% to a level III center. The most geographic maldistribution of perinatal services was found in the mostly rural western portion of the US (excluding the Pacific Coast) and Alaska. There was considerable variation in driving time. The study concluded that regional obstetric workforce planning and policy-making regarding access to care should use geographic information system software.

89. **Skillman SM, Dahal A. Washington State’s Physician Workforce in 2016.Seattle, WA: Center for Health Workforce Studies, University of Washington; February 2017 2017.**
The supply of physicians per capita in Washington is comparable to national averages, but there is significant variation in distribution based on whether an area is urban or rural, with there being fewer physicians (both total and for primary care) in the latter. Furthermore, there is a lower per capita supply in the eastern counties as compared to the western ones. One possible approach to this problem would be creating more residencies in these underserved areas and for specialties in which underserved areas are especially affected. It could also help stabilize the workforce to target retention of younger physicians, especially for the rural areas where over half of physicians are 55 years of age or older.

90. **Hale RW. Medical Professional Liability Revisited. *Obstet Gynecol.* 2006;107(6):1224-1225.**
The increasing cost of liability insurance is a problem for obstetric care which ACOG has prioritized responding to. ACOG's national surveys and their members' responses nationally have confirmed other research on this topic. About 14% ACOG members cease practicing each year, worsening the number of areas where there is no nearby obstetrician and increasing the need for patients to drive extremely far for care. In addition, obstetricians who continue to practice have changed how they approach their patients, such as by no longer caring for high-risk patients or by turning quickly to a cesarean delivery if there is any sign of a complication, particularly malpresentation. Furthermore, some obstetricians are not accepting referrals or are limiting the new patients that they take in.

91. **Stulberg Debra, Hoffman Yael, Dahlquist Irma Hasham, Freedman Lori. Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns’ Experiences. *Contraception.* 2014;90(4):422-428.**
Tubal sterilization continues to be one of the most commonly requested contraceptive methods nationally. All sterilization is prohibited by Catholic hospitals' policies, which are not however uniformly enforced. This study investigated the beliefs and experiences of ob-gyns concerning tubal ligation at Catholic hospitals. The participants did not agree with a strict prohibition of sterilizations, especially when denial results in greater medical risk. They were also frustrated by prohibitions of tubal ligation during a cesarean delivery, resulting in the patient requiring a subsequent surgery. They reported that some hospitals allowed tubal ligations in certain situations, but this was dependent on enforcement which could change. Some reported that the hospital policy was a greater barrier for low-income patients and patients with insurance restrictions. The participants did not share official Catholic positions on sterilization.

92. **Series on Rural-Urban Disparities | Rural Washington: Closing Health Disparities. Tumwater, Washington: Washington State Departmetn of Health, Office of Community Health Systems; 2017.**
This Department of Health fact sheet reports that "[o]verall, communities in rural areas are at a disadvantage on multiple health and health-related measures." In 2015, there were statistically significantly differences ($p < 0.05$) in health outcomes for Washingtonians living in small towns/rural areas compared to urban residents. Specifically, those living in small towns/rural areas were less likely to have had an annual dental care visit and more likely to to have not

received preventative screening for breast cancer or colon cancer. Additionally, based on self-reported risk factors and health outcomes, those living in small towns/rural areas were more likely to currently smoke, be obese, and to have had coronary heart disease than urban counterparts. Adults living in large towns were also more likely to currently smoke and be obese than urban counterparts. Adults living in suburban areas were more likely to smoke than urban Washingtonians. Other health related measures were not statistically significantly different. "In general, people with high behavioral risk factors profile are very likely to have actual poor health status."

93. **Health Washington State Department of. 2018 Washington State Health Assessment. March 2018 2018.**
The *State Health Assessment* provides an overview of health and well-being of Washington residents. It outlines the changing population trends --increasing in number, becoming more racially and ethnically diverse, and aging. It also discusses disparate health outcomes experienced by various populations within Washington.

94. **Garcia Macarena C., Faul Mark, Massetti Greta, et al. Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States. *Centers for Disease Control and Prevention | Morbidity and Mortality Weekly Report.* 2017;66(2).**
This CDC MMWR, addresses the five leading causes of excess death in the United States: heart disease, stroke, chronic lower respiratory disease, cancer, and unintentional injury. in 2014, approximately 62% of all 1,622,304 deaths in the United States were related to the five leading causes of death (6). During 2014, the number of potentially excess deaths from the five leading causes in rural areas was higher than those in urban areas. Analysis found that "the percentage of potentially excess deaths from heart disease, stroke, and chronic lower respiratory disease is higher in rural than urban areas in all 10 regions of the U.S. During 2003-2012, the overall cancer-related age-adjusted deat rate decreased by 1.5% per year. However, rates declined less in rural than urban areas. Authors note that age-adjusted death rates from cancer mirrored decreases in the prevalence of risk factors like smoking tobacco. Therefore, they postulate that rural-urban difference in death rates may reflect differences in tobacco-use in rural areas and lack of access to cancer screening and other follow-up medical care. During 1999–2014, the age-adjusted death rates for unintentional injuries were approximately 50% higher in rural areas than in urban areas.

95. **Ivey-Stephenson Asha Z., Crosby Alex E., Jack Shane P. D., et al. Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death — United States, 2001–2015. *Centers for Disease Control and Prevention | Morbidity and Mortality Weekly Report.* 2017;66(18).**
Suicide is one of the top ten leading causes of death in the U.S. This CDC MMWR reports that "suicide rates increased across the three urbanization levels, with higher rates in nonmetropolitan/rural counties than in medium/small or large metropolitan counties." Specifically, in nonmetropolitan/rural and medium/small metropolitan counties, increases in suicide rates occurred during 2001–2007 and the increases accelerated in 2007 and 2008. Authors noted the Great Recession officially began in 2007 and ended in 2009. From 2001 through 2015, 114,559 total suicide deaths were recorded in nonmetropolitan/rural areas, for an overall rate of 17.32 per 100,000 (range 15.50 to 19.74 in 2001-03 and 2013-15, respectively).

Suicide death rates over the reporting period (2001-2015) were 14.86 per 100,000 for medium/small metropolitan areas and 11.92 per 100,000 for large metropolitan areas.

96. **Shlafer R. J., Hellerstedt W. L., Secor-Turner M., et al. Doulas' Perspectives about Providing Support to Incarcerated Women: A Feasibility Study. *Public Health Nurs.* 2015;32(4):316-326.**
Shlafer et al. analyzed case notes from 6 doulas about their experiences with 18 pregnant women in one Midwestern state prison. Prior research shows that women in prisons face a sleuth of health risks, and are more likely than women in the general population to experience poor perinatal health outcomes, including preterm and small gestational age infants. Only about half of pregnant women in state prisons received some sort of pregnancy care. Further, "some [...] state prisons failed to meet the nutritional recommendations for pregnant women or accommodate the labor, rest, sleep, and clothing needs of pregnant women." Women of color are disproportionately incarcerated and also experience higher rates of poor pregnancy and birth outcomes than white women. Doula support in prisons is rare. Prior research that examined doula suppoort to 18 pregnant women in Washington State urban jails described their observations: "Incarcerated pregnant women were typically transferred to a local hospital in early labor to forestall birth in jail, often arriving in leg irons or handcuffs. Once admitted, they were not permitted to leave the hospital room, have visitors, or use the phone. Labor and birth routinely took place in the presence of multiple unfamiliar providers, under constant sight surveillance of armed officers. After birth, mothers were usually transferred back to the jail within 24 hr, while their babies were placed with a relative or foster family supervised by child welfare services. Often, infant placement could not be arranged before birth, adding to the mothers' anxiety (p. 53)." The researchers in this study identified major themes related to doulas' perceptions of providing care for incarcerated women. The results show that doulas were able to empower clients, establish trusting relationships with clients, normalize the delivery, and support women as they were separated from their newborns. The researchers called for doula training that is specifically for providing care in institutional settings.

97. **Health Washington State Department of. Infographic of competencies according to WAC (PDF). Birth Doula Program2023.**
Washington State's Birth Doula Program posted this table of birth doula competencies relevant to doulas seeking state certification. The table includes requirements related to 3 pathways to receiving state certification.

98. **Rules in Progress - Birth Doulas. Available at: https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/birth-doulas/rules-progress. Accessed, 2024.**
The Washington State Department of Health conducted rulemaking regarding birth doulas. Information about the rulemaking process is available at this webpage. Engrossed Substitute House Bill (ESHB) 1881 (chapter 217, Laws of 2022), codified under chapter 18.47 RCW, created birth doulas (doulas) as a new health profession in the State of Washington. The adopted rules establish the profession's education, training, and certification requirements.

99. **Certification Requirements - Birth Doulas. Available at: https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/birth-doulas/certification-requirements. Accessed.**
The Washington State Department of Health published information about certification requirements for birth doulas on this webpage. The website includes state certification application requirements and materials.

100. **Hegde R., McCormick, E., Payne, H., Barker, A. The Role of Culturally Congruent Community-based Doula Services in Improving Key Birth Outcomes in Kansas City.Center for Health Economics and Policy: Institute for Public Health at Washington University 2022.**
Hedge et al. wrote this research brief that describes an analysis of health outcomes of a non-profit organization (Uzazi Village) providing culturally congruent community-based doula care in Kansas City, Missouri. Prior research has shown that continuous doula support during labor is associated with greater likelihood of vaginal birth and shorter labor periods. The research has also found that, "[w]omen were less likely to have anesthesia and synthetic oxytocin during the birthing process, cesarean births, negative feelings about giving birth, lower APGAR scores, or admission to the NICU, and were more likely to breastfeed 1 to 2 months after giving birth." A separate 2022 study found that people who utilized doula services and people who used doula services during and after birth had 57.5% and 64.7% lower odds of postpartum depression, respectively. The researchers of this study compared Uzazi Village birth outcomes to Kansas City's overall birth outcomes. Measures studied were gestational age, birth weight, APGAR scores, and whether a neonatal intensive care unit (NICU) stay was needed. Uzazi Village data was from 2012 to ___ and included 321 records. Kansas City Health Department data from 2013 to 2020 were included. More Uzazi Village clients gave birth in a birth center or at home compared to the general population (9% compared to .05% and 6% compared to 1.0%, respectively). The researchers found that Uzazi Village measures were better than Kansas City measures across all 3 primary health outcomes. Premature birth rates were 40% lower, low birthweight was 8.5% lower, and low APGAR rates were 19% lower.

101. **Mohamed Sumaya Bashir. *Rag waa shaah, dumarna waa sheeko: Men are like tea, women are like conversation.***
***Culturally Congruent Somali Perinatal Care in Seattle, WA - A Feasibility Study*: Global Health, University of Washington; 2022.**
Mohamed conducted a feasibility study in this thesis, which was submitted in partial fulfillment of the requirements of a Master of Public Health degree in 2022. The study examines the Mama Amaan Perinatal Care Model, which is an intervention designed to improve prenatal, birth, and post-natal experiences and outcomes. The program provides culturally congruent care to Somali refugee and immigrant households in the South King County area of Washington State. The author defines cultural congruence as, "increasing provider quality of services by situating patient needs within their broader, dynamic, and relevant cultural context." Separate researchers have defined cultural congruence as, "a standard of care that is viable when providers and clients create an appropriate fit between professional practice and what patients and families need and want in the context of relevant cultural domains." The program bundled birth information and services for clients through perinatal pop-up sessions, social media campaign information, and referrals. The project also trained East African doulas, nurses, and health educators in culturally

congruent birth education classes. “Participants were provided free certified birth and postpartum doula care.” The project “delivered doula services to 16 participants who utilized pop-partum doula services which includes 3 who also received birth doula services.” The researcher conducted focus groups, interviews, participant observations, and collected survey data to evaluate the program’s model. The researcher used community-anchored qualitative research methods throughout the study. Feasibility, acceptability, and implementation of the program were evaluated. Participants reported that the benefits of attending Mama Amaan sessions were learning about rights and options in healthcare, gaining a support system, and having fun and relieving stress. The researchers stated that participants reimagined a new framing of community congruence, “which included three core principles: 1) transformative mutual reciprocity; 2) constant cycle of flexibility, adaptability, and a little chaos; and 3) relational practice of listening, connecting, and building trust.” The program increased awareness of doula services. The researcher stated that participants received tools, resources, and strategies to advocate for themselves and their community.

102. **White Supremacy Culture. Available at: https://www.thc.texas.gov/public/upload/preserve/museums/files/White_Supremacy_Culture.pdf. Accessed, 2024.**
The Minnestoa Historical Society published this overview of white supremacy culture, compiled from "Dismantling Racism: A Workbook for Social Change Groups, by Kenneth Jones and Tema Okun, ChangeWork, 2001". White dominant or white supremacist culture includes norms such as perfectionism, a sense of urgency, defensiveness and/or denial, quantity over quality, worship of the written word, the belief in one “right” way, paternalism, either/or binary thinking, power hoarding, fear of open conflict, individualism, progress defined as more, the right to profit, objectivity, and the right to comfort.

103. **Henley M. M. . Alternative and Authoritative Knowledge: The Role of Certification for Defining Expertise among Doulas. *Social Currents.* 2015;2(3):260-279.**
Henley used narrative data from 25 interviews with birth doulas in the southwestern U.S. to analyze the role of certification in legitimating doulas’ alternative knowledge about childbirth. The research aimed to “understand the rationales that doulas have for choosing whether to obtain certification, the importance that certification plays in establishing legitimacy to [birthing people] and/or the medical community, and their view of the role of certification versus alternative indicators of knowledge for obtaining legitimacy.” Participating birth doulas were recruited through local doula organizations, hospital and birth center postings, web listings, and snowball sampling. Participants volunteered to meet (in person, by video call, or by phone call) for a semi-structured interview (nonrandom sampling). Henley recorded and transcribed the interviews and highlighted key themes within the transcripts. The sample was majority white (80%), and 3 participants identified as Hispanic, 1 identified as half Asian and half white, and 1 identified as mixed race. Participants ranged in age from 24 years of age to 66 years (median 40 years, mean 42 years). Most participants (92%) had either some college or a bachelor’s degree, and 5 (20%) had a nursing degree. The average income from dual work was $4,384 per year. Most reported that the husband’s salary allowed them to do the work, while others reported working another job (6) and some (5) reported offering extra services (e.g., massage, photography) to earn extra money. Overall, 14 participating doulas were certified and 6 had a certification in progress (total 80% with or pursuing certification), and 5 had received training

but chose not to get certified. Most doulas interviewed in this study "indicated that experience mattered more to their clients than did certification, but doulas believed that the authoritative experts on birth (medical clinicians) valued certification more than clients did." Overall, "80% of doulas argued that certification would create a standard whereby medical clinicians [physicians, nurses, and hospital personnel] would be more likely to welcome doula care as a legitimate part of labor and delivery." Birth doulas who choose not to become certified shared a desire be free from perceived restrictions on their practice, felt that certification did not matter for recruiting clients, and believed "doulas would not achieve expert status by working within the medical system." Uncertified doulas "argued that other factors such as their rapport with clients, their years of experience, or the number of births they have attended legitimated doula work." Henley reported, "[this] research suggests that certification plays an important role in legitimating alternative knowledge." Limitations of the study and opportunities for future research include incorporating perspectives of medical providers and pregnant people.

104. **Dill J., Morgan J. C., Van Heuvelen J., Gingold M. Professional certification and earnings of health care workers in low social closure occupations. *Soc Sci Med.* 2022;303:115000.**

Dill et al used the Current Population Survey (IPUMS CPS), from January 2015 through February 2020, to assess the benefits of professional certification for healthcare workers—specifically, personal care aides, medical transcriptionists, medical assistants, and community health workers—in occupations where "certification is generally not required by state scope of practice regulations but may be valued by employers." Authors noted that the credentials are increasingly required of workers without a college degree and that this certification system is embedded in "trade, industry, and professional associations that offer occupational certifications that vouch for an individual's work-related skills and abilities" rather than the formal education system. The analysis looked at which workers were more likely to gain occupational certification and measured the relationship between weekly earnings and occupational certification (and the relationship between weekly earnings and unionization) among healthcare workers in low social closure occupations. Authors also assessed differences in rewards across gender and race-ethnicity. The sample from the UPUMS CPS, a monthly U.S. household survey conducted by the U.S. Census Bureau and the Bureau of Labor Statistics, included 5,185 workers (i.e., employed as a wage or salaried worker; worked full-time; and worked as 1 of the 4 healthcare occupations of focus). Of the sample, 60% of workers did not have a professional certification or union coverage, and they were predominately women (87%) and earned on average $634 per week. Workers who had a professional certification earned $719 per week on average, 90% were women, and a higher percentage of workers with professional certification were white (60%) compared to other groups of workers. Workers who were unionized earned an average of $704 per week, and 80% were women and a higher percentage of unionized workers were people of color (22% Black, 25% Hispanic, and 15% another race-ethnicity). A small number (n=158) belonged to a union and had a professional certification. In addition to dependent variables (i.e., attainment of a professional certification and natural log of weekly earnings) and independent variables (i.e., professional certification, union membership/union contract, occupation) researchers included demographic variables (i.e., sex, race-ethnicity, country of origin, age, educational attainment, geographic region) and weighted analyses to ensure that the sample was representative of the U.S. population. Results of the models showed that "workers of color [had] significantly lower odds of attaining a certification, while women [were] 1.2 times more likely than men to an earn a certification." Authors reported, on average, workers who had earned a professional certification had weekly earnings that were 4.8% higher ($p < 0.001$) than workers who did not have a certification, while controlling for education and other demographic characteristics. Specifically, "the returns on professional certifications range from 5.6% higher weekly earnings for medical assistants, 3.3% higher earnings for personal care aides, and 13.7% higher earnings for community health workers. However, given the modest wages […] the increase in weekly earnings may not be very substantial." Workers who were unionized had weekly earnings that were 6.9% higher than workers who were not unionized ($p < 0.001$), indicating that "other social closure mechanisms, like unionization, may have similar or greater wage benefits for workers." Data indicated women experienced lower gains in weekly earnings from professional certification (3.8% higher weekly earnings than women without a certification) compared to men who had a professional certification (11.3% higher weekly earnings than men without a certification). Finally, "Black and Hispanic workers experience[d] modest rewards for certification (weekly earnings that [were] 1.2% and 5% higher, respectively) that [were] lower than the rewards gained by white workers (6% higher weekly earnings)." Results indicated "the rewards for unionization are more equitable across racial-ethnic groups, suggesting that the group bargaining power is more protective of marginalized workers as compared to individualized credentialing and merit." Authors concluded results showed "evidence that having a professional certification is related to modestly higher weekly earnings among workers in [the] sample, [and] findings raise concerns about variation in access to professional certification and the equity of rewards for certification."

105. **DONA International. Available at: https://www.dona.org/. Accessed 2024.**
DONA International is a nonprofir organization that provides training and certification for doulas. DONA has certified more than 14,000 DONA International doulas in more than 50 countries.