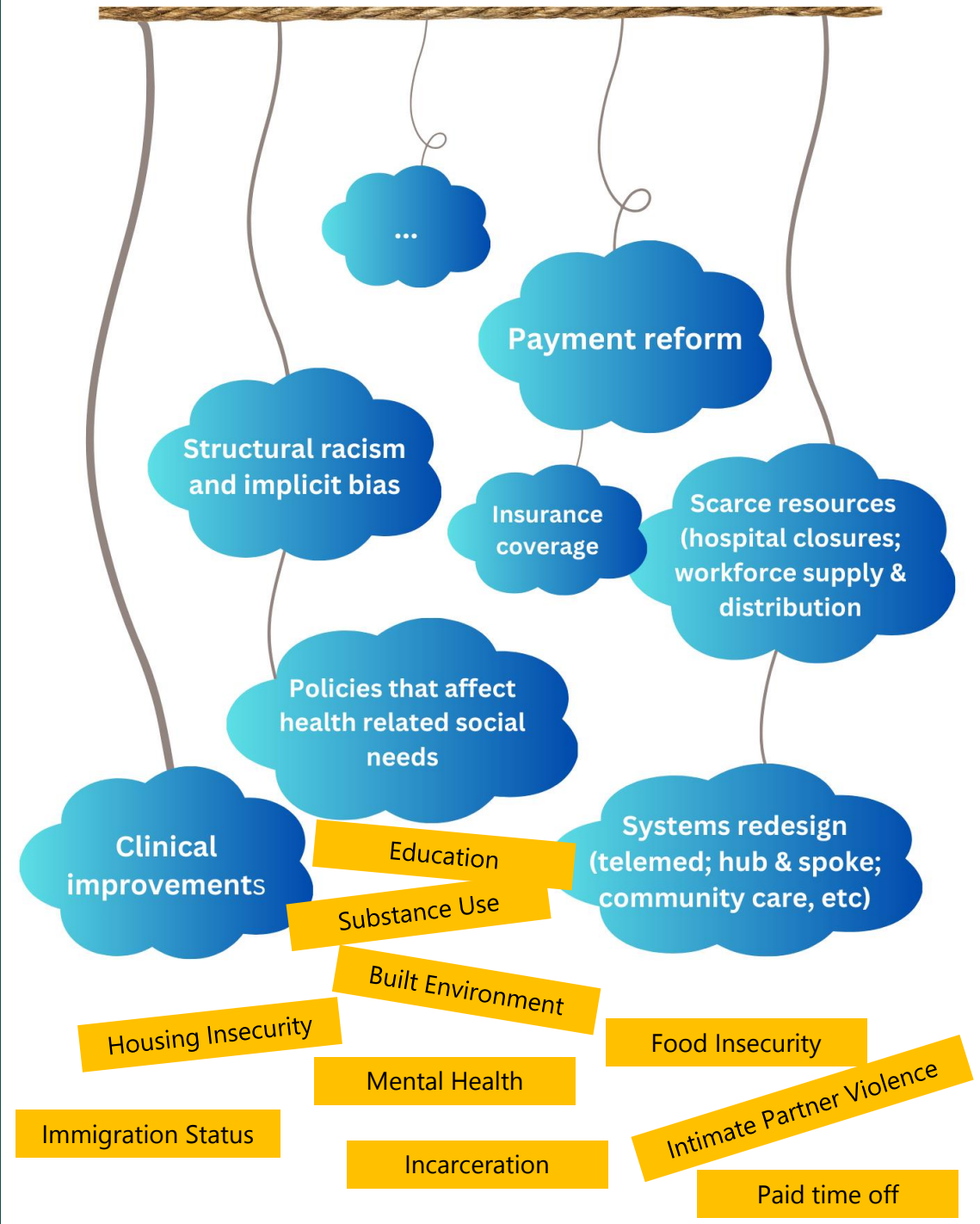
Integrating Midwives and Birth Centers

A Powerful Strategy in a Devastating Crisis

Holly Smith, CNM, MPH, FACNM

Objectives

- ✓ Understand the midwifery model of care (and specifically in CA)
- ✓ Understand the role of Birth Centers to improve access, outcomes, and patient experience
- ✓ Identify what YOU can do to advance midwifery in CA



Maternity Care Improvement Ecosystem

- Vast, confusing network of interconnected concepts → Clinical improvements alone won't solve the problem

Birth Equity

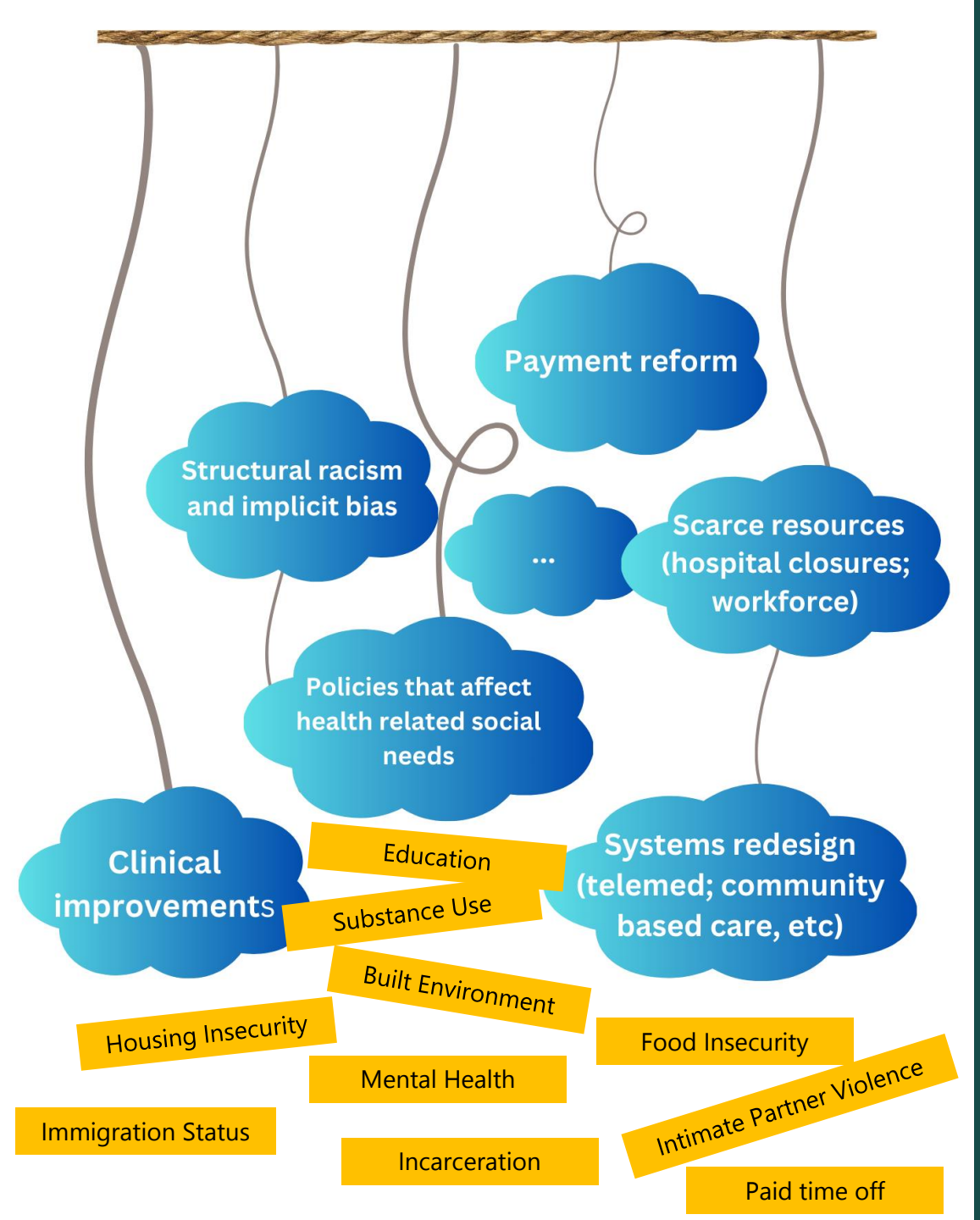
Birth Equ·i·ty */noun/*

1. The assurance of the **conditions** of optimal births for all people with a **willingness** to address **racial and social inequalities** in a **sustained** effort.

- Aspirational
- Constant gardening (no one-offs)
- Emotional Intelligence
- Radical Empathy
- Innovative thinking
- Deconstructing harmful power centers
- Systems change
- Consider upstream social determinants of health
- Deal with health-related social needs
- Requires us to break our bias and destigmatize
- Trauma-informed

Typical Clinical Quality Improvement Efforts

Outcome-oriented
Cookie Cutter processes
Concrete measurable data sets
Target goals that are "good enough"
Low-hanging fruit
Start and stop
Behavior change but not hearts and minds

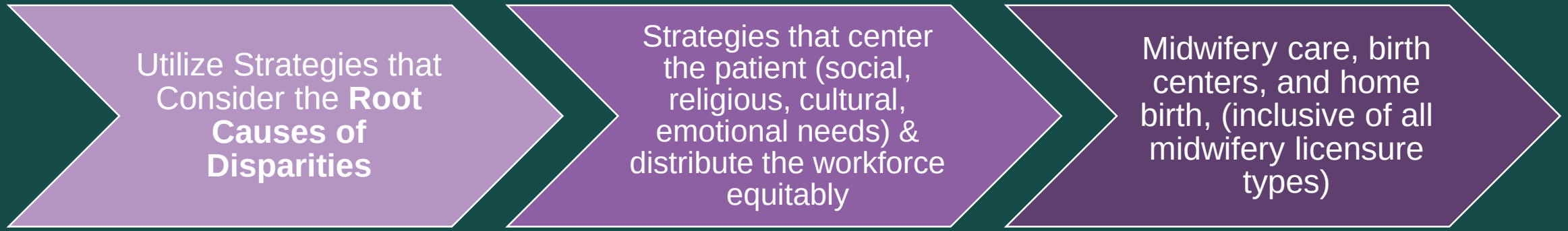


The Work Must Be Intentional…

- ✓ Consider community needs/wants in our approaches to quality improvement (patient and community-centeredness)
- ✓ Incorporate improvement measures that evaluate respect, dignity, and implicit bias in childbirth
- ✓ Humility to accept that what we are doing right now isn't working for everyone
- ✓ Use all the tools in the toolbox, not just the easy "low-hanging" strategies
- ✓ **Utilize strategies that consider the root causes of disparities**

Birth Equity

The assurance of the **conditions** of optimal births for all people with a **willingness** to address **racial and social inequalities** in a **sustained** effort.



Midwifery & Racism Based Disparities

Black Mamas Matter Policy Agenda

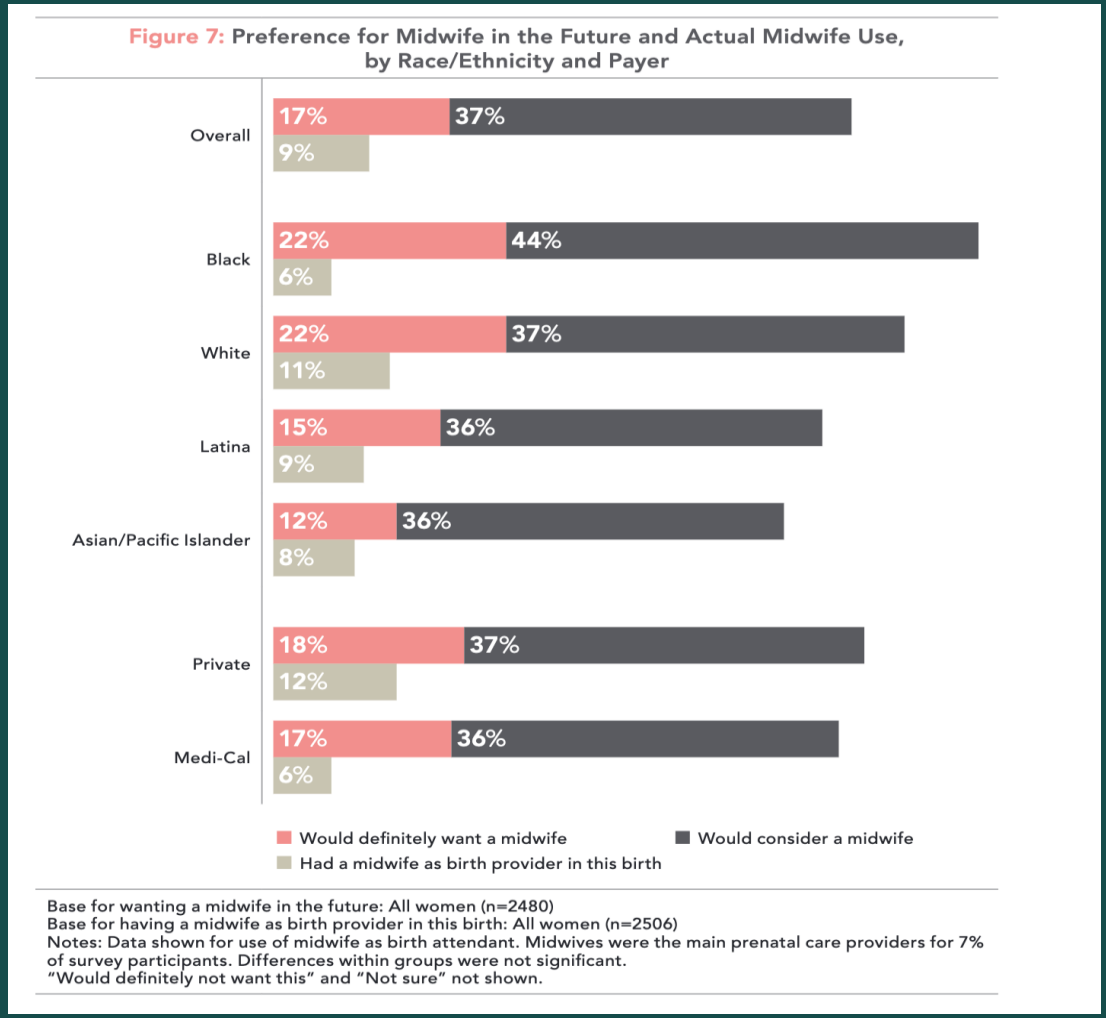
- Expand midwifery licensure and access
- Increase access to birth centers
- Develop home birth infrastructure

The California Black Birth Justice Agenda: Unifying the Vision for Systemic Change 2023

- Expand Coverage for Community-Based Care to Increase Access to Holistic Support

Battling Over Birth: Black Women & The Maternal Health Care Crisis in California

- Black women identify increased access to the midwifery care as one of the key interventions to solving the Black maternal and infant mortality and morbidity health crisis in California.

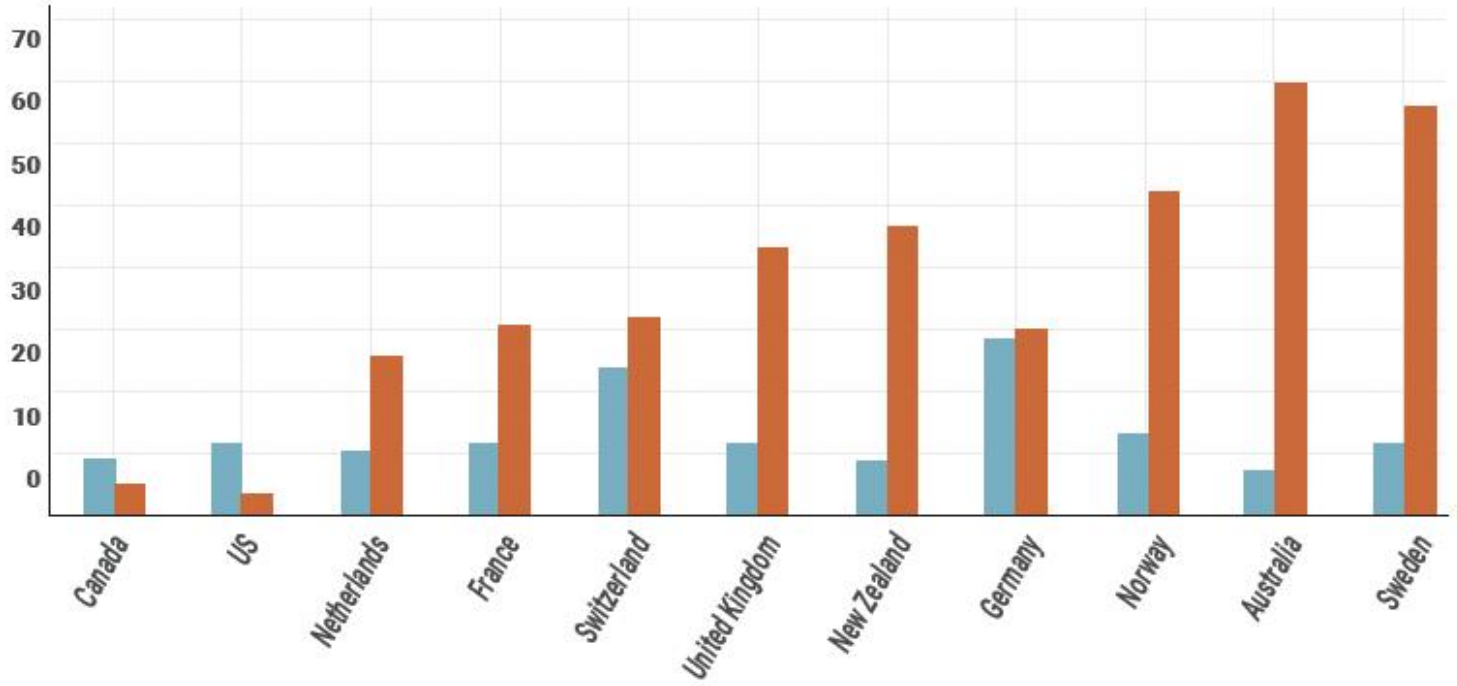


Source: https://blackmamasmatter.org/wp-content/uploads/2023/04/0411_BMMA_PolicyAgenda_v5.pdf
https://www.amazon.com/Battling-Over-Birth-Maternal-Health/dp/1946665118
https://www.cablackbirthjustice.com/_files/ugd/7182a6_1470f2ddaa5743408ecf659a8f454b76.pdf
https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf

Midwifery Care

The midwifery model of care is standard in all countries that have better birth outcomes

Figure 14. Midwifery around the world: Comparison of United States to other Countries

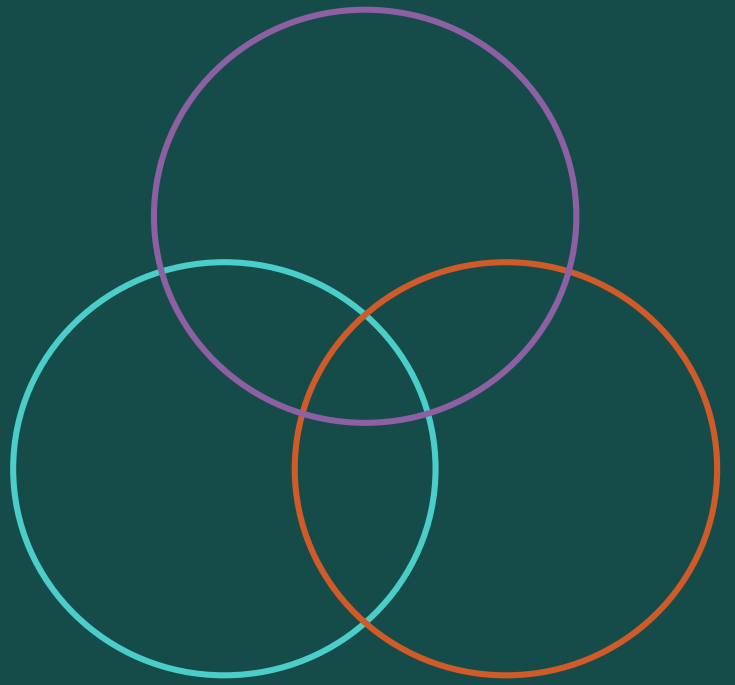


Source: Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal Mortality and Maternity Care in the United States and Developed Countries. 2020 https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries

Midwifery Care

Midwifery philosophy has long preserved three immutable elements:

- Patient-centeredness
- “The therapeutic use of the human presence”
- Nonintervention unless necessary for the health and well-being of the pregnant person and/or fetus



Sources:
1.Akileswaran CP, Hutchison MS. Making Room at the Table for Obstetrics, Midwifery, and a Culture of Normalcy Within Maternity Care. Obstet Gynecol. Jul 2016;128(1):176-80. doi:10.1097/aog.0000000000001493
2. ACOG. Collaboration in Practice: Implementing Team-Based Care.

Midwifery Care

The WHO defines midwifery as:

> *“ the skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from prepregnancy, pregnancy, birth, postpartum and the early weeks of life.”*

In California: CNMs also do well-person gynecology and medical and aspiration abortion in the 1st trimester.

Birth Centers

The birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. The bir th center is **freestanding** and not a hospital.

Birth centers are an **integrated part of the health care system** and are guided by principles of prevention, sensitivity, safety, appropriate medical intervention and cost-effectiveness. While the practice of midwifery and the support of physiologic birth and newborn transition may occur in other settings, this is the exclusive model of care in a birth center.

The birth center **respects and facilitates a woman's right to make informed choices** about her health care and her baby's health care based on her values and beliefs. The woman's family, as she defines it, is welcome to participate in the p regnancy, birth, and the postpartum period.

Benefits of Midwifery Care

MORE Likely With Midwifery Care:

- Spontaneous Vaginal Birth
- Trial of Labor After C-Section (TOLAC)
- Vaginal Birth After C-Section (VBAC)
- Breast Feeding
- Patient Confidence & Control
- Patient Centered Care
- Lower Costs

LESS Likely With Midwifery Care:

- Cesarean birth
- Operative Vaginal Delivery
- Induction of Labor
- Episiotomy
- Perineal Lacerations
- Use of Pain Medicine
- Epidural Anesthesia
- Continuous Fetal Monitoring
- NICU Admissions
- Preterm and low birth weight
- Fewer Infant Emergency Dept Visits & Hospitalizations
- Fewer Neonatal Deaths

Sources:
CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: https://www.cmqcc.org/VBirthToolkit
CMS Strong Start for Mothers https://www.cms.gov/priorities/innovation/files/reports/strongstart-prenatal-fq-finalevalrpt.pdf
Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, Cheyney M, et al. (2018) Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLoS ONE 13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523
An alternative model of maternity care for low-risk birth: Maternal and neonatal outcomes utilizing the midwifery-based birth center model https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14222

PRENATAL CARE: Community Based Midwifery vs Routine Care

Community Midwifery Model of Care

4-10 hours of face to face time with the provider

- Typical Visit Schedule:
  - 8-10 visits
  - Typically 30 min - 60 min with the pregnant person
- Between visits:
  - Availability of midwife via phone, text or email between visits
- Integration of childbirth education, doula services, Breastfeeding education
- Referral as needed for additional support

Typical / Routine Model of Care

50 min-2.5 hours of face-to-face time with the provider

- Typical Visit Schedule:
  - 8-10 visits
  - Typically 15 min for whole visit (chart review, visit and charting on patient). Often 6-10min of actual facetime with the pregnant person.
- Between visits:
  - In some practices, availability of after hours support from other team members
  - Urgent Care/ER for after hours care
- Referral as needed for additional support

LABOR & DELIVERY Community Based Midwifery vs Routine Care

Community Midwifery Model of Care

Labor & Delivery planned for home or birth center

- Continuity of Care:
  - Midwife is known to the birthing person before labor begins
  - **Continuous labor support midwife present from start of active labor through early postpartum**
- High-quality safe care:
  - Ability to identify and treat many obstetric emergency on site.
  - Identification of indications for transfer of care.
  - The majority of transfers are for pain management or stalled labor not for emergencies.
- Team for delivery and postpartum
  - Minimum two trained health care providers at delivery
  - Doula support is routine
- Pain Management
  - Tools include: continuous support, massage, water therapy, nitrous oxide
  - Doula support routine

Typical / Routine Model of Care

Labor & Delivery occurs in the hospital

- Team for Delivery
  - L&D nurse (RN) routinely new the patient
  - Often the provider (MD or CNM) may be new to the patient
  - **Providers may or may not be in the hospital until birth is imminent (MD or CNM) and typically leave within 15-30 min after delivery**
  - Multiple healthcare providers present at delivery, often many are new to the patient
- Ability to identify and treat obstetric emergency on site.
  - Ability to care for higher risk pregnancies
  - Access to medications and team to manage care for preeclampsia, hypertension, diabetes, etc.
  - Hospitals vary with their ability to identify & treat ob emergencies: Anesthesia may or may not be in house, OB trained in surgery may or may not be in house etc.
- Pain Management:
  - Tools include: fentanyl, epidural. More rarely may include: Nitrous, and water therapy.
  - Doula support if the pregnant person has personally arranged for a doula

IMMEDIATE POSTPARTUM (first 24 hrs) – Community Based Midwifery vs Routine Care

Community Midwifery Model of Care

- Pregnant person is routinely home in their own space at 4-6 hours postpartum (if birth occurs outside the home)
- **Active support for rest and recuperation of birthing person and support for breastfeeding**
- Newborn Care:
  - Newborn exam
  - Breastfeeding support
  - Newborn medications (Vit K, Hep B, Erythromycin)

Typical / Routine Model of Care

- Birthing person and newborn typically hospitalized for 24-48hrs after birth
- Screenings and visits for birthing person and baby typically performed on schedule of staff person (disruptive to rest and recuperation of birthing person)
- Newborn Care:
  - Newborn Exam
  - Breastfeeding support
  - Newborn medications (Vit K, Hep B, Erythromycin)

POSTPARTUM CARE (first 6 wks) Community Based Midwifery vs Routine Care

Community Midwifery Model of Care

2-4 hours of face-to-face time with provider. Every visit includes care for postpartum parent and the newborn (dyad care)

- Typical Visit Schedule:
  - 3-4 visits within the first 6 weeks
  - 30min - 1 hour with provider each time
- Dyad care every visit includes:
  - Maternal health assessments at each visit: vitals, mental health screening, social support needs & breastfeeding support. Preconception counseling and birth control.
  - Infant health assessment: vitals, weight gain, screenings, breastfeeding support

Typical / Routine Model of Care

24-48 TOTAL min of face-to-face time with providers. Not dyad care.

- Typical Visit Schedule:
  - Usually 1 visit in 3-6 weeks
  - 6 – 12 minutes with provider per visit
  - Maternal health assessments: vitals, mental health screening, social support needs & breastfeeding support. Preconception counseling and birth control.
  - Separate newborn visit with pediatrician; 18-36 min with provider for 2-3 separate visits for the newborn over 8 wks.; includes infant health assessment: vitals, weight gain, screenings, breastfeeding support (usually referred to nurse or lactation consultant for breastfeeding)

CMS Strong Start Study

Compared outcomes of comparable patients in 3 expanded prenatal and birth care service types:

- Maternity Care Homes (e.g., care coordinator, enhanced care management; over 26,000 enrollees)
- Group Prenatal Care (over 10,000 enrollees)
- Birth Centers (over 8,000 enrollees)

Source: Strong Start for Mothers and Newborns Evaluation of Full Performance Period (2018): https://www.cms.gov/priorities/innovation/files/reports/strongstart-prenatal-fg-finalevalrpt.pdf

CMS Strong Start Study

Strong Start Participants in **Birth Centers** and **Group Prenatal Care** had **better outcomes** at **lower cost** relative to other Medicaid participants with similar characteristics.

	Maternity Care Homes	Group Prenatal Care	Birth Centers
Costs	• Higher costs through delivery period and following year.	• Costs $427 lower per woman during 8 months before birth.	• Costs $2,010 lower through birth and year following for each mother-infant pair.
Utilization	• Fewer prenatal hospitalizations • More infant emergency department visits and hospitalizations	• Fewer emergency department visits and hospitalizations for women and infants	• Fewer infant emergency department visits and hospitalizations
Quality	• Higher rate of low birthweight • More weekend deliveries^	• Lower very low birthweight rate • More weekend deliveries^ • More VBACs+	• Lower low birthweight rate • Lower preterm birth rate • More weekend deliveries^ • More VBACs+ • Fewer C-sections

^weekend deliveries indicate fewer scheduled inductions and scheduled C-sections
+VBAC=vaginal birth after cesarean

CMS Strong Start Study

Birth Center participants have **better outcomes** relative to Maternity Care Home participants **after controlling for demographic, medical and social risks**

	Maternity Care Homes	Group Prenatal Care	Birth Centers
Quality	This mode experienced: Preterm birth: 13% Low birthweight: 11% C-section: 31%	After controlling for risks, no significant differences in outcomes between Group Prenatal Care and Maternity Care Homes.	After controlling for risks, • Lower rates of preterm birth • Lower rates of low birthweight • Lower rates of C-section • Higher rates of VBAC

Source: Strong Start for Mothers and Newborns Evaluation of Full Performance Period (2018): https://www.cms.gov/priorities/innovation/files/reports/strongstart-prenatal-fg-finalevalrpt.pdf

CMS Strong Start Study

KEY TAKEAWAYS

Women who received prenatal care in Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start. In particular, rates of preterm birth, low birthweight, and cesarean section were lower among Birth Center participants, and costs were more than $2,000 lower per mother-infant pair during birth and the following year.

These promising Birth Center results may be useful to state Medicaid programs seeking to improve the health outcomes of their covered populations.

Midwives in California by the Numbers

1139 Total Midwives in the state

- 386 LMs
- 753 CNMs with Active Licenses

890 Midwives Enrolled in Medi-Cal

- 847 CNMs
- 42 LMs

Sources: 2019 CHCF report on Midwives (p 19) in 2019 (likely under reporting) ;

Medi Cal FFS Provider Listing downloaded on 6/6/23. (likely over reporting)

Birth Centers in California by the Numbers

Birth Centers

- 39 total Birth Centers Open (2023
- 14 Birth centers closed since 2021 (26%)

Licensed/Accredited

- 7 Licensed (17%)
- 11 Accredited (28%)

Practice Types

- 11 Solo LM
- 1 LM open model
- 11 LM group
- 9 LM ad & CNM group
- 5 CNM group

Source: American Association of Birth Centers California Chapter

Birth Numbers in CA by Provider Type

Table 1. Number of Annual Births, by Practitioner, California, 2007-2017

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Doctor of Medicine	501,262	486,714	461,951	443,563	435,221	434,621	421,882	426,326	411,158	405,219	386,646
Doctor of Osteopathy	16,187	16,854	16,423	17,220	18,661	19,575	22,243	23,959	25,027	26,860	27,414
Nurse-Midwife	42,966	42,162	42,239	42,974	41,782	42,510	43,123	45,023	47,642	48,895	49,512
Licensed Midwife	929	1,372	1,447	1,645	1,907	2,168	2,396	2,657	2,849	2,821	2,908
Other (e.g., paramedic)	4,746	4,363	4,626	4,423	4,209	4,489	4,713	4,538	4,755	4,679	4,759
Unknown or not stated	285	270	288	331	313	349	312	332	302	332	394

Source: United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, *Natality Public-Use Data 2007–2017*, on CDC WONDER Online Database, October 2018.

Over 52,000 births in CA by midwives= 11% of births in the state

*Slide source: CHCF *California's Midwives: How Scope of Practice Laws Impact Care.* 2019.

Overview of Birth Numbers in CA by Provider and Setting (2017)

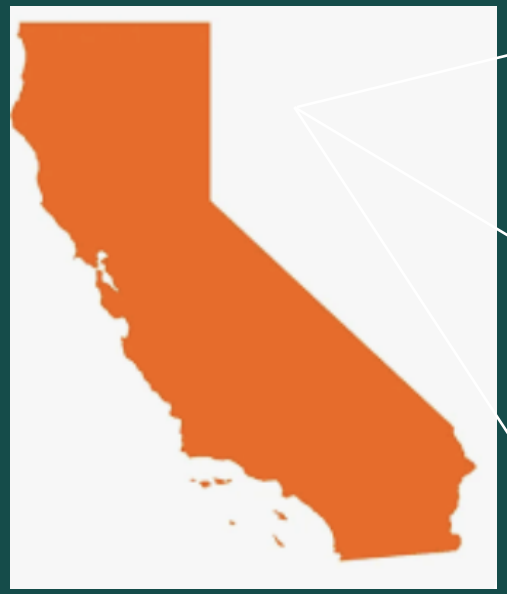
Table 2. Birth Settings, by Practitioner, California, 2017

	DOCTOR OF MEDICINE (MD)	DOCTOR OF OSTEOPATHY (DO)	NURSE-MIDWIFE (NM)	OTHER MIDWIFE
In Hospital	386,581 (99.98%)	27,414 (100.00%)	48,402 (97.76%)	84 (2.89%)
Freestanding Birth Center	0	0	781 (1.58%)	618 (21.25%)
Residence	44 (0.01%)	0	310 (0.63%)	2,157 (74.17%)
Other	21 (0.01%)	0	19 (0.04%)	49 (1.69%)
Unknown	0	0	0	0

Notes: *Other midwife* is the terminology the CDC uses for non-nurse midwives. There may be errors in the data associated with hospital birth attendance. California birth certificates also do not state the planned birth location.

*Slide source: CHCF *California's Midwives: How Scope of Practice Laws Impact Care*. 2019.

Midwives in California: LM and CNM



HOSPITAL FACILITY

CNM

FREESTANDING BIRTH CENTER

LM = CNM

LM > CNM

Education/Training for California Midwives

Nurse-Midwifery Education program approved by Board of Registered Nursing → American Midwifery Certification Board Exam (AMCB) → CNM certification

3-year Midwifery education program approved by the Medical Board of CA → North American Registry of Midwives Board Exam (NARM) → CPM certification

*CNMs and LMs may also meet equivalent and/or "challenge" processes approved by their respective Boards)

What Does Integrated Midwifery Care Look Like within the Larger System?

- No universal definition
- We can draw from other definitions – e.g., integrated health care generally and accepted definitions of integrated maternity care
- Other countries serve as a model
- Both micro (clinical level; interprofessional level) and macro level (state/federal) concepts of midwifery integration

What Does Midwifery Integration Look Like?

Culture of interprofessional partnership (easy access to physician consultation and collaboration); including interprofessional education

Community and hospital midwives are represented in the state perinatal collaborative

Outcomes data are readily accessible

Birth centers are licensed, accredited, or meet equivalent standards

Midwives have admission and discharge privileges

Equal reimbursement; coverage for midwives/birth centers by all payers

State laws allow midwives to practice to the full extent of education & training, including prescribing all drugs and devices in their scope

Guidelines for safe, efficient, respectful transfer exist and are created through a collaborative process

Sustained growth of community midwives,BIPOC providers

Valuing midwifery and physician care as equals (right care at the right time philosophy)

All midwifery credential types recognized in your state and regulated according to the ICM standards

Midwifery Integration HASN'T Been Achieved If….

Policy and practice founded on supervision rather than collaboration among colleagues

Hospitals in your region refuse community birth transfers

CNMs are licensed in your state but not CPMs and CMs

Midwives are privileged at your facility but function as an extension of physicians

Valuing or trusting one midwifery licensure type over another (CNM>CPM)

Hospital midwifery embraced but community birth is disparaged

Midwives in your region have a restricted scope of practice below their actual education and training

Midwives can't prescribe or access the medications they need to provide safe care

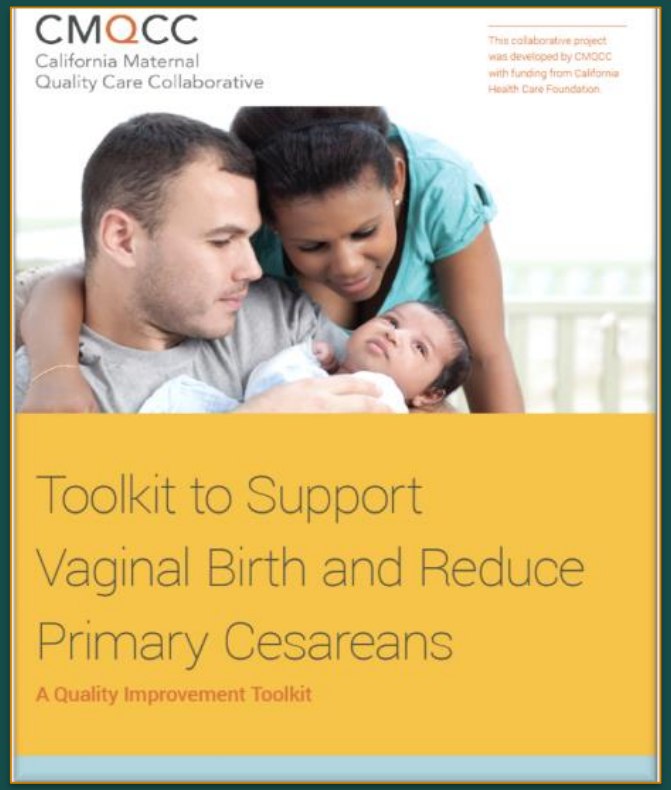
Insurers don't cover community birth (midwives not easily accessible to the public); or otherwise engage in unequal reimbursement

Patients receive disrespectful care or judgment when transferring to hospital from community birth setting

Refusal to believe that diverse care models are critical to addressing the root causes of health care disparities

CMQCC Resources

Toolkit (Part V)

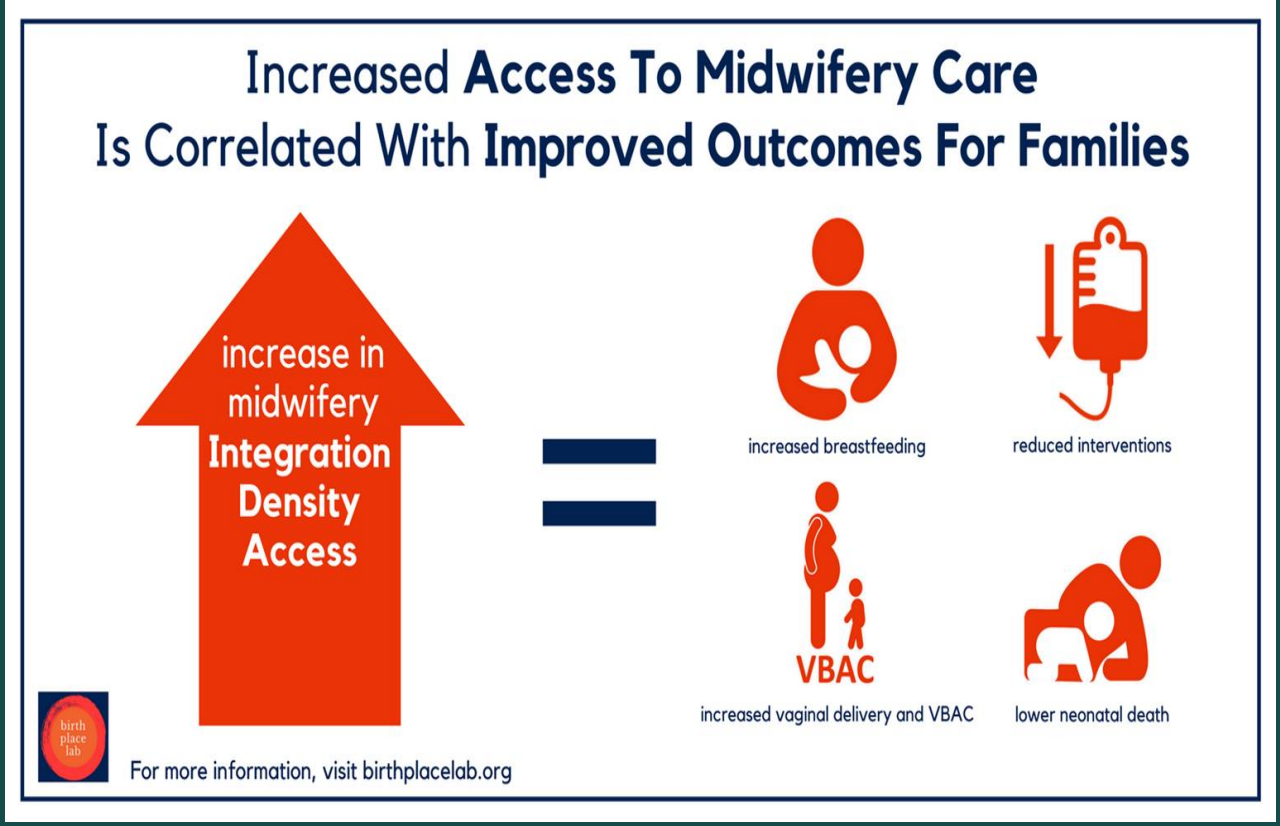


Webinar:

Tackling the Midwife Question: What is midwifery integration and why is it important for moms and birthing people in California? (May 9, 2023)

Recordings at https://www.cmqcc.org/resources-tool-kits/webinars

Does Midwifery Integration Matter?



PLOS ONE

RESEARCH ARTICLE

Mapping integration of midwives across the United States: Impact on access, equity, and outcomes

Saraswathi Vedam[1,2]*, Kathrin Stoll[1], Marian MacDorman[3], Eugene Declercq[4], Renee Cramer[5], Melissa Cheyney[6], Timothy Fisher[7], Emma Butt[1], Y. Tony Yang[8], Holly Powell Kennedy[9]

UBC birth place lab

Original Research

OPEN

Birth Outcomes for Planned Home and Licensed Freestanding Birth Center Births in Washington State

Elizabeth Nethery, MSC, MSM, Laura Schummers, ScD, Audrey Levine, BA, Aaron B. Caughey, MD, PhD, Vivienne Souter, MBChB, MD, and Wendy Gordon, DM, MPH

OBJECTIVE: To describe rates of maternal and perinatal birth outcomes for community births and to compare outcomes by planned place of birth (home vs state-licensed, freestanding birth center) in a Washington State birth cohort, where midwifery practice and integration mirrors international settings.

METHODS: We conducted a retrospective cohort study including all births attended by members of a statewide midwifery professional association that were within professional association guidelines and met eligibility criteria for planned birth center birth (term gestation, singleton, vertex fetus with no known fluid abnormalities at term, no prior cesarean birth, no hypertensive disorders, no prepregnancy diabetes), from January 1, 2015 through June 30, 2020. Outcome rates were calculated for all planned community births in the cohort. Estimated relative risks were calculated comparing delivery and perinatal outcomes for planned births at home to state-licensed birth centers, adjusted for parity and other confounders.

RESULTS: The study population included 10,609 births: 40.9% planned home and 59.1% planned birth center births. Intrapartum transfers to hospital were more frequent among nulliparous individuals (30.5%; 95% CI 29.2–31.9) than multiparous individuals (4.2%; 95% CI 3.6–4.6). The cesarean delivery rate was 11.4% (95% CI 10.2–12.3) in nulliparous individuals and 0.87% (95% CI 0.7–1.1) in multiparous individuals. The perinatal mortality rate after the onset of labor (intrapartum and neonatal deaths through 7 days) was 0.57 (95% CI 0.19–1.04) per 1,000 births. Rates for other adverse outcomes were also low. Compared with planned birth center births, planned home births had similar risks in crude and adjusted analyses.

CONCLUSION: Rates of adverse outcomes for this cohort in a U.S. state with well-established and integrated community midwifery were low overall. Birth outcomes were similar for births planned at home or at a state-licensed, freestanding birth center.

(Obstet Gynecol 2021;138:693–702)
DOI: 10.1097/AOG.0000000000004578

A small but increasing[1] number of families are choosing community births[2] at home or in freestanding (out of hospital) birth centers in the United

Summary:

- Outcomes are similar for home birth and birth center birth in a well-integrated system.

- The perinatal mortality rate was identical to what ACOG cites as the hospital benchmark against which home birth perinatal mortality should be compared:

CONCLUSION: Rates of adverse outcomes for this cohort in a U.S. state with well-established and integrated community midwifery were low overall. Birth outcomes were similar for births planned at home or at a state-licensed, freestanding birth center.

(Obstet Gynecol 2021;138:693–702)
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well-integrated midwifery.[36–39] Although we are limited in this study in not having a readily available planned hospital birth cohort for direct comparison, we comprehensively compared the absolute risk of adverse outcomes with those reported in previous studies included in the recent meta-analysis[5] of planned home birth. Furthermore, the perinatal mortality rate in our cohort (0.57/1,000: 0.38 in 1,000 [intrapartum] and 0.19 in 1,000 [neonatal]) is identical to the rate ACOG cited as a benchmark against which home birth perinatal mortality should be compared: "0.57 per 1,000 (0.4 in 1,000 and 0.17 in 1,000 for intrapartum and neonatal deaths, respectively)."[11]

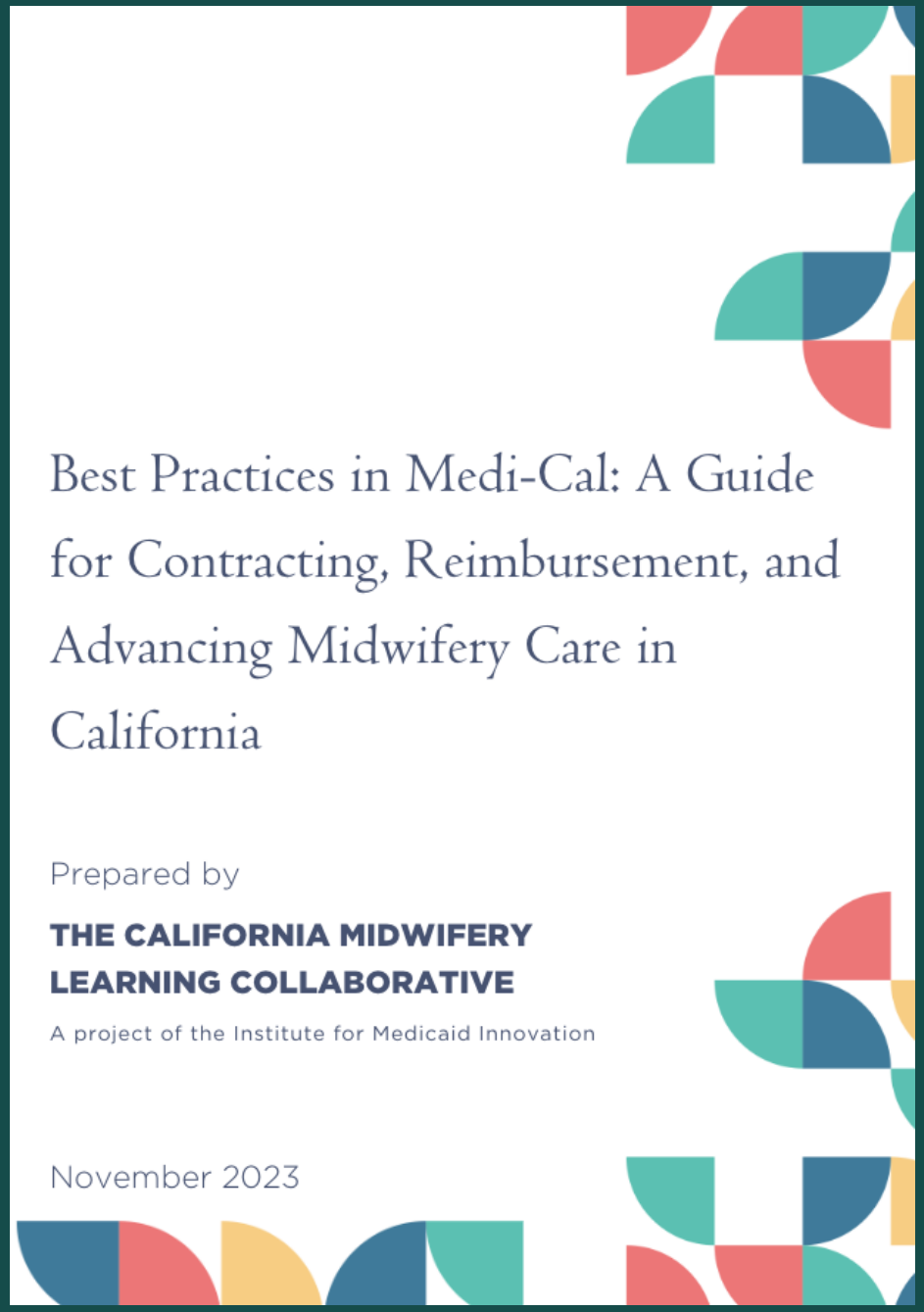
California Midwifery Learning Collaborative

- A large collaboration of midwives, advocates, state and local agencies, Medi-Cal MCOs
- Our aim: **to improve health equity and reduce disparities** for Medicaid beneficiaries, with a focus on sexual and reproductive healthcare, care during the childbearing year, and newborn care – **through midwifery integration and by increasing access to midwife-led care in all practice settings.**

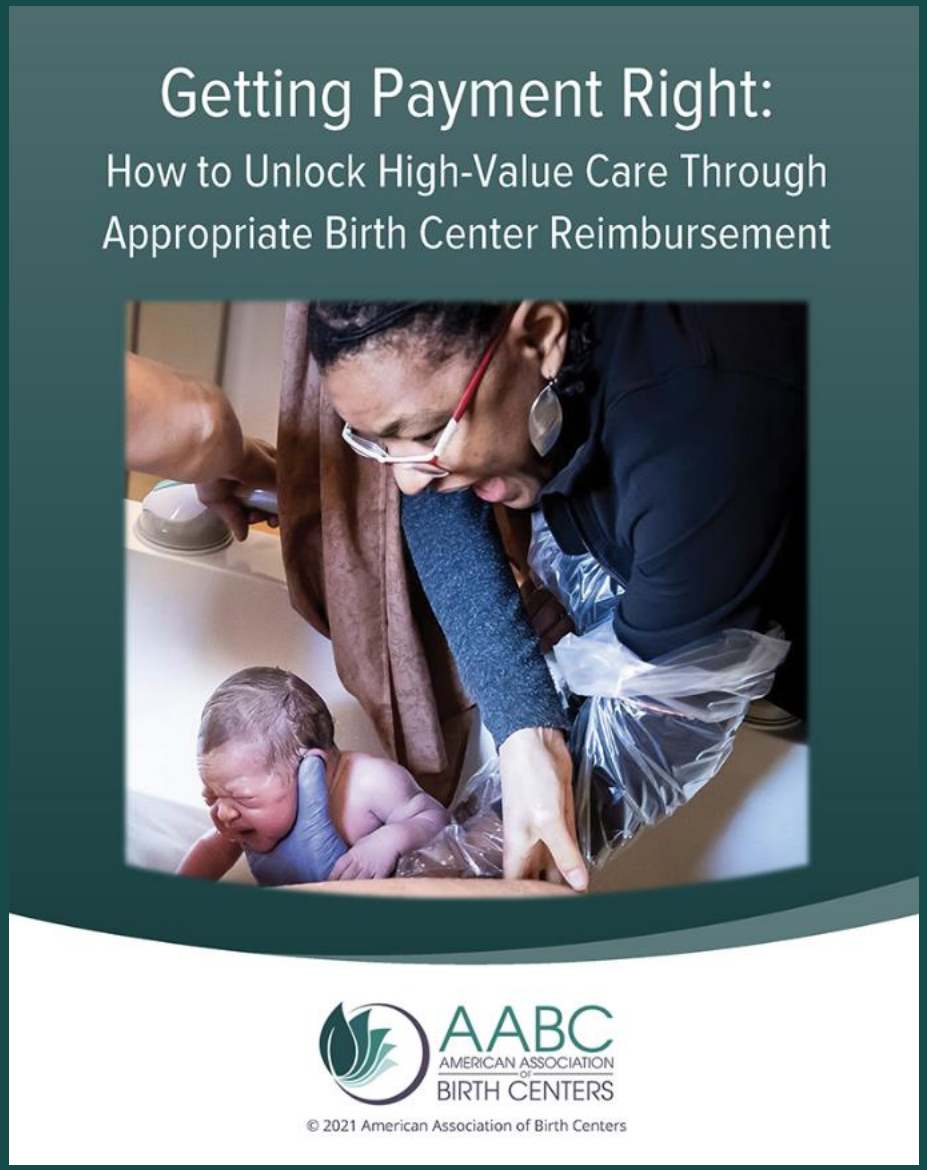
- 33 Total members
- 15+ practicing midwives
  - Including home birth practices, birth center practices, home + birth center, birth center + hospital, and hospital
- California Department of Health Services (DHCS)
- LA DPH Perinatal Equity Initiative
- 2 LA Area Medi-Cal Health Plans:
  - LA Care
  - Blue Shield Promise
- Community Advocacy Organizations:
  - California Coalition for Black Birth Justice
  - Black Maternal Health Center of Excellence at Charles Drew University
  - Maternal Child Health Access
  - National Health Law Program

Recent Work of the California Midwifery Learning Collaborative

Join our Collaborative!

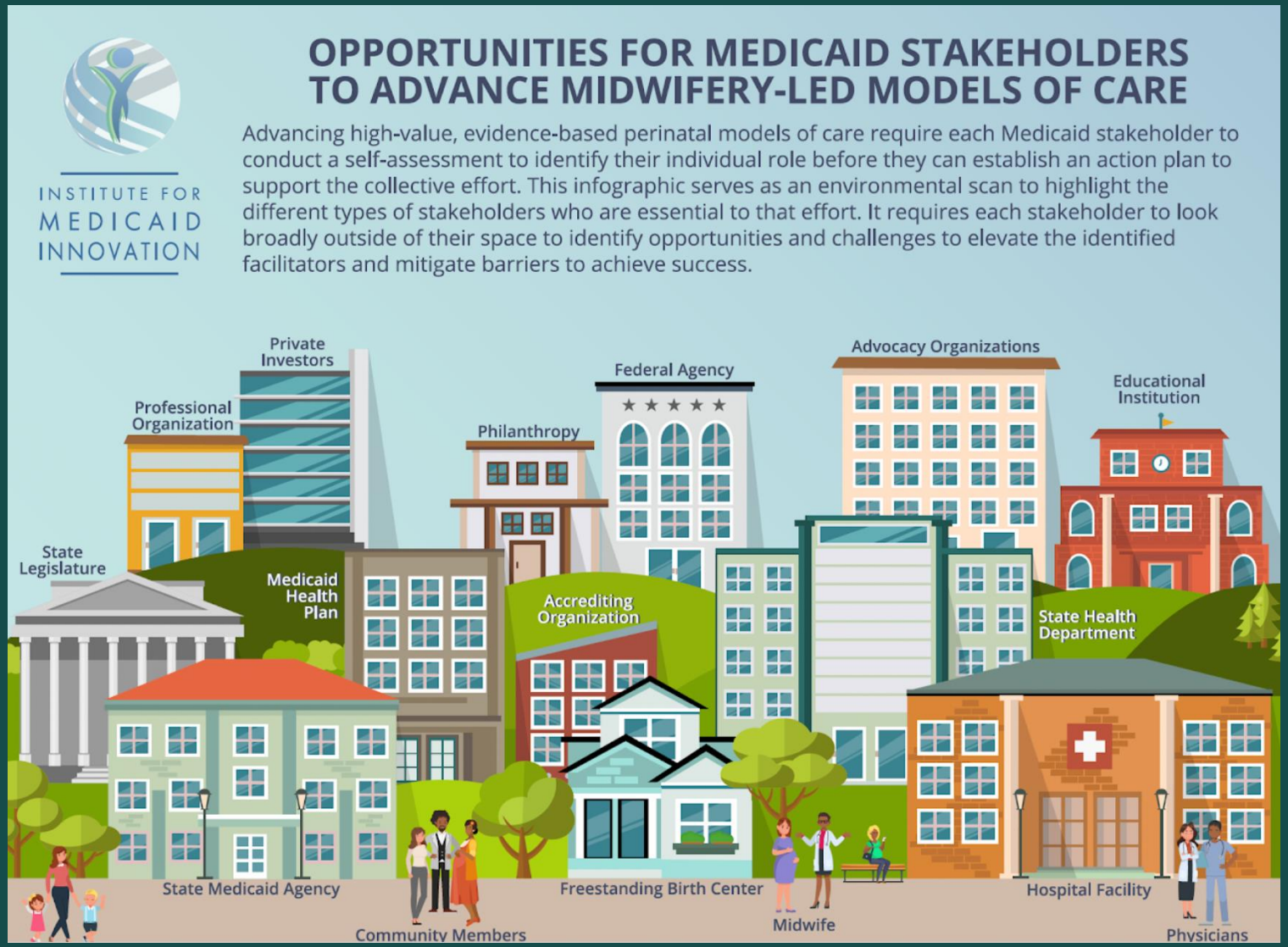


AABC Resource



https://www.birthcenters.org/

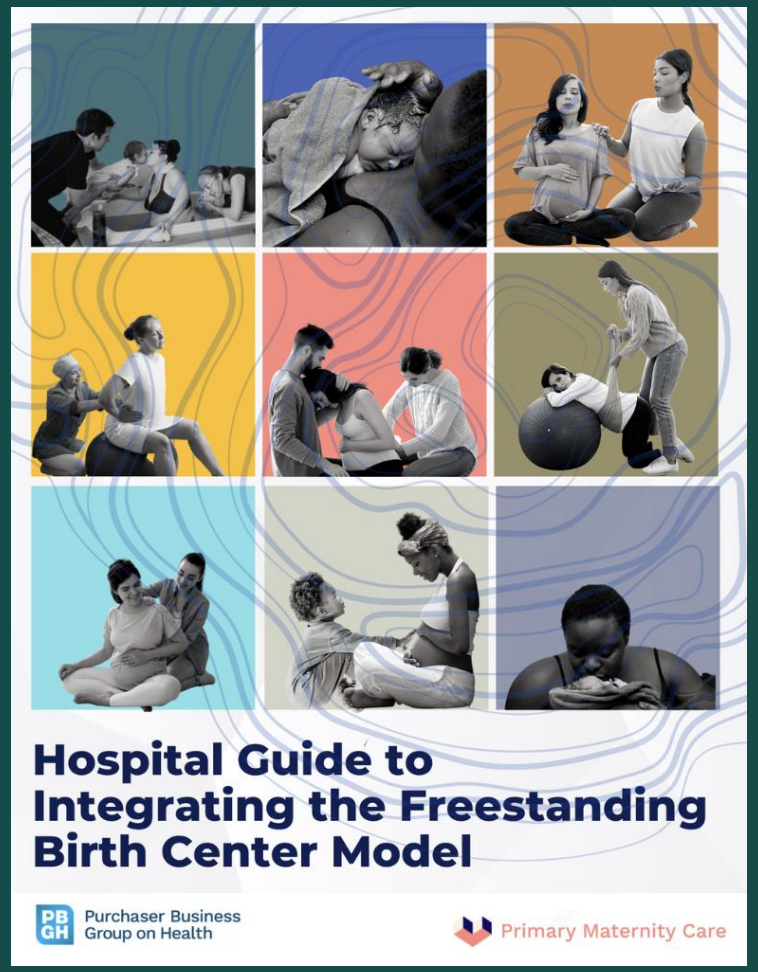
Institute for Medicaid Innovation Resource



INSTITUTE FOR MEDICAID INNOVATION

http://tinyurl.com/StakeholderChecklist

Purchaser Business Group on Health (PBGH) Resource



Let's Midwife the System

Excerpt from *Let's Midwife the System*

By Amy Romano, CNM, founder of Primary Maternity Care

Honestly, it might be our only hope...

We need a new maternity care system in the United States

One that reliably provides access in the communities where people live and work.

One that upholds fertility, pregnancy, childbirth, and the postpartum period as whole-person, whole-family experiences.

One that educates, activates, and empowers people and invites shared decision making.

One that elevates the role of the community and society in promoting and protecting the health of women and infants.

One that fights and dismantles misogyny, racism, homophobia, and all forms of bias and injustice.

One that works towards families thriving, not just surviving.

One where women and babies, especially Black women and babies, aren't dying every day of preventable complications.

Let's midwife the system.

For questions, or to join the Midwifery Learning Collaborative,

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