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Increased Access to Doulas, Midwives and Birth Workers is Key to Improving Michigan's Black and Indigenous Pregnancy-Related Health Outcomes

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Introduction

Michigan has one of the highest death rates among Black pregnant people in the country.^{1,2} Black and Indigenous Michiganders live with reduced access to health care, fewer financial resources, less access to stable housing, and more food insecurity.³ During pregnancy, these harms are compounded by providers and institutions that devalue their lives. This compounded harm underlies the increased risk of pregnancy-related deaths and complications in Black and Indigenous communities. Medically, pregnancy-related deaths are frequently attributed to blood loss, infection, or heart complications,⁴ and pregnancy-related complications are attributed to high blood pressure and blood loss.⁵ However, these outcomes reflect systems and institutions that fail to provide Black and Indigenous people with comprehensive, high-quality care. Increasing access to doulas, midwives and birth workers would significantly improve Michigan's Black and Indigenous pregnancy-related outcomes.

More than **6 in 10** of Michigan's pregnancy-related deaths are preventable - which is higher than the national rate. And Black pregnant Michiganders die at a rate of **2.8 times** more than white pregnant Michiganders.

Stark Racial Disparities: Michigan Pregnancy-Related Death and Complications for Black and Native Birthing People

In Michigan, disparities persist across pregnancy-related injuries and complications and pregnancy-related deaths. In 2019, approximately 2,000 pregnant people in Michigan had life-threatening pregnancy complications, such as severe bleeding or infections after childbirth and high blood pressure during pregnancy.⁶ But these harms do not fall equitably. **Black pregnant people are more than twice as likely as white pregnant people to experience a severe pregnancy complication⁷ and most of these pregnancy-related complications are preventable.⁸**

While Michigan's overall pregnancy-related death rate is lower than the national average⁹, there are stark disparities between Black and white deaths. Black pregnant people in Michigan die at a rate 2.8 times higher than white pregnant people.¹⁰ Historically, Michigan's death rate disparity was one of the highest in the country, surpassing 35 other states¹¹ and higher than the national disparity rate.¹² Notably, more than 6 in 10 of Michigan's pregnancy-related deaths are preventable;¹³ also higher than the national rate¹⁴.

Unfortunately, there is no comparable data for Indigenous pregnant people in Michigan. Nationally, Indigenous pregnant people die at a rate almost 2 times higher than white pregnant people.¹⁵


Flaws in the System: Barriers in Accessing Pregnancy-Related Health Care

Pregnancy-related deaths not only result from centuries of policy decisions regarding how Black and Indigenous women and birthing people live, learn, work and play; but also, from how Black and Indigenous pregnant people are valued and validated while receiving care. Other systemic factors, including biases within the health care system and economic security, contribute to maternal mortality. Health care coverage, providers that value the patient's participation in their care, employment, financial resources, and poverty, all contribute to the health of the individual and pregnancy-related outcomes. In all measures, Black and Indigenous people have fewer resources and greater restriction of choices.

Lack of access to comprehensive, high-quality care, including reproductive care, increases the risk of

pregnancy-related complications and deaths.¹⁶ In Michigan, Black and Indigenous women of reproductive age are particularly impacted. They are less likely to have employer-based coverage and more likely to experience uninsurance or gaps in coverage.¹⁷ Indigenous women of reproductive age specifically are over 2.5 times more likely to be uninsured than white women in Michigan.¹⁸ When pregnant people lack health coverage, they are more likely to skip early prenatal care visits, which leads to higher pregnancy-related death and complication rates.¹⁹ Furthermore, reduced access to contraceptive care and family planning counseling in Black and Indigenous communities increases rates of unintended pregnancies and reduces time between pregnancies.²⁰

When Black and Indigenous women and birthing people do seek out care, they are also less likely to feel listened to by providers, included as part of the process, and trusted as an expert on their bodies and how they feel. A Mothering Justice and National Women's Law Center's online poll of 525 Michigan Black women, conducted in February 2020, affirmed this experience. More than 8 in 10 Black women had at least one adverse interaction with a health care provider, including providers ignoring patients' reports of pain, dismissing patients' input, misdiagnosis or delaying diagnosis, and patients being talked down to and disrespected by providers.²¹ These experiences with providers not only reduce quality of care in the moment, but the experiences fracture trust Black and Indigenous pregnant people have in the broader health care system and affect their ability to manage their health. **In fact, 12% of Black women and 27% of Indigenous women reported avoiding visiting a doctor or seeking healthcare for themselves or other family members for fear of discrimination or poor treatment.²²**



Even during a pandemic, 8 in 10 Black women in Michigan report being ignored, dismissed, talked down to, misdiagnosed, and/or disrespected by health care providers.

Research has demonstrated that the weathering hypothesis – the connection between chronic social and economic discrimination that creates poor physical health – explains

a wide range of racial disparities in health that also impact pregnancy-related outcomes.²³ Black and Indigenous pregnant people are disproportionately overrepresented in low-paid occupations that lack fair scheduling, paid leave, and other health related benefits. Prolonged exposure to poverty and economic insecurity causes Black and Indigenous communities to experience higher rates of chronic health conditions like heart disease, high blood pressure, and obesity.²⁴ Weathering, combined with lack of access to comprehensive, high-quality care, cause Black and Indigenous pregnant people with chronic health conditions to experience elevated risk of death and complications.²⁵

INCARCERATION & MATERNAL HEALTH

Michigan's systemic incarceration of Black and Indigenous people worsens health outcomes for Black and Indigenous pregnant people. The number of women incarcerated in Michigan has increased dramatically over the last four decades. The number of women in jails increased 362% and 239% in prisons, respectively.²⁶ In 2019, Black and Indigenous women were over 3 times more likely to be incarcerated than white women.²⁷ While Black people make up only 15% of Michigan's population, they account for 53% of the prison population and 37% of the jail population.²⁸ Prisons and jails lack comprehensive prenatal care including proper nutrition, screening for high-risk pregnancies, and access to doulas and birth workers.²⁹ The failure to provide quality prenatal care results in poor health outcomes for pregnant people who are imprisoned, as well as their infants.

To achieve better health outcomes for Michigan's pregnant and parenting people of color, policymakers and elected officials must tackle the full ecosystem of systemic poverty that persists in marginalizing and making unhealthy Black and Indigenous communities.

Access to Doulas, Midwives, and Birth Workers Can Save Lives

Michigan's Black and Indigenous pregnant people require legislation that addresses systemic poverty,³⁰ as well as high-quality care before, during, and after pregnancy. An important strategy for achieving better health outcomes is to increase access to doulas, midwives, and birth workers.

Access to doulas, midwives, and birth workers improves the quality of care and could immediately impact Michigan's maternal morbidity and mortality. Patient-centered care providers, such as doulas, midwives, and birth workers, advocate for patients who are systematically discriminated against in health care settings and increase utilization of prenatal care.³¹ Pregnant people with doulas during childbirth have more positive birth experiences and fewer birth complications.³² **A pregnant person with a doula is also four times less likely to have a low-birth weight baby, two times less likely to have a medical intervention including instrument use in delivery and medications such as epidurals, and almost 10 times more likely to breastfeed.**³³ **Doulas reduce rates of cesarean delivery by 40%.**³⁴ Doulas additionally increase utilization of postpartum health care visits that reduce complications after delivery and reduce postpartum depression and anxiety.³⁵

Doulas, midwives, and birth workers not only improve pregnancy-related health outcomes, but lower birthing and postpartum costs. Pregnancy complications are associated with high costs and increase the likelihood of further hospitalizations, raising costs even more. The average cost of an uncomplicated delivery is around \$5,700, but a delivery with a complication can cost nearly \$18,000.³⁶ Considering state Medicaid programs pay for just under half of all births and their associated complications,³⁷ increasing access to this care can provide a significant investment return for Michigan. **Doula care alone is estimated to save almost \$1,000 per birth.**³⁸ **This would have translated to a savings of \$104,000,000 for the state of Michigan in 2020.**³⁹

Unfortunately, the communities most at risk of poor health outcomes during pregnancy and childbirth cannot afford access to doula, midwife, or birthing care due to costs.⁴⁰ In fact, Black people were found to be more likely than white people to desire, but unable to afford, doula services.⁴¹ Increasing Medicaid reimbursements for doula care expands access to doulas, especially for low-income and Black and

Indigenous pregnant people. Reimbursements, however, must also be enough for birth workers to financially support themselves. Four states, including neighboring Indiana, have met these dual interests by providing a \$350 to \$500 reimbursement for doula services during labor and delivery.⁴²

Moreover, the field of birth work is inaccessible for many Black and Indigenous community members. State licensure requirements can bar many Black and Indigenous birth workers from this work. For example, in the state of Michigan, birth workers, such as midwives, encounter educational fees greater than \$19,000⁴³ and licensing renewal fees of \$500 every two years.⁴⁴ Many Black and Indigenous people simply do not have the financial resources necessary to pay these costs. State licensure also includes an English proficiency test and a criminal background check,⁴⁵ both of which can prevent Black and Indigenous birth workers from supporting pregnant people in their own communities. For example, an individual can be barred for several years from receiving a license if they have been convicted of a crime, including crimes such as shoplifting or possession of a controlled substance.⁴⁶ This is particularly prohibitive for Black Michiganders, who are overrepresented in the criminal legal system.

INDIGENOUS PREGNANT PEOPLE & BIRTH WORKERS

For Indigenous populations, cultural practices may be passed down through informal education that can bar them from becoming licensed for not meeting the state's educational requirements. Moreover, some Indigenous populations are adamant about keeping their culturally informed and holistic birth care practices apart from the American medical system because it often fails to treat Indigenous patients with cultural competency.⁴⁷ There is significant work and data collection to be done to fully include Indigenous pregnant people and birth workers in the American health system.

Conclusion

Michigan's women and birthing people need concrete policies that expand and sustain access to doulas, midwives, and birth workers. Comprehensive legislation to improve Black and Indigenous pregnancy-related health outcomes must: provide full coverage of prenatal, delivery and postpartum doula, midwife, and birth worker care; reduce onerous financial and administrative barriers to licensures; and provide access to patient-centered care.

In addition to strengthening the industry of birth workers, Michigan lawmakers must also ensure that all Michiganders – especially Black and Indigenous Michiganders – can afford high-quality care that validates them before, during, and after pregnancy. Michigan's Black and Indigenous women and pregnant people also need robust legislative fixes that provide paid sick days and paid family and medical leave; fair scheduling for those in the essential, but low-paid, service industries; access to affordable, quality health insurance coverage; sustained support for child care programs and providers; and equal pay – including raising the minimum wage and eliminating the tipped minimum wage.

Passing comprehensive birth care access legislation as well as ensuring economic security for all is an opportunity for lawmakers to correct Michigan's shameful Black and Indigenous pregnancy-related health disparities.

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- 6 The data specifically refers to “women”, however, in this factsheet we use “pregnant people” for inclusivity. Michigan had a rate of 194.3 severe maternal morbidity complications per 10,000 deliveries and a total count of 2,026 severe maternal morbidity complications in 2019. See Michigan Department of Health and Human Services. “Overview of Severe Maternal Morbidity in Michigan 2011-2019.”
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- 10 The data specifically refers to “women”, however, in this factsheet we use “pregnant people” for inclusivity. In Michigan, the pregnancy-related death rate for Black women from 2014-2018 was 24.1 deaths per 100,000 while the rate for White women was 8.5 deaths per 100,000 live births. See Michigan Department of Health and Human Services. “Maternal Deaths in Michigan, 2014-2018 Data Update.”
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