# Phase 1: Preparation Report

Prepared for American Association of Birth Centers (AABC)

This report presents key findings from the first phase of diversity, equity, and inclusion strategy-building (**Phase 1: Preparation**) reflecting facilitated conversations and literature review conducted by EnterChange Group, LLC for AABC between October 2020 and April 2021.

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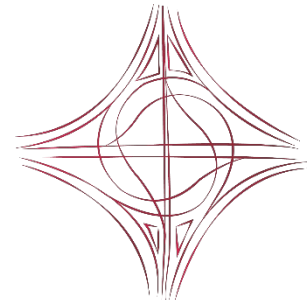
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Background

In October 2020, the American Association of Birth Centers (AABC) contracted with EnterChange Group, LLC to provide diversity, equity, and inclusion (DEI) consulting services toward the first phase, **Preparation**, of developing and implementing strategies to increase inclusion and build diversity across the national association, with emphasis on improving services to people of color, LGBTQIA+, and gender diverse individuals. Between November 2020 and January 2021, EnterChange Group conducted six facilitated conversations with AABC leadership, including members of the Board of Directors, DEI Committee, and senior AABC staff members.

These members were asked to participate in an initial survey and sign up for a date to engage in a facilitated conversation. 30 individuals completed the survey, and 25 (83.3%) of these individuals participated in a conversation. All the participants identify as women, and 5 (16.7%) identified as persons of color. Participants included those who identify as student-midwives, community midwives, certified nurse-midwives (CNM), certified professional midwives (CPM), and doulas. There was also a breadth of professional experience including those actively working within a birth center, those owning and operating a birth center, and those seeking to start a new birth center. Finally, the duration of membership in AABC ranged from individuals who had joined less than two years prior to individuals who have been members for over two decades.

These introductory conversations had the following main goals:

- Exploring the context in which AABC is pursuing this work (what is bringing us to this work)
- The history of DEI and midwifery as it relates to AABC (where we're coming from)
- How this history and context will shape the specific work of this project (where we're going)

Conversation participants were asked to respond to two primary questions:

1. **What stories do we need to know and include?** Participants were prompted to consider:
    a. Midwifery in the US
    b. AABC's history in general
    c. AABC's history with DEI

2. **What are the greatest factors affecting AABC's work to be more diverse, equitable and inclusive? What factors do you need to know more about?**
    In addition to responding verbally to this second prompt, participants were also asked to anonymously type in a shared Google document, listing contributing factors and providing any questions they had about these factors.

EnterChange Group consultants took notes during each of these conversations. We then conducted data analysis of our six sets of notes and six Google documents. From this analysis, we identified a central DEI problem, key themes or issues that contribute to this problem, and specific factors underpinning each theme/issue. This report provides findings from this analysis along with recommendations for next steps to advance this important work.

Approaching the Work through Historic and Current Contexts:

The first overarching question that EnterChange facilitators posed to conversation participants was: **What stories do we need to know?** Respondents were asked to think about this big question both in terms of EnterChange Group as DEI consultants stepping into this space and in terms of AABC leaders seeking to purposefully move the work forward. While we were open to any stories that respondents wanted to share, we also specifically prompted for answers around **midwifery in the US** and **AABC history (in general and with DEI in particular).**

History of Hierarchy in US Midwifery – Key Challenges

All six conversation groups first spoke of the importance of portraying and celebrating the accurate history of midwifery in the US. This section outlines the challenges that conversation respondents shared, along with a brief exploration of the roots of these challenges—expanded upon through environmental scanning and literature review. Patriarchy and racism as tools to control power are at the heart of the oppression that midwives have experienced over the centuries. Central to midwives' effectiveness is their willingness to *share power with* the persons to whom they are providing care. Midwives tend to *facilitate*, to ease the birthing process rather than forcing it, and they tend to honor and respect the *person* giving birth, rather than viewing such persons as objects within a scientific procedure that must be controlled. Unfortunately, centuries of oppression, power-holding, and socialization by dominant groups (i.e., cis-gender, white, straight, wealthy males) have resulted in whitewashed narratives, restrictive laws and regulations, negative perceptions, and loss of awareness and trust in midwifery practice, especially community-based practice. Such sexism, racism, and classism have also contributed to the severe perinatal health disparities seen across the US today (Suarez, 2020). While the effects of this longstanding oppression occur in a variety of ways, we highlight several specific challenges raised during the AABC facilitated conversations.

Challenge #1: Erasure of Black Midwives

Respondents tended to agree that formal education on midwifery too frequently focuses on the rise of nurse-midwifery with the Frontier Nursing Service in the 1930s. In fact, as respondents described, the history of midwifery in the US starts with immigrant midwives and the community, or "grand" midwives in the South, most of whom were Black women who were enslaved or descendants of those enslaved. These midwives provided birthing services, family support, and other remedies to those enslaved and slaveowners alike. These midwives were essential to the reproduction of the early United States, yet their history has largely been erased from educational narratives. Several respondents, especially student-midwives of color, shared that their educational experiences emphasized white perspectives of midwife history and often neglected to mention grand midwives at all. Of further note, respondents frequently used the term "granny midwives" to refer to these early Black midwives of the South. Some practitioners and scholars question the respectfulness of this term. Researchers Goode and Rothman (2017) explain that the term "granny" usually refers to the fact that these midwives were older women who had survived their own childbearing years and had assisted midwives in several more births; thus, they were well-positioned and well-skilled to help other families. Nevertheless, they note the negative implications of the term, "as it echoes connotations of passivity and servility and is closely related to the

image of the mammy, caretaker for slaveowners and their children. Neither the term granny nor mammy accurately portrays the immense wisdom" and skill sets of these early midwives (p. 73). Accordingly, Goode and Rothman champion use of the term *grand midwives* instead. How we name and talk about aspects of our history and present help shape the values, beliefs, and foundational truths upon which we build our future. That respondents across all the facilitated conversations—regardless of race—brought up the need to address the erasure of Black midwives from US history is an important testament to the willingness of participants to engage in meaningful diversity, equity, inclusion, and *justice* work. Respondents were able to collectively name this problem, though it is also critical to note that the terms used are imperfect and potentially harmful. Collectively, this means AABC has a lot of work to do to ensure that DEI efforts center the voices of those most impacted, that reckoning and healing is included in the work, and that the process embraces transparency, accountability, and intentionality.

Challenge #2: Navigating the Patriarchal Takeover of Childbirth

In discussing the history of midwifery in the US, conversation participants lamented that students are not taught the complete history of midwifery in school. Rather, they shared, stories and even existence of grand midwives has largely been erased from dominant historical narratives that instead tend to focus on the nurse-midwife practice that began in the 1930s with the Frontier Nursing Service (Thompson and Burst, 2016). Nurse-midwifery developed as a response to white, male obstetricians moving birth care services largely into hospital systems in the early 1900s. Regrettably, the emergence of physicians and the medical profession embraced an oppositional approach to community-based healthcare (Suarez, 2020; Ehrenreich & English, 2010). These obstetricians argued that birth services needed to be regulated to ensure the health of mother and baby. However, many of the respondents to our facilitated conversations acknowledged that this shift was heavily motivated by sexist and patriarchal values, coinciding with the de-valuing of women healthcare workers, community-based healthcare models, and the policing of women's bodies. The intersection of sexism, racism, and classism further devalued and erased the presence of practitioners of color, all the while Black bodies continued to be objectified and used for medical experimentation without consent (Goode and Rothman, 2017).

Nevertheless, the 1930s development of nurse-midwives corresponded with an attempt to validate the midwife industry by aligning it with the white male-driven regulations and standards of the healthcare industry. Thus, historically, there was little concern for the inaccurate representations and loss of important historical facts and an entire identity of community caregivers that resulted. In trying to push back against sexism and patriarchal oppression, the midwife industry allowed institutional racism to suppress its origin stories and to erase Black midwives from its history.

Furthermore, these attempts to align midwifery with patriarchy-driven medical practice has facilitated the construct of a hierarchy of midwives in which certified nurse-midwives (CNMs) are viewed as superior to certified professional midwives (CPMs/CMs) who are viewed as superior to direct-entry or community midwives who may or may not be viewed as superior to student-midwives. CNMs may obtain licensure in all 50 states and Washington, DC, while CPMs could only obtain licensure in 30 states, as of 2018. As Vedam et al (2018) describe, "Wide variations in state regulatory conditions for midwifery practice, especially with respect to birthplace, have created an environment of interprofessional hostility in some jurisdictions and interprofessional cooperation in others" (p. 3-4). Respondents to the AABC facilitated conversations shared stories of bullying, hazing, and infighting within midwifery

practices, frequently directed from those in positions of power to those presumed "inferior," such as community midwives and student-midwives. They further noted how folks positioned lower on the hierarchy thus have difficulty accessing meaningful preceptorships, mentorships, and even work opportunities. Midwives within hospital systems further reported difficulty—even among nurse-midwives—in advancing into leadership roles due to bias and discrimination. Respondents acknowledged the likely connection between this behavior and internalized oppression and trauma that midwives must constantly endure. Such oppression and trauma are common among actors operating under a scarcity mindset – that resources are limited, power is fiercely held and protected by a few, and everyone is expected to accept and endure this unchangeable situation. In truth, this is an example of the worst side of capitalism and business/power structures. At best, hierarchies allow for the organizing of productive workflows and worker responsibilities; at worst, they represent a tool for holding power-over others, promoting internalized oppression, and reaffirming harmful beliefs around production, solo leadership, independence, autonomy, and superiority over reproduction, shared leadership, collaboration, unity, and the valuing of difference. Addressing the root causes behind the hierarchies affecting midwifery today will be a critical foundational step toward realizing inclusive practice.

Current Climate of Midwifery and Care Work in the U.S. and Beyond

As we look at AABC's history and the history of midwifery in the US, we see how the industry continues to struggle with oppression and discrimination:

1. The erasure of Black midwives and community midwives from the history that is most commonly accessible and taught to emerging practitioners contributes to a dominant narrative of midwifery as a service for privileged white women. Even since the resurgence of community-based care in the form of direct service or "home birth midwives" starting in the 1960s and 1970s, most people who have out-of-hospital births have been white, middle- or upper-class women. Funding, education, and resources flow through economic, educational, and professional systems that perpetuate this systemic racism, reducing access both for patients and practitioners of color. Over the decades, Black, indigenous, other people of color (BIPOC) perceive (through lack of representation, inclusion, or access to resources) that they are not welcome within the midwife industry as care workers or clients.
2. The midwife industry has struggled against a patriarchal culture that devalues professional practices that do not conform to rigid, empirically tested regulations and standard operating procedures. One conversation respondent aptly stated, "Patriarchal values and discriminatory practices are perpetuated within orgs and community when midwifery credentials are differently valued." As with care work and healthcare in general, gendered occupational segregation persists, in which most midwives and related staff identify as women and are paid much less for their roles than similar positions in other industries[1].

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[1] Gendered occupation and pay disparities are evident in analysis of the *American Community Survey.* Analysis of 2017 data, for example, finds that women in healthcare tend to be under-represented in higher-paying diagnosis and prescribing occupations (surgeons and physicians) and over-represented in lower-paying frontline and support roles (nurses, aides, attendants, etc.). See also Oxfam's (2020) *Time to Care* report for an international perspective.

Such issues are further complicated in the ways that they affect and are influenced by current events and issues facing US society today. Grotens, Van Dijk, and Van Vugt (2018) describe the complex, "wicked problems" that 21st century leaders face as:

> "unique, unknown issues that due to their interconnectedness and ambiguity are almost insoluble, in that (1) the solution cannot be found retrospectively, (2) there is no right or wrong decision, at most better or poorer alternatives, and (3) there is a high degree of uncertainty" (p. 30).

Examples of such wicked problems in recent times include climate change, food security, and the aging population (Grin et al, 2018), as well as refugee relocation, financial market volatility, and natural disasters (Shields, et al, 2017). The COVID-19 pandemic is the latest though possibly most far-reaching example. Such problems are difficult to navigate on their own, and when coupled with prejudice, discrimination, and violence toward persons on the basis of race, gender identity and expression, sexual orientation, ability, etc., they become all the more wicked and evident of the volatile, uncertain, complex, and ambiguous (VUCA) world in which we live.

The role of digital technology also has critical implications, facilitating the rise and reach of social movements such as the Arab Spring, #BlackLivesMatter, #SayHerName, #MeToo, and #HeforShe. It allows us to record and share information with unprecedented ease and swiftness, which has allowed for the magnification of horrific acts of racism, violence, and police brutality among US residents of color, especially toward Black and African American persons, and—fueled by the previous Presidential administration's blaming of the coronavirus on China—persons of Asian descent. On the other hand, digital technology has also brought with it the rise of *misinformation*, or what the World Health Organization (2021) has called an *infodemic*, in which large portions of the population receive and rely on false messaging. Determining how to navigate and effectively use digital communication for accountability, transparency, activism, and advocacy will be essential for AABC to move toward positive, transformative change.

Furthermore, midwifery's struggle for legitimacy in competition with institutional healthcare in the U.S. unfortunately aligns with a dominant paradigm in which business practices (practices to advance capitalist profit) are viewed as necessary standards applicable to all organizations. Over the past several decades, nonprofit and care-based organizations have increasingly been called to embrace business principles such as sustainability, competitive advantage, continual improvement, and innovation. These business principles can contribute to positive outcomes when they are used in tandem with strengths-based, care-based, and people-centered principles. Unfortunately, doing so is not the norm; thus, these business principles tend to uphold infrastructural and systems practices that maintain white supremacy and patriarchy, especially when such principles become the focus of decision-making rather than the impacts such decisions will have on diverse internal and external stakeholders.

Similarly, as psychologist and critical race scholar Derald Wing Sue (2015; 2021) argues, traditional leadership and decision-making approaches consistently reinforce and privilege white supremacist and patriarchal values such as rugged (masculine) individualism and a mistrust of collective movement, overreliance on seeming-objective and empirical data (numbers valued more than stories and lived experience), and the illusion of meritocracy (that each person starts at equal status and can advance on the basis of merit or hard work alone). As organizational development scholars Montuori and Donnelly

(2018) warn, society's wicked problems cannot be solved through such archaic *command-and-conquer* styles of leadership and governance:

> "Particularly in times of anxiety, change, and threat, it is easy to fall back to these images, and demand 'real' leaders, strong decisive leaders who act first and ask questions later, when in fact the complexity of the situation may require a very different form of leadership" (pp. 335-336).

It is not difficult to see how these ideals have close connection with and likely great influence on the erasure of Black midwives and community midwives from the history of midwifery in the US, diverse pregnant persons' lack of equitable access to midwifery care, as well as the continual de-valuing of the midwifery, birth center, and community-based models. Researchers Almanza et al (2019) cite a 2013 national sample of childbearing individuals, reporting that "69% of African American respondents were interested in having an out-of-hospital birth, but only if they could find a perinatal clinician who shared their cultural identity and experience" (p. 598). The authors further report that with only 5.8% of certified midwives identifying as people of color and only five (5) African American-owned birth centers in the U.S. (at the time of the article's publication), diverse representation of midwives and birth centers is very difficult to access. Accordingly, actualizing change will require identifying and rejecting values that do not serve and focusing instead on communicating commitment, demonstrating accountability, and engaging in authentic acts to center social justice, equity, and inclusion and build/restore trust among AABC's most marginalized stakeholders.

Undertaking such action authentically and vulnerably will also require AABC to carefully and intentionally examine: the association's core values, how information is accessed and shared, and what information is valued. During the AABC facilitated conversations, several respondents of color asserted their experience that BIPOC-led contributions to the field of midwifery/perinatal care are often eclipsed, especially if they are happening at a grassroots or community level. Thus, when research is conducted and promising practices explored across the nation, the ways in which BIPOC folks are leading in their own care — as providers, patients, and activists—may be overlooked and emphasis placed on what more-visible, white-led organizations are doing.

Institutionalized racism and sexism are also at the heart of health disparities in birth-related outcomes for pregnant persons and their children. As Avery et al (2020) report, "The United States spends more on perinatal care than any other nation yet has the highest maternal mortality rate among developed countries," (p. 258) and Black and American Indian/Native American women and their babies are at considerably higher risk of pregnancy-related complications and death than are white women and their babies (Artiga et al, 2020). These researchers continue to chronicle factors that contribute to these poor birth-related outcomes; among them, racial bias is consistently at the top of the list, alongside lack of access to care and insurance coverage to pay for care. Correspondingly, public health efforts to explore the social determinants of health have increasingly advocated to include racial justice, the need for racially concordant care, and to understand racism as a public health crisis (Krisberg, 2021; American Public Health Association, 2020). The Centers for Disease Control and Prevention (CDC) are the latest of a growing body of thought leaders, politicians, and activists to declare racism "a serious public health threat" (Walensky, 2021), citing the severe disparities affecting BIPOC patients' access to COVID-19 screening, health care, and vaccinations.

Disparities in access to equitable birth-related care are further compounded by the lack of economic opportunity for persons of diverse identities *and* persistent de-valuing of gendered, care work occupations[2], at which midwifery and birth-related care is the heart. In their 2020 report *Time to Care*, international agency Oxfam finds that care workers are paid as much as 40% less than people working similar jobs in non-care industries. In addition to lower pay levels, care workers also face **time poverty**, meaning they lack time for rest and leisure due to long hours of work and caregiving (Oxfam, 2020). This issue has been exacerbated during the COVID-19 pandemic, as parents (and especially mothers, due to long-held gender roles in U.S. society) struggle to balance work and caregiving responsibilities. As the Pew Research Center (Igielnik, 2021) finds, teleworking moms were twice as likely as dads to say they had a lot of childcare duties while working. Moreover, 54% of mothers and 43% of fathers felt they needed to reduce their work hours to provide home care during the pandemic. Time poverty further affects the provision of respectful patient care; within hospital settings in particular, care providers report "that the lack of time led to perfunctory informed consent devoid of true shared decision making and informed choice" (Almanza et al, 2019, p. 601).

Care-based industries have an overrepresentation of women and female-identifying workers, and thus it is little surprise that women have borne the brunt of increased caregiving responsibilities and disconnection with the paid labor market over the past year. Community births increased by an average of 72% across the nation between 2004 and 2014 (Vedam et al, 2018), and as the US population continues to learn about the benefits of comprehensive birth care, community and home birth rates are likely to continue to grow. This has played out during the COVID pandemic: as similarly sized nonprofits, schools, and childcare centers have been forced to halt operations and/or lay off workers during the pandemic, birth centers have seen a continuing rise in homebirths among pregnant persons, especially given hospital safety restrictions (Imlay, 2021; Monteblanco, 2021). Thus, it is highly conceivable that birth center workers are experiencing a confluence of demanding constraints tied to the pandemic, including 1) engaging in both paid and unpaid care work inside and outside of their homes, 2) increased time poverty, 3) health concerns affecting themselves and their loved ones, and 4) potential loss of income and economic opportunity—all of which are inordinately compounded in devastating and traumatic ways for folks who are also enduring persistent racism and racist violence (again, most notably directed toward Black and African American, Asian, and immigrant communities).

Overall, the issues described above interconnect to comprise a complex national (and global) environment with strong implications on AABC's work and the midwifery industry more broadly This complex context will be important to keep in mind as AABC undertakes its DEI efforts.

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[2] The Organisation for Economic Co-operation and Development (OECD; Ferrant, Pesando, and Nowacka, 2014), defines each word. **Care** involves all activities providing what is necessary for the health, well-being, development, maintenance, and protection of someone or something. **Work** means that these activities involve mental or physical effort, possibly requiring advanced education to perform, and they are costly in terms of time and resources. Paid care work frequently refers to caring for people or doing domestic work for pay (Lawson et al, 2020), and within healthcare, education, and nonprofit/social services, it typically refers to those with direct patient/student/client interactions.

Advancing AABC's DEI Work within this Context

Central DEI Problems:

1. Lack of diverse representation (esp. BIPOC, gender-nonconforming, and/or queer) of midwives and related leadership/staff across the industry, within AABC as an association, and within birth centers across the nation.

2. Absence of clear, established and communicated definitions and values around diversity, equity, and inclusion from AABC

Emerging Themes within these Problems:

Participants within each facilitated conversation were provided with a shared Google document where they could anonymously respond to the questions: **What are the greatest factors affecting AABC's work to be more diverse, equitable and inclusive? What factors do you need to know more about?**

EnterChange Group consultants aggregated these documents and conducted a thematic analysis of these factors. Four themes emerged, that is, the factors tended to cluster around these four areas:

1. Equitable Access to Services
2. Birth Center Start up and Sustainability
3. Culture of Internalized Oppression and Silence (internal)
4. Inclusive Professional (Working) & Educational (Learning) Environment

This next section of the report presents the factors that were clustered within and thus contribute to each theme. Some factors relate to more than one theme and are listed accordingly.

Theme 1: Equitable Access to Services

Contributing Factors

Across the six workshops, six (6) contributing factors were identified in relation to the theme of **Equitable Access to (Birth Center/Midwifery) Services.** These include:

1. **Public Perception of Midwifery**: One of the biggest contributing factors to equitable access to services is a negative or limited public perception of midwifery and birth centers. Respondents tended to share the perspective that the general public considers birth centers to be **less valid** or **legitimate** than hospital systems. Several respondents further suggested that members of underserved communities believe birth centers are designed for and thus cater to those with privilege (generally considered to be wealthy, white women), and thus are **not** well-equipped or prepared to serve folks of diverse identities, including survivors of trauma. While these perspectives were shared anecdotally, such de-valuing of midwifery and birth center care strongly aligns with the overall commodification and de-valuing of care work in the U.S. and globally (Barnes, Beall, and Holman, 2021; Harquail, 2020; Oxfam, 2020). Within the midwife industry in particular, scholars have traced how propaganda put forth by medical practitioners in

the early to mid-20th century demonized midwives (especially community midwives of color) as ill-informed and unsanitary, serving to further reinforce racist and sexist stereotypes (Goode and Rothman, 2017). Such messaging has perpetuated negative public mindsets against trusting midwifery as a safe birthing practice. Furthermore, struggling birth centers lack the means and resources to engage in the market research and public relations activities needed to measure and change public perceptions.

2. **Identity-based Discrimination:** Public devaluing of midwifery and the birth center model of care is predicated on historic socialization designed to perpetuate (neoliberal) capitalism, racism, patriarchy, heteronormativity, classism, and ableism across U.S. systems, institutions, organizations, and communities (Harquail, 2020; Fraser, 2017). Despite notable trans-national research that finds midwifery is distinctively positioned to provide *respectful care* inclusive of patients' diverse identities and backgrounds (UNFPA et al, 2014), conversation respondents described a continuum of oppression and identity-based discrimination within U.S. birth center staff. Such discrimination ranged from unfamiliarity with diverse populations (especially gender non-conforming/non-binary and LGBTQIA+ persons) to targeted and intentional racism, sexism, transphobia, and homophobia. Respondents also noted a tendency for birth center workers to struggle with *internalized oppression* across multiple, intersectional levels including workers' midwife status (community, student, certified, nurse), race, gender, and sexuality, and level of education.

3. **Legislative and Regulatory Barriers:** Respondents further noted that legislative and regulatory barriers frequently impede birth centers' effective start up process. Regulations intended to standardize quality of services can especially pose a barrier to community-based midwifery (and reinforces the notion that hospital systems are "more legitimate" providers of birth-related care). Resources that could be directed toward equitable access to services are often redirected to meeting these requirements. That such requirements differ from state to state makes it even more difficult to address these issues holistically or centrally. Respondents further raised the question as to whether such legislative and regulatory barriers have inordinate, negative impacts on BIPOC-led birth centers and birth centers located in communities with greater numbers of BIPOC patients.

4. **Medicaid Payments:** Birth centers' ability to accept Medicaid payments presented a fourth contributing factor to equitable access to services. Across all of the conversations, this issue consistently arose as one of the biggest contributors to inequitable access, especially as it overlaps with identity-based discrimination and potentially regulatory barriers as well. As one respondent explained, "Many birth centers don't take Medicaid and are cash only. Therefore they don't/won't serve low income people in general who are disproportionately POC. This perpetuates BCs taking care of white people in much greater numbers and those with less access continue to have less access."

5. **Location/Geography:** Participants agreed that the geographical location of birth centers substantially contributes to patient/customer access. Specifically, respondents acknowledged that birth centers are more frequently located in urban areas, and thus pregnant persons in more rural regions have difficulty accessing services. Even within more urban and metropolitan communities, the location of the birth center may still pose a barrier to underserved populations; folks who rely on public transportation, for example, may not be able to easily travel to the birth center if it is not located along bus, train, or subway routes. Ride-hailing services such as taxis, Uber, and Lyft could also be more inaccessible for folks with limited socio-economic means.

6. **Technology:** Related to geographic location, technology is also a contributing factor to equitable access to services. As one respondent stated, "Not everyone has access to technology

(computers, smartphone). As we reach out to women and families in a virtual manner, can they all access us with equity?" Another respondent further noted that inequitable access within rural areas is compounded not only by location, but also by technological limitations, such as areas with poor wireless connectivity or signal transmission (i.e., dead zones).

Potential Actions to Address these Factors

After discussing the factors contributing to (in)equitable access to midwifery services, respondents were asked to consider what AABC might do to help address and overcome these issues. Respondents' suggestions include:

- Develop and publicize a clear statement of AABC's commitment to diversity, equity, and inclusion. This must include how AABC defines these and associated terms (such as social justice, racial equity, gender equity, etc.).
- Develop a national public relations campaign to engage stakeholders at all levels (government, funding bodies, hospital systems, partnering agencies, educators and accreditors, community-based organizations, patients, and their families). The goals of the campaign would be to raise awareness of, support for, and equitable access to the birth center model of care
- Conduct research to better understand how folks currently access birth centers
- Provide education and resources to help birth centers address barriers to access
- Advocate for national licensing and credentialing – this would serve to both negate the difficulty of navigating individual state regulations and would work to raise the value and legitimacy of the midwifery industry
- Advocate for national Medicaid reimbursement for all birth centers

Theme 2: Birth Center Start up and Sustainability

Contributing Factors

Across the workshops, four contributing factors were identified in relation to the **Theme 2: Birth Center Start up and Sustainability**. These include:

1. **Public Perception of Midwifery**: As described in the first theme above, birth centers consistently struggle against public views of midwifery as less valid than hospital systems in providing pregnancy-related care, despite national and international studies that more frequently find the opposite—midwifery is consistently more likely to provide respectful care leading to better birth outcomes (UNFPA et al, 2014). Respondents shared their experiences that funders do not seem to understand or appreciate the midwifery model in general nor the birth center model in particular, and thus they frequently are biased toward more formal health care settings.

2. **Inequitable Fund Distribution due to Identity-based Discrimination:** Several respondents of color further noted especial difficulty for BIPOC-led and BIPOC-serving birth centers to receive funding. Across the workshops, respondents agreed that AABC was not previously aware of the level of difficulty BIPOC leaders face in attaining start-up and sustainability funding for their birth centers. Unfortunately, recent studies of philanthropic giving consistently reinforce a substantial underrepresentation of BIPOC and LGBTQIA+ organizations (both those led by and those with a focus on serving folks with these identities) in the distribution of charitable funds to nonprofit organizations (Thomas-Breitfeld and Kunreuther, 2017a, 2017b). In 2016, the D5 Coalition reported on the extreme lack of diversity among foundations, noting that 92% have white presidents. Implicit bias and the "just like me" effect thus frequently play out in the form of white-led foundations funding largely white-led organizations. Correspondingly, Dorsey et al (2020) find that leaders of color face four bias-based barriers to equitable philanthropic giving: **1) Getting Connected** to funders is a barrier due to inequitable social networking and foundations' tendency to support people and organizations they already know[3]; **2) Building Rapport** with funders is limited due to implicit bias and microaggressions; **3) Securing Support** from funders often feels one-sided as leaders of diverse cultures may use forms of evaluation and story-telling that do not satisfy funders' over-reliance on empirical data and logic models; and **4) Sustaining Relationships** may be hard to achieve if bias remains unchecked; moreover, funders may stop funding to nonprofits deemed "non-compliant" for not meeting the funders' white-centric standards for performance measurement.

3. **Legislative and Regulatory Barriers:** As described above, respondents cited the lack of equitable insurance reimbursement and state-specific regulations as further barriers to the start-up and sustainability of birth centers, especially those that practice and/or prioritize community midwife care within diverse communities. These requirements exacerbate what many

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[3] For greater depth on inequitable social networking, see Urban Institute researchers Simms et al's 2015 report *Structural Barriers to Racial Equity in Pittsburgh*, in which they discuss the geographic isolation and exclusion from social networking that have resulted from historic racial segregation. Their findings are all too common in cities across the US. For greater depth on philanthropic knowledge gathering and decision-making, see The William and Flora Hewlett Foundation's commissioned report, *Peer to Peer: At the Heart of Influencing More Effective Philanthropy* (February 2017).

respondents considered to be inordinately **high start-up costs** for birth centers who are already struggling with limited time, people, and resources. To the extent that these regulations are rooted in systemic racism, sexism, and classism further compounds the identity-based discrimination that non-dominant groups face in achieving legitimacy and adequate funding.

4. **High Start-up Costs:** All the conversation groups mentioned finances and financial strategy in discussing challenges to not only starting up and sustaining birth centers, but also to implementing DEI strategies within individual centers and across AABC.

Potential Actions to Address these Factors

- As Thomas-Breitfeld and Kunreuther (2017a, 2017b) assert, professional associations may have more access to people in powerful funding positions (within government and foundations), along with greater levels of influence through thought leadership. Frequently, associations play an important role in establishing new sector norms and standards. Accordingly, the authors call on associations to prioritize racial equity *within* an intersectional approach to DEI, as their nationally representative surveys of nonprofit leaders finds that folks with intersectional identities describe "race as having a negative impact on their career advancement far above the impact of sexuality" (2017b, p. 23). Moreover, within healthcare specifically and care work more broadly, gender bias persists as a major source of inequality (Hansen et al, 2019). Thus, AABC must address equity through an intersectional lens, while simultaneously acknowledging racial and gender biases as priority areas with large and substantial impacts on healthy birth outcomes. Through embracing transparency and collaboration in this process, AABC can build a role of thought leadership in such forms as public communications, educational resources, conversations with funding leaders, and collective movement convening to propel positive and inclusive changes in equitable philanthropy to support diverse birth centers across the US.
- Several respondents were interested in learning more about organizations like the Birth Center Equity Fund (BCEF) and their capacity to address inequitable funding for birth centers. AABC has already begun to develop a working partnership with BCEF. Important components of this work will be to: 1) identify shared goals and the partnership structure, 2) continue to identify people and entities conducting similar funding equity work, 3) work to develop a shared network for collective movement toward equitable philanthropy. This movement could be birth center and midwife-specific, it could more broadly focus on healthcare and care work, or it could even be part of a much larger conversation around intersectional equity in nonprofit/charitable giving.
- One of the biggest priorities for conversation participants is the need to address Medicare/Medicaid reimbursement. As one respondent stated, birth centers desperately need, "New models of reimbursement that are based on the value of prenatal and preconception care." Respondents perceive that AABC has an opportunity—if not responsibility—to more actively engage in (and perhaps lead) advocacy efforts for more equitable insurance reimbursement.
- AABC might consider conducting research to further identify other factors that contribute to high start-up costs for birth centers. To some extent, finances will always be a concern for any non-profit entity; however, it might be important to conduct this research to identify the extent to which birth centers are encountering financial barriers that are rooted in systemic inequity based on intersectional identities and/or sector status (private versus public centers, standalone or community-based centers versus those connected to/within hospital systems, etc.).

- Respondents further discussed AABC's educational resources, including videos, downloadable materials, and coaching/mentoring. Folks urged AABC to consider ways to meet the needs of birth center owners, especially those that are small and individually owned. Another respondent further cited the need for members "to financially project and build sustainable centers," and they prompt AABC to consider what resources might be needed within the professional association to support such birth center capacity-building.

Theme 3: Culture of Internalized Oppression and Silence

Contributing Factors

Across the workshops, five contributing factors were identified in relation to the **Theme 3: Internalized Oppression and Silence.** These include:

- **Lack of a Shared Foundation for DEI Work –** Respondents acknowledged that AABC is new to diversity, equity, and inclusion work as specific DEI efforts began about five years ago. This fact, coupled with several relative newcomers to the Board, led to agreement that AABC Board members (conversation participants) lack a shared foundation, that is shared language, values, and commitment for this work. Conversation participants described a DEI training that was held four years ago for the Board of Directors. While this was a solid first step, respondents nevertheless described a lack of action or hesitancy to apply what was learned following the training. One respondent further noted that while a D&I committee was formed alongside this training, this was in part to address and work through some push back against the work[4]. Establishing a shared understanding of intersectional diversity, equity, inclusion, and social justice and how issues relevant to the association's mission must be framed through these lenses is a critical first step toward developing any kind of collective commitment to and strategy for action and advocacy (Bey, Clemm, and Diggs, 2016).
- **Lack of Member Awareness of DEI –** Conversation respondents also noted their experiences with members who are not aware of or who fully understand the need for diversity, equity, and inclusion work within AABC. As one respondent observed, there seems to be a "lack of awareness by most white people/midwives that institutional racism is actually a problem, that their own biases are actually a problem." This observation connects to a common problem surrounding identity-based and internalized oppression. Critical race scholars describe the Cycle of Socialization/Oppression, in which individuals are born free of any bias or knowledge of the world (Harro, 2018 – first published in 2000). Humans first learn through mimicry, imitating those around us (Palagi and Scopa, 2017). Thus, from our early years we are taught society's expectations, biases, and stereotypes, and we begin to internalize these values and beliefs. That is why girls as young as age five have expressed body image problems connected to Western ideals of feminine beauty and thinness (Rauscher et al, 2013), and studies have found as many as 40-60% of girls ages 6-12 express concerns about controlling their weight (Smolak, 2011). As

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[4] It is unclear if the respondents specifically meant pushback to the distribution of labor associated with executing the DEI work, or if the pushback were directed at the DEI work itself. Obtaining more clarity around this issue will be part of the equity assessment.

adults, we continue to use *behavioral mimicry* to manage our impressions and affiliations within groups and organizations, even as we become more aware of the intricacies, power dynamics, and sometimes inauthenticity in doing so (van Shaik and Hunnius, 2016; Sue, 2015). Accordingly, most if not all of us have become both oppressed and oppressor, constantly striving to conform to the social expectations we have internalized. These social expectations or *social scripts* apply to our intersectional identities, cutting across age, race, gender, sex, sexuality, ability, class, and so forth (Shaw and Lee, 2020). With regard to racial identity in particular, Sue (2015) finds that white individuals tend to move through seven phases of development: 1) Naïveté, reflecting Harro's assertion that humans are born free of bias; 2) Conformity, in which white children receive messages that white culture and whiteness are superior to any other culture or color – this can also result in assimilation-based values and beliefs such as color-blindness and All Lives Matter; 3) Dissonance, as events and experiences lead folks to acknowledge inconsistencies between the bias/stereotype messages they've accepted and seeing the real effects of racism and related prejudices (sexism, ageism, ableism, classism, etc.), 4) Resistance and Immersion, in which folks begin to question and challenge what they've been taught (this can also result in what Sue terms *White liberal syndrome*, in which white folks may engage in a paternalistic protector—or savior—role and/or overidentifies with a minority group); 5) Introspection, in which folks interrogate their experiences and belief systems, honestly confronting their biases; 6) Integrative Awareness, a constant effort to form a nonracist white, Euro-American identity and to value authentic multiculturalism; and 7) Commitment to Antiracist Action, in which folks are personally accountable for continuing to learn, for seeking interracial experiences and relationships, and for engaging in meaningful activism to support antiracist causes. Similar continua have been developed regarding attitudes toward sexuality (Raju et al, 2019; Riddle, 1994) and gender equality (Jackson et al, 2019), emphasizing that it takes years of persistent effort to change human attitudes and associated behaviors. Accordingly, respondents' observations around members' different levels of awareness of, understanding of, and commitment to diversity, equity, and inclusion is a common and important issue to address.

- **Members' Resistance to Change –** Several conversation participants further raised concerns around the *willingness* of AABC leaders and members to authentically engage in DEI change efforts. Respondents shared their immediate experiences engaging with fellow AABC members. One of the most painful and public incidents occurring in recent history was a racist post made to the AABC forum. That the post was made at all, and that some folks defended aspects of the post, points to the presence of AABC members who are resistant and perhaps actively oppositional to DEI change. In other examples, respondents discussed AABC conflicts that have arisen in conjunction with annual conferences, such as exhibits that erased Black midwifery and a tour of a white-led, Christian birth center that left some attendees, particularly those from underrepresented communities, feeling uncomfortable. Such incidents prompted the facilitated conversation participants to question their stance on inclusivity across potentially competing values, such as religious and reproductive freedom. Respondents also questioned the extent to which AABC could require privately-owned birth centers to be accountable for DEI. Overall, respondents felt that resistance may come from folks who are actively against DEI work, those who do not yet understand the need for the work, and those who may see the need for the work but are not willing to dedicate the resources required to approach and implement the work in a meaningful, lasting way.

- **Members' Politeness Protocol --** In other cases, respondents perceive some members to be simply silent on these issues – expressing positions that are neither for nor against equity, inclusion, and justice work. Some respondents attributed this to organizations striving to remain "neutral" to avoid losing staff and volunteers over controversy. One respondent attributed this silence to members being "Minnesota nice[5]" at all different levels of the work. Each of these responses reinforces what psychologist and critical race scholar Derald Wing Sue (2021; 2015) terms the *politeness protocol*:

  > "Race talk or discussions of race…is a socially taboo topic that often pushes powerful emotional hot buttons in people; exposes major differences in worldviews; creates discord, disagreement, and conflict; and threatens social harmony. When topics on race, racism, power, and privilege arise in conversations, the ground rules governing how they are handled and discussed among individuals are triggered…In such situations, a conspiracy of silence operates to prevent the authentic self from emerging, and what is presented in the tactical self is often inauthentic in order to preserve social harmony" (p. 62).

  This politeness protocol and its corresponding silence and conflict avoidance is especially prevalent among women and female-identifying persons who are likely to have internalized gender-based social scripts around gentility, passivity, and preserving harmony (Shaw and Lee, 2020). Nurturance, active listening, consensus-building, and compassion are critical to respectful care work, and exploring the politeness protocol should in no way diminish these qualities and their role in transformative leadership and social organizing. Nevertheless, part of DEI work is a continual self-interrogation of how we are presenting ourselves and interacting with those around us in positive ways. Politeness and silence are frequently associated with privilege; that is, when one has the *privilege to choose to remain silent* on issues, especially if the person can be silent because the issues at hand (bias, discrimination, microaggressions, etc.) do not affect them directly. When silence, conflict avoidance, and being nice begin to interfere with authentic engagement, when they impede inclusion and equity, and when they uphold unjust and unfair principles, they no longer serve. Part of EnterChange Group's work with AABC will be to create spaces and opportunities for vulnerable and authentic interpersonal engagement toward building equity and inclusion across the association.

- **Financial Costs of DEI Work –** Members shared their perspectives that financing DEI work, both at the association-level and at individual member or organization levels, will pose a challenge. As described above, several members voiced concerns that AABC might resist deep engagement with DEI out of fear of loss of membership and corresponding revenue from dues. These respondents worried that some leaders in AABC might view such lost revenue plus the added expense of investing in consultants and/or internal positions and resources to support the work as too costly. Despite expressing this concern, however, none of the respondents (all of whom represent Board and Committee members within AABC) expressed holding these perspectives

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[5] Since "Minnesota nice" is a colloquial term, we could not use the dictionary to define it, so we ultimately turned to Wikipedia (2021) as a source of pop culture references and learned this term implies, "unusually courteous, reserved, mild-mannered and passive aggressive. The phase also implies polite friendliness, an aversion to open confrontation, a tendency toward understatement, a disinclination to make a direct fuss or stand out, apparent emotional restraint, and self-deprecation."

themselves; rather, all respondents who shared their opinion on this matter expressed support for AABC's investment in DEI work.

- **Emotional Costs of DEI Work –** In addition to financial costs, respondents expressed concerns regarding the emotional costs of DEI work. Care work already involves considerable **emotional labor** (Harquail, 2020), and asking folks of marginalized identities to take part in DEI efforts *also* requires substantial emotional labor. Accordingly, during the AABC facilitated conversations, some AABC members shared that, despite their enthusiasm and passion for the work, they are facing burnout and fatigue. This was especially the case for BIPOC members who perceive that 1) they are carrying or expected to carry more responsibility for idea generation and task execution than white members, and/or 2) ideas or tasks that they have suggested are not taken seriously or acted upon by AABC. Invalidating the experience and concerns of a non-dominant group is a microaggression, and persistent microaggressions (especially those that are race-based) cause long-lasting damage to recipients' mental and physical health (Sue 2015; Torino et al, 2018; Sue et al, 2021). Thus, these members' concerns are critical and must be addressed if AABC is sincere about striving for racial equity and justice.

  Folks of dominant identities (e.g., white, heterosexual, cis-gender, male, etc.) and folks of non-dominant identities who have internalized oppression must also engage in the emotional labor of unpacking and deconstructing values and belief systems they were socialized to accept throughout their lifetimes. Some respondents shared that they are open to learning ways to do this, but the fear of saying or doing something that would harm other folks and/or incur backlash makes them hesitate to act. Unfortunately, such hesitation often comes across to non-dominant groups as a lack of concern for or willingness to address systemic oppression. As one white-identifying respondent observed, "We don't want to cause pain, but we cause pain through *inaction* instead." Taking responsibility for one's behaviors and power in relation to other folks is difficult, yet as this respondent acknowledged, NOT taking responsibility has much deeper and longer-lasting negative repercussions.

Potential Actions to Address these Factors

- Respondents' concerns around member awareness and understanding of, as well as their attitudes and potential resistance toward diversity, equity, and inclusion work within AABC will be measured within EnterChange Group's equity assessment. The fact that these concerns were raised is further evidence of the need to conduct this assessment as part of the **Discovery** phase.
- Moreover, respondents expressed a desire to start to address these concerns through education, training, and related resources designed to promote members' awareness, knowledge, and understanding of why diversity, equity, inclusion, and social justice are needed across AABC's culture and its working and learning environments. Some respondents further recommended incorporating specific training and resources on behavioral health, wellness, and trauma-informed care "both to improve client care AND to support midwives/staff (many of whom are survivors of trauma)". Respondents also specifically requested that AABC provide DEI training for members that they could then use with their staff.
- Authentic commitment to DEI must incorporate commitment to social justice, to racial justice, to gender justice, to LGBTQIA+ justice, to disability justice, to intersectional justice. The work must be shared, the issues must be named, and positions must be taken. Thus, part of

EnterChange Group's work with AABC will be to discuss ways to practice what adrienne maree brown (2017) calls *collaborative ideation* and what Sandberg and Elliott (2019) have termed an *ethos of care* in shaping and sharing the emotional and labor burdens of the DEI work.

- In her book *Emergent Strategy*, adrienne maree brown (2017) speaks to the importance of collective movement building, noting that social justice work must happen *at the speed of trust*. Related to the emotional costs of DEI work, then, are the very important foundational steps of establishing community agreements and DEI values that are grounded in the trust- and relationship-building as well as personal accountability and emotional investment needed to advance this work authentically and meaningfully. Building from this foundation, it will also be essential that AABC continually and carefully consider who is asked to do what work, who is carrying what responsibilities, and how the DEI work may be distributed and compensated fairly.

Theme 4: Inclusive Professional (Working) & Educational (Learning) Environment

Contributing Factors

Across the workshops, five contributing factors were identified in relation to the **Theme 4: Inclusive Professional (Working) & Educational (Learning) Environment**. Before discussing these factors, though, it is important to note those groups who feel excluded from AABC and midwifery currently. Respondents identified Black, indigenous and people of color (BIPOC), gender non-conforming folks and non-female folks in general (including men), and folks of diverse sexualities. Respondents discussed how lack of representation of these (intersectional) identities among care providers results in a lack of culturally congruent care for patients, which furthers the public perspective that birth centers are not meant for folks of these identities. As a professional situation, AABC is uniquely situated to convene, collaborate with, and positive influence stakeholders at all levels (from educators to birth centers to policymakers) and to start to break this cycle of oppression. Contributing factors that must be addressed include:

- **Perceived Lack of Belonging in AABC–** Conversation respondents discussed their immediate experiences with trying to recruit midwives of diverse identities into AABC. Several respondents shared stories and survey results of how these folks—particularly individuals who were gender diverse and/or people of color—did not feel welcome, that they perceived a "lack of shared values," and thus "backed away" from involvement with the association. Overall, respondents agreed that while AABC has been "passively" welcoming to diverse members, the association could do much more to become "actively welcoming".
- **Perceived Lack of Belonging in Educational Environments –** Respondents further acknowledged that many of their educational experiences centered whiteness, perpetuated the historical erasure of Black midwives, and did little to welcome students of color and gender non-binary students into the learning environment. As one respondent shared, such "harmful spaces" only serve to "deter[] POC from applying or continuing studies."
- **Lack of Evidence of AABC Commitment to DEI –** Across the conversations, participants—especially AABC members of color—consistently expressed the need to see meaningful evidence and clear communication of AABC's commitment to DEI. As one member shared, "We need a sense of what the leadership and membership understand about what DEI means and to gauge

willingness to make important changes." Within another conversation, a member of color asserted that it is critical for AABC to "articulat[e] clear values around equity and justice—there is no middle of the road with addressing institutionalized racism." These comments tended to follow the group discussion about the history of midwifery in the US, and the role(s) that AABC can play in acknowledging, deconstructing, and advancing an accurate history that addresses racism and sexism toward midwifery in general and BIPOC community midwives in particular. The erasure of Black midwives and their important contributions to the development of midwifery in the US is a specific example of how the history of midwifery is interwoven into a continuing cycle of oppression against diverse care workers and pregnant persons. Perpetuating a false narrative—whether within a specific organization or across an entire professional industry—allows for the loss of accurate institutional memory, which in turn allows for the perpetuation of systems, policies, standards, and practices that uphold white supremacy and patriarchal values. From these conversations, it is evident that AABC members are watching for AABC leadership to lead by example, to establish the association's definitions of diversity, equity, inclusion, social justice, and related, identity-specific terms (such as racial justice, gender equity, etc.), to establish measurable standards of practice and cultural norms and monitor progress toward transformative change, and to continually build and provide resources to support this progress, including research, advocacy, training and educational materials, coaching, and importantly, association-level metrics and evaluation of progress.

● **Lack of Access to Transparent Information –** Though this factor was not discussed by respondents, during the conversations it became evident that different members have different access to information, regardless of the fact that each of these participants have leadership roles on AABC's Board of Directors and/or committees. Non-transparent and inconsistent information sharing contributes to confusion, miscommunication, inaccuracies in institutional memory/history, and limits accountability to members.

● **Limited Funding/Compensation Options –** Respondents across all the conversations consistently discussed financial challenges in both accessing and supporting midwife education—especially for BIPOC midwives—and for equitably compensating birth center workers and supporting their ongoing professional development. Some respondents noted that it is especially hard for free-standing birth centers, as they often lack the resources to pay staff at rates comparable to those working in hospitals. Participants recognize that the ability to increase funding for students and employees is connected to U.S. economic and political systems. As one respondent stated, the "Midwifery model and birth center care need recognition and value among funders, policymakers, and general U.S. culture."

Potential Actions to Address these Factors

● Respondents expressed the desire to see AABC work to 1) provide more meaningful and inclusive spaces for professional development, 2) to dedicate resources to DEI-related professional development, 3) to uplift and amplify organizations who are actively recruiting and supporting folks of diverse identities who have been underrepresented in midwifery (e.g. Melanated Midwives), and 4) to positively influence midwife educators, institutions, and educational programs to commit to building more inclusive and welcoming learning environments. Several participants urged the association to understand that long-term social justice/DEI investment is required of AABC and of its members. As one respondent stated, "a 1-2

hour diversity training will not suffice for unaware/racist providers. It takes years of work, reflection, and effort to break the cycle."

- While most respondents agreed that long-term investment is required that moves beyond short-term training, several also acknowledged that AABC should provide members with access to intentional, intersectional, and accountability-focused DEI training opportunities. Consideration may also be given to different levels and roles that members play within their birth centers, affiliated organizations, and as community service providers/advocates. As one member shared, it is important that AABC align training offerings with their values around DEI. For example, the respondent questioned, is it even possible to provide "culturally incongruent care safely"? If so, how might AABC provide membership support to midwives who must provide such care? How can AABC provide resources to help members build more inclusive work environments that attract, support, and retain diverse practitioners?
- Respondents explored other ways that AABC could provide member access, resources, and support toward their DEI goals, including member scholarships to BIPOC-owned birth centers and birth center mentorships that include both culturally-congruent mentorship as well as access to other sources of knowledge that may be concentrated in traditionally white-dominated spaces.
- Respondents also suggested that AABC explore the role and effectiveness of committees in addressing the current lack of inclusive working and learning environments.
- AABC should work to create a more inclusive, consistent, and transparent structure and processes for members to access information and resources. The equity assessment will also measure respondents' perceptions of and experiences in accessing DEI-related information and resources within the association. Overall, AABC should strive to center inclusion, equity, and accessibility in all that they do, including the membership experience, internal staff and operations, leadership roles, and the structuring of education and professional development content and opportunities.
- Respondents voiced support for AABC to continue to engage in advocacy and lobbying work to increase funds for the midwifery model, for birth centers—especially those serving diverse and historically-marginalized populations, and for students pursuing careers in midwifery and perinatal care. One respondent noted that AABC "has the research that birth centers and midwives can positively impact outcomes and peoples' experiences." The respondent acknowledges that this is an important foundation, but alone, it has not been enough to spur change. Many respondents agreed that using such research to influence policymakers and the general public should be part of AABC's efforts to increase members' access to equitable funding.

Consultant Observations:

Next Steps

The above findings reflect Preparation Phase conversations with 26 AABC leaders, supplemented with EnterChange Group's literature review and scan of the midwifery environment across the United States. It will be important to balance insights from this report with the perspectives across AABC's diverse membership via the Discovery phase equity assessment. Once this comprehensive data has been gathered and analyzed, findings from the equity assessment will be compared with these Preparation report findings. Collectively, this information will serve as the basis of AABC's DEI strategic planning.

As AABC moves into the Discovery phase, EnterChange Group encourages members to consider the additional promising practices and areas of opportunity for further exploration and strategic growth outlined in the next report section.

Promising Practices and Areas of Opportunity

Research Supports DEI Role(s) within Professional Associations

Recent research supports the importance of professional associations to center diversity, equity, and inclusion. In their survey of 13,299 members from 18 professional associations across the US, researchers Wang and Ki (2018) find that members who perceive that their association fulfills their professional needs and provides organizational support (specifically around professional development, student entry to the field, member discounts, and leadership experience opportunities) are more likely to retain their membership with, to volunteer for, and to donate to the association. These findings emphasize that professional associations in the 21st century face a DEI crossroads: folks *opposed* to aspects of intersectional diversity, equity, and inclusion might opt to leave professional associations who state and act on clear commitment to DEI and social justice. However, Wang and Ki's study suggests that to attract and retain folks of these diverse identities as well as to further the association's mission to provide comprehensive professional services to folks of such identities, the association **MUST** adopt and integrate corresponding organizational values and supportive resources.

Moreover, in looking at a health care professional association specifically, Ki (2016) finds that benefits customized to association members is positively correlated with member renewal. She further finds a new, potential connection between *personal benefits* (such as access to career advancement and networking opportunities) and members' likelihood of recommending the association to other people. This finding is important for two reasons: first, it is contrary to previous studies that found no connection between personal benefits and membership. Second, Ki notes that demographic factors such as race, gender, and age had no statistically relevant correlation to member retention or members' likelihood to recommend the association to other professionals. However, the survey only measured folks who identify as female (46%, n=320) and male (54%, n=396), thus not counting folks of diverse genders nor sexualities. Moreover, the association had an overrepresentation of white respondents (84.5%, n=696), and under-representations of respondents of color: Black/African American respondents (7.3%, n=60), Asian respondents (5.6%, n=46), and respondents of all other races were combined due to the small samples, totaling 2.6% (n=21). Thus, readers cannot be confident that the

perspectives of members of diverse races have been accurately collected and represented in this study. Accordingly, it is quite possible that the measured influence of *personal benefits* could in part be reflective of members' need for professional associations to do more to provide welcoming, safe, and inclusive spaces that support members' intersectional identities. This example also reinforces the critical need for the voices of the most historically-marginalized populations to be centered in diversity, equity, and inclusion work—that this work is not and cannot be complete without these voices—with substantial support and shared responsibility from dominant groups.

Enhancing Diversity and Inclusion in Professional Membership Associations

Enhancing diversity and inclusion in professional membership associations requires work, research, collaboration, flexibility, and a willingness to learn from mistakes, experience, try different tactics, and engage persons not generally brought to the decision-making table. For organizations to achieve greater diversity and membership support, they must ensure that the time, effort, and financial contributions of members meets or matches the expectations of rewards. Blanket efforts provided for or created for all members will always fall short as they will ultimately exclude some members. Organizations must identify their key definitions, goals, and values related diversity, equity, inclusion, accessibility, and social justice. Furthermore, they must often make difficult decisions accordingly to ensure that member events, advocacy efforts, resources, and supporting programs meet the direct needs of members and the work of the industry. That the midwifery industry specializes in respectful care further supports the need for AABC to model this care and an ethics of care in supporting its members.

Engaging in or seeking diverse leadership or board appointees

In looking to engage leaders from underrepresented backgrounds, organizations must take into consideration the emotional labor and frequent time poverty of these organizations and their leaders. Often these individuals will express they are already stretched thin and/or are terribly busy. Organizations must not assume that the prestige of serving on a nationally or internationally recognized or notable organization will be enough to encourage board membership or leadership opportunities. Time commitment is often a barrier, and so it is important to again remember the reward must match or exceed the time, effort, or financial contribution.

Values Statements and Communications

Organizations must be explicit in their diversity and values statements, ensuring it is inclusive of all groups represented and supported. Creating a blanket statement out of fear of omitting someone will inevitably exclude some folks, or it will send a message that the organization is not truly invested in supporting members from diverse or underrepresented backgrounds, identities, or communities (Dowell and Jackson, 2020). Naming all groups shows a commitment to serving diverse groups, and to understanding all needs are different. Committing to being explicit in naming diverse groups and their needs thus requires associations and organizations to take the time and resources needed to 1) gain deeper knowledge and understanding of the needs of these diverse groups, and 2) be intentional about how the association (AABC) will work to become more inclusive and equitable in meeting these needs.

Better practices for creating a diverse and inclusive membership organization

The best programs include underrepresented groups at the planning and implementation stages. It is important to empower members and provide opportunities and support for members to create programs and initiatives of their own that serve their specific needs. Once these programs are up and running, those belonging to the intended target group should provide feedback to ensure the program or initiative is serving its intended purpose. Active and visible support and backing from leadership is crucial to successful DEI efforts. It is also important to intentionally identify champions of supporting initiatives, and have those champions clearly state, communicate, and demonstrate their support.

Several organizations provide examples of promising initiatives for more inclusive midwifery practice. This next section highlights some of these organizations and the potential for partnership with AABC:

Sister Song

SisterSong Women of Color Reproductive Justice Collective was formed in 1997 by 16 organizations of women of color from four mini-communities (Native American, African American, Latina, and Asian American) who recognized "that we have the right and responsibility to represent ourselves and our communities, and the equally compelling need to advance the perspectives and needs of women of color."

Displayed better practices of Sister Song:

- They are explicit in their mission as a reproductive justice organization
- They clearly state and acknowledge "Indigenous women, women of color, and trans* people have always fought for Reproductive Justice", thereby affirming rather than erasing the history of leadership of people from these communities.
- "They recognized that the women's rights movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women and trans* people." This statement shows they understand that only by centering those most marginalized can they create better outcomes for those they seek to serve.
- They recognize reproductive justice is a human right, and that it's about access not choice.
- To achieve repro justice one must, analyze power systems, address intersecting oppressions (to do this a clear understanding of intersectionality must be obtained and agreed upon), center the most marginalized, and join together (with partners and those with shared values and goals) across issues and identities. This means, "All oppressions impact our reproductive lives; RJ (reproductive justice) is simply human rights seen through the lens of the nuanced ways oppression impacts self-determined family creation. The intersectionality of RJ is both an opportunity and a call to come together as one movement with the power to win freedom for all oppressed people."

The National Association to Advance Black Birth

Mission: To combat the effects of structural racism within maternal and infant health to advance black birth outcomes.

Purpose:

- Advocate for Black maternal-infant health through advocacy, research, educational programming, activism, and policy change.
- Work to equip birth workers (doulas, midwives, nurses, and doctors) and maternity institutions with the practical tools and education they need to improve outcomes for Black women and persons.
- Develop and support innovative models of care that are sensitive to the cultural and social needs of Black families.
- Partner with organizations that are connected to and can help advance our vision.

Key takeaways from their purpose include: intentionally inclusive language such as "Black women and persons", explicitly stating who they are supporting, and how they intend to provide support. They are also explicit in their purpose to engage in partnership with other organizations.

Furthermore, the association promotes their **Black Birthing Bill of Rights**:

- I have the right to be listened to and heard.
- I have the right to have my humanity recognized and acknowledged
- I have the right to be respected and to receive respectful care.
- I have the right to be believed and acknowledged that my experiences are valid.
- I have the right to be informed of all available options for pain relief.
- I have the right to choose how I want to nourish my child and to have my choice be supported.
- I have the right to early postpartum visits and individualized postpartum ci have the right to restorative justice and mediation to address obstetric violence, neglect, or other injustices.
- I have the right to choose the family and friends that are present during my pregnancy, birth and postpartum care.
- I have the right to receive accurate information that will allow me to give informed consent or refusal.

Patient advocacy information is posted on their website. The bill of rights is also available as a downloadable pdf.

Overall, this organization has a very clear mission, vision, purpose, and cause for justice and support for marginalized people. Their information and resources are easily accessible, which is further important for promoting collaboration and engaging diverse persons, including those with disabilities.

National Birth Equity Collaborative

Another organization that is conducting promising work and research in this area is the National Birth Equity Collaborative. Working toward a vision in which *All Black mothers and babies thrive*, NBEC's mission is to "create[] solutions that optimize Black maternal and infant health through training, policy advocacy, research, and community-centered collaboration." Dr. Joia Crear-Perry (June 16, 2020) authored a set of policy recommendations that NBEC advocates entitled *The Birth Equity Agenda: A Blueprint for Reproductive Health and Wellbeing*. Among the recommendations within this equity agenda are that the government support "healthcare transformation efforts" that center health equity and the needs of communities of color, and that fully integrate reproductive health care in equitable and trauma-informed ways. Similarly, the recommendations urge the federal and state governments to remove reproductive health care restrictions and coercive practices, instead emphasizing "patient choice and fully informed consent."

To help support action around these policy recommendations, NBEC engages in several programs and services. These include the **Maternal Telehealth Access Project** (MTAP) designed to increase access during the COVID-19 pandemic, and the **Birth Equity Research Scholars Program** in which selected doctoral students engage in a two-year, multidisciplinary leadership development program with emphasis on collaboration with Black-women led community-based organizations related to reproductive, maternal, and infant health. Finally, members of NBEC engage in further community research and policy-building initiatives, such as the **Mothers Voices Driving Birth Equity** initiative. The goal of this initiative is to "develop and apply a community-informed theoretical model in the creation and testing of a participatory patient-reported experience metric (PREM) of mistreatment and discrimination in childbirth."

Overall, NBEC's work has substantial overlap with AABC's work, especially pertaining to racial and gender equity in pregnancy-related care. While NBEC does not provide a list of partners, they do have an advisory board consisting of representatives from AmeriHealth Mercy, 76 words, National Healthy Start Association, and the Michigan Public Health Institute. Organizations partnering on the Mothers Voices Driving Birth Equity initiative specifically include the American College of Obstetrics and Gynecology (ACOG), and California Maternal Quality Care Collaborative (CMQCC) based at Stanford University. This brief list of collaborators provides a list of potential additional partners for AABC to consider. Taken in combination with the various projects outlined above, this list also reaffirms the positive potential for AABC to consider connecting with NBEC and exploring ways to effectively partner to advance racial equity, gender equity, and inclusive access to comprehensive pregnancy-related care.

Preceptorship and the Intergenerational World of Nursing

In this article, researchers Foley et al (2012) share the positive outcomes for preceptors and students who engage in intentionally inclusive, supportive, and open engagement in relationships. Though this research is specific to intergenerational differences, these outcomes can be applied to any relationship where people from diverse backgrounds must come together in these professional mentorship or partnership scenarios. Researchers found that the formation of a positive working relationship between a student and a preceptor highly influences the overall success of the preceptorship experience. In

today's nursing clinical practice settings, there can be up to four generations and each can be said to have its own distinct worldview. Researchers identify that within the discipline of nursing, values and expectations are often deeply rooted in traditions and customs of nursing practice and invariably as the younger generation brings new ideas to the practice setting, clashes between the generations are occurring and these can be difficult to resolve. This can also be true of nurses, preceptors and nursing students who come from different backgrounds, identities, and learned practices. The three emerging themes are the feeling of being affirmed, being challenged, and of being on a pedagogical journey. In focusing on the first theme of being affirmed, there are five sub themes. For students, they identified outcomes of gaining a professional role model, and building confidence. For preceptors, they experienced feeling valued and respected, being able to impart a legacy, and "strengthening nursing knowledge." (Foley, et al., 2012, p.7). This study highlights the rewards of participating in, supporting, and creating positive relationships between experienced nurses, and less experienced nurses or nursing students, including relationships where there are notable differences.

Keys to building positive relationships include:

- Preceptors' willingness to share knowledge and experience, including the "unwritten rules"
- Openness and receptiveness of preceptors to students' ideas or thoughts
- Constructive thoughtful feedback

Positive outcomes for preceptors include:

- Feeling respected and valued
- Feeling a sense of reward to see students do well/succeed
- Imparting a legacy
- Strengthening nursing knowledge

This study provides a promising example for how midwifery preceptorships might be improved to be more inclusive and equitable.

Now is a "Focusing Event" for Policy Advocacy for the Midwifery/Birth Center Model

The COVID-19 pandemic, increasing calls for social justice and intersectional equity, and continuing research highlighting the centrality of respectful care and identity-concordant care as critical elements of addressing the social determinants of health are culminating into what Monteblanco (2021) terms a *focusing event*, that is, a massive and complex disruption that allows historically silenced or overlooked groups to draw political attention toward meaningful change. Monteblanco points to New York's Executive Order No. 202,11 from March 27, 2020, which modifies the New York Professional Midwifery Practice Act to permit licensed midwives from across the United States and Canada to practice in the state of New York as a key example of how policymakers have become open to positive shifts in regulations to allow more midwives to serve patients during the pandemic. She encourages professional associations to advocate for both immediate policy changes "to help mitigate the strain placed by COVID-19 pandemic on hospitals" as well as long-term policy changes that would reduce regulatory barriers and promote the safe and legal practice of midwives—including community midwives—across the nation (p. 3-4). This focusing event may also open doors to unprecedented partnership and equity-driven collaboration with medical professional associations such as the American College of

Obstetricians and Gynecologists (ACOG) toward deconstructing outdated hierarchies of practice and instead promoting a comprehensive, collective, and community-driven model of perinatal care.

Neutrality is Not an Option

In talking through AABC's role in centering equity, inclusion, and social justice, a conversation respondent shared her perspective on the difficulty of birth center leaders to navigate multiple stakeholder priorities. She noted that historically, white executive leaders such as herself have felt stakeholder and institutional pressures to "stay as middle ground/neutral as possible" on controversial aspects of DEI, such as LGBTQIA+ equity, reproductive freedom versus religious freedom, and even around racial justice, particularly in more conservative areas. Some respondents discussed feeling such pressure from a business and sustainability perspective, and the fear of alienating too many folks, which could lead to loss of association members and loss of business in birth centers.

However, several of these respondents also shared that while their educational experiences may not have done an adequate job in preparing them to navigate institutional racism, sexism, classism, and ableism in their field, since they started working in midwifery, they have become more aware of these issues and thus more committed to taking an active stance to promote equity and inclusion *even if it means loss of support from those who remain opposed*. Overall, respondents collectively agreed that **AABC must engage in deep, authentic, and meaningful learning about structural racism and how it operates at multiple levels across institutions, organizations, communities, and individuals. Respondents urged AABC to take a clear stance on intersectional equity issues, beginning with racism and racial justice, and creating a set of values and a position statement that members should live daily.** Remaining neutral on these issues—when the evidence clearly supports that racism is behind racial disparities in birth outcomes, when BIPOC and LGBTQIA+ pregnant persons are being denied comprehensive and respectful care—is not an option.

Conversation respondents further emphasized the need for expanded regulatory standards that center AABC's commitment to racial equity, are explicitly inclusive of all types of midwives, and that do not create undue hardship for birth centers with limited resources. In fact, respondents tended to agree that AABC's long-standing commitment to inclusion of all midwives is a key strength that AABC should lean on as the association continues to build out its DEI initiatives. Emphasizing equality among all midwife types could be part of establishing a culture of healing, respectful care, and shared leadership/power within AABC and its member communities.

In writing on the embodiment of transformative change and healing from trauma, Staci K. Haines asserts, "Because most of the root causes of trauma stem from power-over conditions, we need to both heal and organize for social justice. We need to mend from deep hurts and violations *and* we need to change social and economic conditions that are causing the next generations of trauma" (2019, p. 59). Part of addressing these social and economic conditions, involves individual members committing to deep exploration of power in relation to themselves and others (Hardy and Bobes, 2016), and taking personal responsibility to build deeper understanding of the different lived experiences, perspectives, histories, challenges, and needs of their diverse colleagues and patients. From this enhanced understanding, then we can begin to build better systems that emphasize a strengths- or abundance-based approach to the work (rather than a deficit- or scarcity-based approach), as well as one that is

trauma-informed and healing centered. To work towards this deepened understanding, Haines recommends working through these questions:

- Who is (systematically) offered safety, belonging, dignity, and resources? Whom is it taken from, to do this?
- Who is (systematically) denied safety, belonging, dignity, and resources? And then, blamed for it?
- Who benefits from this system/policy/norm/infighting? Which people, communities, and nations benefit?
- Who suffers from this system? Who pays—with their health, labor, and lives?
- Who decides? Who defines reality, the dominant narrative, history, possibility?
- Which peoples and what resources are exploited to concentrate wealth, power, and decision making in the few?
- Who is poor and who is wealthy? Which people, which communities? How is this perpetuated? Whom does this serve?
- How are the poor, the exploited, and the victimized described by or blamed in the dominant narrative?
- What does it take to transform how power-over social conditions have been embodied in us, even when they are not what we believe in?
- Even when our thinking might have shifted, how have our actions changed? Has how we spend our lives, time, and resources changed to align with these values?
- What does it take for us to work collectively, when there has been so much wounding between us and our peoples? When these power differences still operate? If, when under pressure, we tend to polarize and make each other wrong?
- Have you integrated an understanding of trauma and healing into your strategy and work? Have you accessed healing and transformation for yourself and your organization?

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DEI Facilitated Conversations (aggregated)
What do you see as the greatest factors affecting AABC's work to become more diverse, equitable, and inclusive?
Consider (*but do not feel limited to*) these factor categories: social/cultural, environment, technology, economy/finances

Factor (what we know)	Questions about this factor (what we need to know)
Willingness of the leadership and membership to acknowledge our history and change our future	We need a sense of what the leadership and membership understand about what DEI means and to gauge willingness to make important changes
Financial barriers to continuing paid DEI work	We need to know how to make a plan for financially supporting DEI work
Financial - ability for AABC to continue to support paid DEI Work, ability for members to fund continuing DEI work in their organizations	We need a way to support members in quality, cost effective DEI trainings
Resistance from membership around training and promoting change	
economy/finances	Availability of start-up funds (loans, grants, etc.) Birth center payment - can be unsustainable
Environment -	where the BC is physically located, what community, where in the community
% BCs not accepting Medicaid	
BC salary and work/call hours	
Technology	As we reach out to women and families in a virtual manner, can they all access us with equity?
Educational systems - racism, harmful spaces detering POC from applying or continuing studies	

Social	Other members/midwives not embracing the need for DEI work, pushing back, creating harmful spaces
Funding for BIPOC midwives education	
"Don't think of elephants" diversity cycles	
The history story- race and nurse-midwifery	
Perception of birth centers and midwifery as "white"	Does learning about history of Granny Midwives and their successes and suppression affect this? How do birth centers with very limited marketing budgets change this perception when most of the referrals come from word of mouth - white patients tell their white friends? How can AABC help?
Lack of finances for birth centers owned or run by BIPOC	Does the existence of BCEF begin to change this?
Lack of midwives who identify as BIPOC, gender non-conforming	What is the impact of not being able to offer culturally congruent care? How can we support organizations in a big way that are trying to facilitate education of groups that historically have not pursued midwifery? (ex: Melanated Midwives)
Economy/Finances: Reimbursement in birth centers is less than in hospitals. Accepting Medicaid patients is a challenge since reimbursement doesn't cover costs. This can cause birth centers to be unable to take Medicaid/low-income patients who are BIPOC.	What can we do to help support more BIPOC gain access and knowledge of the importance of birth center care. How do we increase Medicaid reimbursement so that all clients on MA can be accepted by birth centers? How can AABC help?
Lack of welcoming of midwives who identify as BIPOC, gender nonconforming, queer	Does the existence of committees like within ACNM, AABC "help" this situation?
Do legislative/regulatory barriers to (community) midwifery care exist to a greater extent in areas with high numbers of BIPOC people? (California, for example)	How does AABC tackle issues like this when the situation is so different in each state or region?

Regarding inclusion of rural people (who are often lower income) in birth center care: technology can be a barrier to accessing e.g. telehealth, if they live in an internet dead zone or area with poor wifi	What other technology limitations are there?
Time + energy...birth centers feeling like they are doing the best they can but are limited with time, people and finances	
Accessing populations who would benefit from birth center care.	
Barriers to black and brown people to become Midwives. Barrier to working in a freestanding birth center because of less pay then working in the hospital.	
Lack of diverse staff in birth centers. Difficulty of birth centers to hire a diverse staff.	Many birth centers want to have training on DEI for staff but it can be expensive. How could AABC provide training for members that they could use with their staff? Maybe already being done with work by Amy Romano.
Technology	Not everyone has access to technology Not everyone has computers or a smartphone. Not all communities with have wifi access
Finances - Being afraid to loose membership for taking a stand, impacting "success" of organization.	Connection finance, wealth and institutionalized racism, inequitable distribution of resources based on race means most birth centers are white-led
Importance of both social and historical context awareness and learning around institutional racism in the field and white supremacy culture in organizations	
Many birth centers don't take Medicaid and are cash only. Therefore they don't / won't serve low income people in general who are disproportionately POC. This perpetuates BCs taking care of white people in much greater numbers and those with less access continue to have less access.	Many BIPOC birth centers do prioritize taking low income and Medicaid folks anyway at a loss because we aim to serve our communities

Patriarchy, particularly in reference to allopathic medicine, and institutions	Patriarchy perpetuated within org and community when midwifery credentials are differently valued
Barriers to entry for Black, Indigenous and people of color leaders opening birth centers	
Marginalization of midwifery - trying to stay in the middle, or even gain ground in a white male supremacist culture	
Importance of articulating clear values around equity and justice - there is no middle of the road with addressing institutionalized racism	
Lack of awareness by most white people /midwives that institutional racism is actually a problem; that their own biases are actually a problem.	
Finances :: equitable insurance reimbursement for work performed, yes absolutely this!	How can AABC push for increased Medicaid reimbursement? How can AABC support the creation of birth centers in underserved locations? How can we help protect the small individually owned centers?
Environment- global warming, increased disasters in some areas	How are centers preparing?
Economics :: ability to financially project and build sustainable centers that can then contribute to AABC	What financial resources are needed at AABC to further this work?
Fear of losing members-this is a big one, being afraid to lose folks who don't want to change.	Are people willing to change their views or be open?
cultural/social- tension between sexual reproductive rights and religious beliefs	How can we continue to be a bridge between diverse groups
Acknowledging reproductive justice and inclusion, tension between moving forward and growth	How to encourage folks to learn and grow gently but effectively?
cultural/social- disparate outcomes between groups, racial and indiginous	How is AABC advocating not just within the board but within the membership and with centers? Creating more centers in areas that need it?

Financial issues are HUGE, especially insurance reimbursement (agree….agree)	How can AABC facilitate this work?
technology	How have centers evolved since COVID with their use of technology and how can this be harnessed moving forward?
Tensions between the desire for accreditation and that process becoming too close to the medical model. Not to mention the expense and perceived worth of accreditation	
Social/Cultural	Lack of diversity with providers and patients Providers are NOT culturally sensitive and aware A 1-2 hour diversity training will not suffice for unaware/racist providers. It takes years of work, reflection -and effort to break the cycle. Understanding the community affected by the problem often is burdened with the solution Black people/POC should NOT have the sole responsibility of undoing and/or fixing the mess that white people created. A OB colleague said to "we think we are the solution but in fact we are the problem. That can be the case with midwifery as well We need to also be inclusive of of folks who are not women. I feel this has not been a big enough focus of AABC.
Economy/Finances	Home birth is for the privilege. Even when payers get on board the copays or the co-insurance may be too much for some It costs so much to start a birth center. Reimbursement from payers are much lower leaving birth centers to turn away some that have insurance Making it hard for non-privileged people to obtain.

	lack of resources for training/student loans/too few preceptorships
	Starting a birth center takes capital. More funding opportunities needed before access will become a reality.
	Diversifying the workforce so more access to midwives and other birthworkers of color. Again needs grant funding for scholarships for education
	We have the research that birth centers and midwives can positively impact outcomes and peoples experiences. Why isn't that enough to make change? When we have the evidence that supports change. We still need to money to lobby for it to do all of these things.
	Recognition of the value of midwifery model and birth center care so that reimbursement is adequate for sustainability and growth. New models of reimbursement based on value of prenatal and preconception care.
	Equity if access to midwifery care by adequate reimbursement by Medicaid
Having funding to help facilitate the needed changes	Recognizing the work that will be needed AABC is considered small fries on a big game. I feel like we are always struggling to do the work!
	More teaching tools for birth center providers on DEI
Most midwives know of the term trauma informed care, and many would probably say that they are providing trauma informed care, whether they have completed a training or not. Unfortunately, we also know that many midwives are survivors of trauma so their ability to provide this care can be affected by their own history.	