Title

Protecting Maternal and Perinatal Healing Spaces: Proposing and Analyzing Global Support Methods that Increase the Wellbeing and Healing of Black Women and Birthing People

Author

Chiddick, Leila

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Protecting Maternal and Perinatal Healing Spaces: Proposing and Analyzing Global Support Methods that Increase the Wellbeing and Healing of Black Women and Birthing People.

Leila Chiddick

International Institute

Ugo Edu, PhD

African American Studies Department

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The support I have received has allowed me to begin the immersive process of becoming a doula and be a part of this community. I have only taken a few steps onto this path but have learned from a tremendous amount of talented, kind, and passionate people. I do not do this work alone. I do this work for and with every woman and birthing person who deserves to be seen, feel safe, and find healing.

Thank you to my mom and the women who came before her.

Language Use

In the words of W.E.B. Du Bois, “there is no one ‘Africa’” (Du Bois, 1943, p. 724). The thesis uses the terms “Black,” “African,” or “Africa,” not as a means to represent Black people and communities, Africans, or Africa as a monolith, but to address the racism that exists in all contexts and countries where Black people exist. This language is up to interpretation, especially as it is potentially exclusionary in a global context and aligns with the American language and purview of race.

Language has often been weaponized against Black communities, in particular Black LGBTQIA+ communities, and continues to be weaponized against them (DeVenny, 2023). This paper switches between the language “mother” and “birthing person” (or uses both terms) because anyone who can give birth is a part of this conversation and deserves to be centered and acknowledged in birth work. The restrictive use of the terms “mother” and “woman” have been weaponized against LGBTQIA+, Queer, and gender-diverse communities. Although some of the language in the thesis explicitly refers to mothers, maternal health, maternal spaces, or women, it is not with the purpose of excluding or harming parents. All people are welcome in this space.

Furthermore, maternal and perinatal healing spaces are not the only terms that can define and describe healing for women and birthing people, and they should not be the only terms. Womb healing spaces, self-realization spaces, and any other terms that suit your identity and needs can be used interchangeably. People often define healing differently, and it comes in many formats — it is not one size fits all.

Language addressing specific global communities varies. The term “third world” is outdated and describes nation-states often subjected to social, political, and economic disenfranchisement by the West or Western nations (Mutua & Anghie, 2000, p. 31). This term is

only used in congruence with TWAIL, Third World Approaches to International Law, specifically aligning with the third world's view of "international law as a regime and discourse of domination and subordination, not resistance and liberation" (Mutua & Anghie, 2000, p. 31). The term has historically been used to create hierarchical separation between nation-states. Therefore, terms such as low-, middle-, and high-income countries are used in place of "third world" throughout the majority of the thesis.

Overall, author Leila Chiddick encourages you to use language that best suits your identity and needs. Any and all identifying terms can be changed and revised, as the purpose of this thesis is to provide guidance and demonstrate the importance of community-engagement in the international studies research space.

Abstract

The World Health Organization has made Black communities the face of the maternal death narrative without consideration for their various cultural, ethnic, racial, and ancestral histories. There is not a one-size-fits-all support method that encompasses the various cultural, ethnic, racial, and ancestral histories of Black communities. So why do international organizations continue to write global guidance that is not contextualized to specific communities? Critiquing the 1987 Safe Motherhood Initiative and global guidance by the World Health Organization, global maternal health initiatives focus on the maternal death narrative rather than healing. Maternal and perinatal healing spaces are safe spaces where women and birthing people feel supported at all stages of their pregnancy; safe spaces that allow for healing from past birth trauma, ancestral healing, and healing from the global erasure of Black life, birth, and peace.

Birthing support people, like doulas, use holistic practices and approaches to provide care within birthing spaces. They can help empower and support Black mothers and birthing people to find healing, rhythm, and community throughout the perinatal (prenatal, birthing, and postpartum) process. Their ability to holistically support mothers and birthing people's intuitive ability to carry, birth, and feed a baby provides insight into how birthing support systems can change.

In this paper, existing global literature is reviewed, sixteen conducted doula and birth worker interviews are analyzed using reflexive thematic analysis, and author Leila Chiddick's participation in doula trainings is assessed. Leila creates *The Holistic Birth Work Global Standard* (HBW-GS) based on the sixteen interviews with doulas and birth workers. The HBW-GS is a guide to holistic care and practices, directly influenced by interviews,

recommendations, and feedback by doulas and birth workers, centering the holistic care of mothers and birthing people. The HBW-GS intends to change how maternal and perinatal health is addressed globally and shift how the World Health Organization creates future global guidance.

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Introduction

Maternal and perinatal (prenatal, birthing, and postpartum) healing spaces are safe spaces where women and birthing people can find healing, autonomy, and support at any stage of the pregnancy process. Within these safe spaces, the birthing person can rely on a support person, like a doula, who provides holistic support, guidance, and education. These co-created safe places can allow Black people and communities to heal from past birth trauma, find ancestral healing, and heal from the global erasure of Black life, birth, and peace.

Doulas provide non-medical support to women and birthing people during the preconception, perinatal, or bereavement period (Birthing Advocacy Doula Trainings, n.d.; Salamon, 2023). As shared by the doulas interviewed by Leila, the all-encompassing term "birth worker" can be used to refer to doulas and is sometimes a preferred title. However, "birth worker" can also refer to other professionals who work with birthing people (Ellmann, 2020). Doulas are an essential part of a pregnant person's care team because they can help their clients implement healthy behaviors, effectively communicate with their medical providers, develop birth plans, and mentally and physically prepare for the experience of childbirth and breastfeeding (Robles-Fradet & Greenwald, 2022). Therefore, support from a doula can empower pregnant people to have positive birth experiences, leading to better outcomes for the mother, birthing person, and child (Gruber, Cupito, & Dobson, 2013).

Healing is deeply ingrained into the purpose of this paper, especially because racism often strips away the belief that Black people deserve joy, possess autonomy, and have the ability to make decisions. This research acknowledges a historical loss of autonomy and intends to highlight healing for Black communities across the globe. Amplifying the voices of birth workers, especially Black birth workers, allows a shift from maternal death narratives to

maternal and perinatal healing narratives. Their critical insight and first-hand experiences can cultivate safe spaces that center women and birth people, allowing for maternal and perinatal wellbeing rather than survival. This shift is guided by key research questions: *(1) What are doula and midwives' recommendations to develop a global standard for holistic birth work? (2) How can this global standard specifically support the perinatal process for Black women and birthing people?*

Existing literature and World Health Organization (WHO) guidance focus more on birthing people's pain and death rather than improving their wellbeing, safety, and healing (Oni-Orisan, 2023). Answering both research questions, this paper develops *The Holistic Birth Work Global Standard* (HBW-GS), which is intended to be contextualized to specific countries, communities, and contexts through community-engaged research that directly involves doulas, midwives, and birth workers. By creating the HBW-GS, global recommendations for maternal and perinatal wellbeing can be shaped by input and feedback directly from community members working as birth workers across the globe. The HBW-GS centers women and birthing people's prenatal, birth, and postpartum experiences, prioritizing their feelings of safety and autonomy.

Literature Review

Background on the Different Types of Birth Workers

Different categories of birth workers exist and describe people who support women and birthing people: (1) birth workers trained and certified under modern, allopathic medical systems, (2) birth workers trained and certified through apprenticeship, mentorship, and generational knowledge, and (3) birth workers who are trained as and certified to provide support

in a non-medical capacity.[1] Birth workers trained and certified under modern, allopathic medical systems are referred to as obstetricians, certified nurse midwives, certified professional midwives, certified midwives, and labor and delivery nurses (BetterHealth Channel, 2024; Mayo Clinic College of Medicine and Science, n.d.; University of California San Francisco, n.d.; Johnson & Johnson, n.d.).[2] Birth workers trained and certified through apprenticeship, mentorship, and generational knowledge are referred to as lay, community, and traditional midwives or traditional birth attendants (TBAs) (National Museum of African American History & Culture, n.d.; Ignite Healthwise, 2024; International Conference of Midwives, 2022; WHO, UNFPA, & UNICEF, 1992; International Council of Nurses, n.d.). They are typically "certified" by community members through trust, not by modern, allopathic medical systems (Pedroso, 2019; Ignite Healthwise, 2024; International Council of Nurses, n.d.).

Regardless of their training and certification, midwives provide person-centered holistic care for pregnant mothers and birthing people, centering their physical, mental, emotional, and cultural needs (World Health Organization, 2024, p. 8). The care from midwives typically reduces health risks for the mother, birthing person, and child (World Health Organization, 2024, p. x). The care midwives provide is holistic, falling under the midwifery model of care, which is person-centered, relationship-building focused, personalized care that mitigates the use of intervention; it can be used throughout all stages of pregnancy and postpartum (World Health Organization, 2024, p. x). However, midwifery is regulated, meaning distinctions are created between midwives who are and are not trained under modern, allopathic medical systems (Barnawi, Richter, & Habib, 2013, p. 114). This distinction has shifted midwifery as a social

[1] The term "modern, allopathic medical systems" and its equivalents refer to the following definition: "A system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery. Also called biomedicine, conventional medicine, mainstream medicine, orthodox medicine, and Western medicine" (National Cancer Institute, n.d.).
[2] The following list is not an exhaustive list and may not include all global terms and designations.

practice, a historically performed practice between women dating back to ancient times, to a medically regulated profession (Barnawi, Richter, & Habib, 2013, p. 115, 120). Therefore, midwives who work outside of regulation are designated titles such as lay, community, and traditional midwives, or traditional birth attendants (National Museum of African American History & Culture, n.d.; Ignite Healthwise, 2024; International Conference of Midwives, 2022; WHO, UNFPA, & UNICEF, 1992; International Council of Nurses, n.d.).

The WHO specifically defines traditional birth attendants as: "a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants." (WHO, UNFPA, & UNICEF, 1992, p. 4). The term itself, "traditional birth attendants," categorizes TBAs as "inferior and undermine[s] their practice" (Musie et al., 2022). Furthermore, midwives have attended births since the Paleolithic era (40,000 B.C.), and Indigenous practices and beliefs continue to be used and followed today (International Conference of Midwives, 2022; Musie et al., 2022). For example, traditional midwives in the Amazon are not formally trained but are widely accepted and acknowledged by the local communities because they are considered to be "practising one of humanity's oldest professions" (Pedroso, 2019). In Kenya, traditional midwives are important in supporting women and birthing people in rural areas. However, they have not been acknowledged for their contribution to birth work but instead blamed for being unhygienic and potentially contributing to high maternal mortality rates (Muiruri, 2023). Furthermore, in the United States (US), traditional Black midwives are often referred to as grand and granny midwives (Black Midwifery Collective, n.d.). However, white physicians, nurse-midwives, and medical societies took over, portraying "home births as unsafe and unsanitary, despite evidence

that midwife-attended home births had as good or even better outcomes as hospital births" (Bonaparte, & Oparah, 2023, 59:07; Generate Health, 2024).

Then there are doulas. They provide non-medical support to mothers and birthing people and can learn, practice, and expand on support skills by attending trainings, receiving certifications, or through apprenticeships or mentorships (Salamon, 2023; Birth it Forward, n.d.). Training and certification requirements vary from country to country, as the regulation of doulas varies from country to country (Fernandes, Mishkin, & Lansky, 2022; Jekel, 2024; Royal College of Midwives, 2017; Searcy & Castañeda, 2021).[3,4] Doulas and birth workers interviewed by Leila shared trainings and certifications they have completed or are in the process of completing: Certified Lactation Counselor Training (COC), Herbalism, Hypnobirth Certification, Placenta Encapsulation Apprenticeship, Rebozos, and Spinning Babies.

Global Racism

The landscape for midwifery amongst African and African-diaspora peoples changed entirely as a result of the slave trade and colonization (Musie, 2022). Healthcare disparities for Black communities across the globe continue to be perpetuated by slavery and colonization in the form of racism (World Health Organization (a), n.d.). There are numerous and varying definitions of "racism." An all-encompassing definition that also provides insight into global health racism is: "the attribution of group identity and low status in the power hierarchy, rooted in enduring social, political, and economic structures, which in combination makes it impossible

[3] There are international training and certification organizations like Doulas of North America (DONA), Childbirth International, and International Doula Institute, but they are not global regulators or authorities of doula trainings and certifications (Childbirth International, n.d.).

[4] In Brazil, doulas are not regulated but are in the process of being federally regulated by Brazil's Bill 3946 (2021) (Gomes, 2021, p. 5). Specific municipalities have already begun to implement regulation. In the US, doulas can be regulated by each state but they are not federally regulated (Jekel, 2024). In the United Kingdom, doulas are not regulated (Royal College of Midwives, 2017).

for those targeted to opt out" (Devakumar et al., 2025). As a socially constructed concept, racism, and its definition, will continue to shift.

Racism allows people, countries, and organizations to continue perpetuating the hierarchical ordering of bodies, in particular Black bodies (Morley, 2022). Assessing racism within Black communities on a global scale is challenging, as each Black racial and ethnic group was and is impacted uniquely. All Black people have been impacted by racism but in different ways, whether direct or indirect. Often, the plight of racism and its history is connected to the United States and African Americans, narrowing racism to a Western-specific perspective when that is not the reality (Kazini, 2023, 54:12; Devakumar, 2025). Racism exists globally (Devakumar, 2025). According to Dr. Jemima Pierre, Africa is racialized through ethnicities (Kazini, 2023, 44:44). In particular, African nation-states' borders were devised by European nations and colonial rule, creating ethnic distinctions and divisions, also constructed by Europeans, as well as grouping distinct ethnic groups together as one (Gashaw, 2017; Kazini, 2023, 44:44). These ethnic distinctions were created as a way to control African people and were not created naturally (Kazini, 2023, 40:20, 46:15). The Europeans made ethnic groups feel so different from one another that they would fight each other (Kazini, 2023, 46:28). It is easy to control people when they are focused on fighting each other rather than who is in power.

For example, Ghana and Kenya under colonial rule and the US and Brazil through slavery have long-standing histories where their Black populations were either pitted against each other through ethnic distinctions and divisions, forced to change societal structures, forced to be laborers in harsh conditions, or forced off of Indigenous land, taken by colonial settlers (Boston University, n.d.; Nyarko, 2023, p. 2; Hall, 2019; Mintz, n.d.; The Brazilian Report, 2020). By exploring the separate and intertwined histories created by slavery and colonialism,

one can understand the long-lasting and overarching reach of global racism against Black people and their communities today. Because of vital economic impacts for the countries that enforced slavery and colonialism, now allowing them to thrive in stolen, bloody, generational wealth, the narratives, outcomes, and violent histories of Black people across the world have been, and continue to be, shaped by imperialism (Hall, 2019; The Brazilian Report, 2020). Although current narratives are not defined or solidified by the horrific wrongdoings of so many countries, which to this day still do not fully acknowledge or atone for their actions, Black people across the globe are impacted both directly and indirectly. Through the racialization of labor and stereotyping of Africa and Blackness as savage, the imagery, presence, and existence of the Black person has changed forever (Kazini, 2023, 29:47).

Africa and Decolonization

Healthcare infrastructure, systems, and access are influenced by a country' economic wellbeing (Hensher, 2020). Colonialism continues to harm Black communities through neocolonial economic control (Du Bois, 1943. p. 721). These underlying economic constraints then limit Black communities' access to competent, holistic healthcare. Twentieth-century sovereign and independent African nation-states have struggled to battle corruption, poor lending practices, and exploitation of land and labor (Cooper, 2015; Lopes, 2024; United Nations Trade and Development, 2021). Although some African leaders have exacerbated corruption, they are not the sole reason for corruption in African nation-states as their infrastructure was poorly created by European colonizers, setting up Africa to fail economically post-decolonization (Ndlovu-Gatsheni, 2021; Cooper, 2015). Colonial structures still exist and leave a lasting impact, continuing to extract and control Africa's resources to the point "that any attempt to reorient

them to serve the majority of African people, sees them founder and collapse" (Ndlovu-Gatsheni, 2021). Furthermore, poor lending and trade practices have caused many African nations to remain in a "cycle of debt" (Lopes, 2024). International systems such as The Bank for International Settlements (BIS) create regulations that favor developed nation-states and punish developing countries (Lopes, 2024). Organizations like the International Monetary Fund (IMF) and World Bank also fail to support African nation-states in moving out of the "cycle of debt" in the long term, allowing the impact of the colonial, extractive raw goods markets to continue to falter African nation-states' economies (Lopes, 2024). Further exacerbating this issue is the international push for developing and expanding special economic zones (SEZs) in Africa. Although painted in a positive light by international organizations, as a means to stimulate economic growth, SEZs allow corporations to extract cheap labor to increase profits from production, receive tax cuts, and by-pass a country's regulations, leaving people and resources vulnerable to exploitation (UN Trade and Development, 2021; CRDF Global, n.d.; Gopalakrishnan, 2007). SEZs are a form of neocolonialism, mimicking economic infrastructural harms already embedded into many African nation-states.

Specifically assessing international organizations' role in decolonization through intersecting lenses of Critical Race Theory (CRT) and Third World Approaches to International Law (TWAIL), the creation of sovereign, decolonized nation-states has neither ended "the political, economic, or racial subordination of [Black Americans or third world nations]," nor granted them independence free from structural inequality (Morley, 2022). The intersection between CRT and TWAIL extends CRT's reach beyond Black Americans and to global Black communities because European "domination is global" (Mutua & Anghie, 2000, p. 38; Du Bois, 1943, p. 727). This legitimizes experiences of structural inequality, de facto colonization, and

global racism that exist today. In the words of Dr. Jemima Pierre, “We cannot be naive to not understand the way that race and anti-blackness [function]” (Kazini, 2023, 32:30). It is not a coincidence “that Africa is at the bottom of every single global hierarchy,” and African nations are not solely to blame for this misfortune (Kazini, 2023, 32:39). For true decolonization to occur for African nation-states, borders must become more malleable, and ethnicities constructed in tandem with colonialism must be allowed room to shift and change (Kazini, 2023, 1:01:33). Without true decolonization, neocolonialism will limit long-lasting and community-driven changes to infrastructural harms to African nation-states, not only impacting the economy but healthcare infrastructure, systems, and access.

The Hyperfocus on Maternal Death Narratives

Created in 1948, the World Health Organization oversees global public health, addressing health concerns for all populations (World Health Organization (b), n.d). The WHO has greatly impacted all facets of public health, including setting “norms and best practices” (CFR.org Editors, 2022). In particular, it has significantly impacted maternal and perinatal health, specifically because it co-founded the Safe Motherhood Initiative in 1987 (Tulchinsky, Varavikova, & Cohen, 2023; AbouZahr, 2003).[5] Through the Safe Motherhood Initiative, the WHO has worked to combat maternal mortality and prioritize safe and healthy pregnancy and childbirth for women (Mahler, 1987; Rana, 2020). However, some of its recommendations and goals are questionable because of their simplification and lack of nuance. For example, emphasizing the need for skilled attendants at births, especially in rural areas (Starrs, Family

[5] Other co-founders include the United Nations Population Fund (UNFPA) and the World Bank (Tulchinsky, et al., 2023).

Care International, & Inter-Agency Group for Safe Motherhood, 1997, p. ii - iii).[6] Furthermore, the WHO paints African women as victims of their situations, implying that modern, allopathic medicine and intervention are the only way to "save" them. Dr. Adeola Oni-Orisan explains the harm in painting women as victims and how organizations like the WHO assume that women and birthing people would undoubtedly agree to their proposed solutions and recommendations when, in reality, they could say "no" (Oni-Orisan, 2023).

Dr. Oni-Orisan calls out the maternal death narrative, particularly created through the lens of "African death" (Oni-Orisan, 2023). The WHO paints African women as victims in their re-published, updated video entitled, *Why Did Mrs. X Die, Retold* (Goldner, 2012).[7] The re-published video contributes to the individual stereotyping of women in Africa and places blame on individuals or communities by labeling Mrs. X's home as a "village" while showing mud huts, which are closely related to African, Indigenous mud huts; or referring to her home as a "remote village," sharing that she lives in "poverty" while showing her hand wash clothing; and sharing sentiments like "She also had had only one antenatal visit. If she'd gone regularly, her problem may have been picked up, she would have been referred to a specialist, and she and her baby could have survived" (Onyejegbu, Okonkwo, & David-Ojukwu, 2023; Goldner, 2012, 3:35, 5:40, 3:39). The video of Mrs. X contributes to the WHO's depiction of African women as the face of maternal death narratives (Oni-Orisan, 2018, p. 72). A pattern has emerged, as the Safe Motherhood Initiative's archival documents share similar sentiments, narratives, and stereotypes. Mrs. X's story is incredibly problematic, affirming that her maternal death narrative

[6] The following list is not exhaustive and exemplifies one of the harmful ways that the Safe Motherhood Initiative has imposed certain recommendations onto women and birthing people, in particular women and birthing people in lower- and middle-income countries.
[7] Only the updated video is accessible for public viewing.

is a norm for women like her. By focusing on death narratives, they become normalized, and alternative narratives become invisible (Oni-Orisan, 2023).

Archival WHO documents and journals, although historical, still represent contemporary perspectives on the development of the Safe Motherhood Initiative. These documents would describe death and illness from pregnancy and birth complications as symptoms of poverty and disadvantage, grouping together a large population of people, often from Sub-Saharan Africa or Southern Asia (Conable, 1987, p. 155). In particular, Barber B. Conable shares in the *WHO In Focus* article on Safe Motherhood, "The women of the Third World are the poorest of the poor, but their work can make the difference between poverty and hope" (Conable, 1987, p. 156). This imagery is further racialized through the description: "It is their backs that are bent in the fields to till, plant, weed, fertilize and harvest; their backs that are bent at the well to draw water and to carry it home; their backs that are bent under loads of firewood and the weight of young children; and their backs that are bent over cooking fires, looms, market stalls and sickbeds" (Conable, 1987, p. 156). It is not racialized to any particular race, however, it aligns with imagery and stereotypes of Africa and Black people as poverty-stricken, underdeveloped and without infrastructure, and dirty, which is harmful (Opoku-Nyarko, 2018). Safe Motherhood was created with the intent to "save" women in developing countries but instead perpetuates maternal death narratives (Conable, 1987, p. 155, 157). Not only are these death narratives demeaning, but they share a narrow view of women and birthing people's experiences (Oni-Orisan, 2018, p. 81).

The maternal death narrative, in particular of African women and birthing people, overshadows all other birth narratives and experiences (Oni-Orisan, 2023). Although it is an effective way to bring attention to the issue of maternal mortality and global solutions to resolve it, it does not center the stories of African women and birthing people (Oni-Orisan, 2023).

Instead, it focuses on their bodies "as sites of knowledge production," inflicting blame onto Black women and birthing people, and traditional midwives and birth workers, moving Black communities further away from maternal and perinatal healing (Oni-Orisan, 2023).

The State of Global Maternal and Perinatal Health for Black Communities

Although maternal and perinatal health is hypervisible in the international space, there is a hidden racial piece. There is a limited breadth of research specifically on the maternal and perinatal health and wellbeing of global Black communities. Although it is challenging to determine how high of a level of maternal mortality Black women and birthing people face as a whole, African and Afro-diasporic populations face high or very high levels of maternal mortality in low-, middle-, and high-income countries (UNICEF, 2025; Small, Allen, & Brown, 2017; Gunja et al., 2024; Silva et al., 2024).

According to the WHO, 70% of global maternal deaths are from the African region (World Health Organization, 2025).[8] However, Black populations outside of Africa also face higher maternal mortality rates compared to the general population (Hoyert, 2023; BR Ministry of Health, 2024; Brader, 2023). For example, in the United States, Black women have a high cesarean rate, breastfeed less, have a higher risk of their children dying within the first year, and have the highest maternal mortality rate at 50.3 deaths per 100,000 births (Bonaparte & Oparah, 2023, 28:39; Hoyert, 2023).[9] Compared to the general US population, which has a maternal mortality rate of 14.5 deaths per 100,000 births, Black women are at a 3x higher risk of dying from birth (Hoyert, 2023).[10] In Brazil, Black maternal mortality rates are increasing and are

[8] The WHO designates specific regions. The African Region does not include all countries on the African continent (World Health Organization (c), n.d.).
[9] Data from the year 2023.
[10] *Ibid*.

currently 110.6 deaths per 100,000 live births (BR Ministry of Health, 2024).[11] In comparison, Brazil's general maternal mortality rate is 57.7 deaths per 100,000 live births (BR Ministry of Health, 2024).[12] Historically, physicians in the US and Brazil are the people primarily attending births (National Academies of Sciences, Engineering, and Medicine et al., 2020; Nunes, 2016). Their primary role is further exemplified by the number of people who give birth in hospitals in the US (98.4%) and Brazil (98.9%) (National Academies of Sciences, Engineering, and Medicine et al., 2020; Gualda, Narchi, & Antunes de Campos, 2013).[13] This is concerning as hospital births are often correlated with increased rates of intervention such as "caesarean section, operative vaginal birth, epidural analgesia, episiotomy, and oxytocin augmentation" (Reitsma et al., 2020). The increased use of interventions on mothers and birthing people does not align with holistic maternal and perinatal healthcare and will prevent the WHO from reaching its Safe Motherhood healthcare goals.

Furthermore, the WHO's Fifth Millennium Development Goal (MDG) to improve maternal mortality rates and provide universal reproductive healthcare leaves out an important piece of how to holistically support communities and their needs to achieve these goals (World Health Organization, 2018). Specifically, the WHO does not address the nuances of race for African countries and Afro-diasporic communities, referred to as *histories of dispossession*. However, the racialization of Black people and reproductive health are historically linked (Oni-Orisan, 2023). Without addressing and contextualizing the history of dispossession that uniquely impacts each Black community and has often uprooted the important work of traditional midwives, the WHO may never reach its goal.

[11] Data from the year 2022.
[12] *Ibid.*
[13] US Statistics from 2017; Brazil statistics from 2010.

Another pressing issue is the lack of representation and centering of Black people in maternal and perinatal health research and data (Small, Allen, & Brown, 2017; UNICEF, 2025). It is unsurprising because international organizations lack objectivity, have been influenced by underlying assumptions, and "have never been legitimate representatives of a universal humanity" (Auld & Elfert, 2024; Whitman, 2008). Furthermore, WHO research falls under the positivist research paradigm, which centers quantitative data over stories and personal experiences (Vázquez, 2024). Positivist research paradigms center deficit-based research, highlighting certain groups' negative experiences and dispositions (Vázquez, 2024; Hyett, 2019). Regarding maternal and perinatal health, the WHO creates deficit-based research, often failing to acknowledge systemic inequality, in particular colonialism and slavery, which impact Black communities (Vázquez, 2024). In addition, the WHO's Safe Motherhood Initiative uses vertical approaches, such as focusing on the location of a birthing person's birth and the people supporting or attending the birth, to address maternal mortality (Oni-Orisan, 2023). Vertical approaches to addressing maternal mortality are complicit with the maternal death narratives because they do not provide long-term, contextualized solutions but rather treat the "solution" to maternal mortality as singular and universal (Partners in Health Engage, n.d.). The WHO can shift maternal and perinatal health research from positivist research paradigms to transformative research paradigms by truly engaging in community-engaged research that centers marginalized communities (Vázquez, 2024). In order to make the shift, the WHO and its researchers must include community members throughout the research process (The University of Chicago Social Sciences Research Center, n.d). By including community members in the research question development, methodology and methods selection, data collection, data analysis, the writing process, and evaluation of the final product, their voices are centered. Furthermore, the WHO

cannot continue to address maternal and perinatal health from a positivist paradigm and vertical approach, as this ignores the myriad of structural, social, and political factors that shape maternal and perinatal health outcomes and care. A lack of maternal and perinatal wellbeing amongst Black communities is much bigger than the eradication of maternal death. It is hinged on various infrastructural issues that cause birthing people to not be heard; not have autonomy; and not be supported before, during, or after birth. It is imperative that the WHO make this shift and work with communities to adequately and more equitably address maternal mortality.

Methodology

Introduction to Methodological Approach

By creating maternal and perinatal healing spaces, researchers can shift away from maternal death narratives. Although this thesis deviates from the community-engaged research model due to limitations in time, resources, and writing restrictions to conduct deep collaboration on the writing process, it is modeled on a community-engaged research framework. The theoretical framework, Critical Race Theory, guides discussions about race and international guidance. This paper develops a global standard for holistic birth work by analyzing global literature, conducting and analyzing interviews with sixteen doulas and birth workers, and researcher participation in doula trainings. The standard is guided by first-hand perspectives from doulas and birth workers.

Theoretical Framework: Critical Race Theory (CRT)

Critical Race Theory emerged in the 1970s and 80s as an “academic and legal framework” to dismantle structural and systemic inequality, specifically in the United States

(Legal Defense Fund, n.d.). However, CRT can extend beyond the US legal system and its power dynamics. CRT allows legal scholars to assess how racism extends beyond social beliefs, stereotypes, and notions and "that racism is embedded in laws, policies, and institutions that uphold and reproduce racial inequalities" (Legal Defense Fund, n.d.). It allows legal scholars, researchers, and community members to understand the intersections of race with law, science, and literature and how they have been weaponized against Black communities (Morley, 2022). International organizations perpetuate racism, especially as they are influenced by the very countries that created them. CRT can be applied at a global scale through international organizations, specifically through international guidance, policy, and law. In particular, CRT can be used to assess the history of colonization, slavery, and "the dehumanization and discrimination" against Black peoples and how Black communities across the globe are impacted today (Morley, 2022).

Literature Review

Literature reviews provide factual and statistical data representations, allowing researchers to formulate research problems and questions (Paré & Kitsiou, 2017). The literature review is intended to extend beyond the researcher's work to bridge gaps between race, birth work, and maternal and perinatal wellbeing within global Black communities. The structure of the literature review is partially guided by community-recommendations, ranging from shared articles, conversation topics, and nuanced perspectives about birth provided by the doulas and birth workers interviewed. Without their perspectives, the literature review would not have reached the depth of knowledge, information, and perspective that it has.

Various studies were analyzed under the Critical Race Theory framework to understand the prominence of race and racism in birth work. It was challenging to find information specifically about Black women and birthing people, as it was fragmented or spread across various resources. Furthermore, one section of the literature review analyzes statistical data. However, statistical data analysis is not the focus and often contributes to the decentering of mother's and birthing people's voices. The literature review demonstrates the need to shift away from maternal death narratives, which are often centered in current literature, to maternal and perinatal healing narratives.

Community Participation

The researcher attended one full doula training course, one segment of a doula training course, and one doula community meeting. The first training was a live, online, all-day course over three days with BiniBirth, a Doulas of North America (DONA) approved training. The second training was a one-day session out of an entire doula training course with Birth Advocacy Doula Trainings (BADT), specifically focusing on how to support Queer and LGBTQ+ families and parents. Each training taught different practices with different types of trainers. Both experiences were very supportive and community-based. It was healing to learn about birth work alongside other doulas and birth workers at varying levels and years of experience. Furthermore, all of the communities were very welcoming, especially to participating in and collaborating on this thesis. The first training did not delve into supporting Black communities in the United States, outside of basic discussion about the existence of racism in medical spaces and the importance of being anti-racist. The second training spoke deeply about the intersection between race, gender, sexuality, and economic status with a US-focused lens. It contributed heavily to the

researcher's positionality and inclusion of LBGTQ+ mothers and birthing people in the thesis. Furthermore, the researcher attended one virtual doula circle, a community meeting allowing doulas and birth workers to speak freely about challenges, frustrations, successes, and questions.

Hands-on engagement and community participation are critical to understanding community needs (Collins et al., 2018). Therefore, the researcher began their journey to become a doula to understand their work, the barriers that they face, and become directly involved in the community. In the researcher's shift to conducting more community-engaged work, the doula trainings they attended created a basis for understanding how to approach conversations with community members, understanding basic medical terminology related to birth, and understanding the support methods used by doulas. Both trainings were selected due to their location online, timing in the winter, and pricing.

Data Generation

Participants

A total of sixteen doulas and birth workers were interviewed.[14] Demographics of each doula and birth worker were collected:

Pseudonym[15]	**Race/Ethnicity**	**Gender**	**Country Where Practicing**
A.B.	Hispanic, Caucasian	Female	United States

[14] After the data analysis process, one interview was conducted with a doula from Brazil. Therefore, seventeen people were interviewed in total, but the analyzed data in this thesis is from only sixteen doulas. The doula interviewed (W.X.) shared the following demographic information in order of race, gender, and country where practicing: Pardo (mix-raced), Mulher (woman), and Brazil.

[15] The initials assigned are not affiliated with the real names or initials of the doulas and birth workers interviewed.

P.Q	African American with Caribbean Roots Diaspora	Female	United States Belize (only supporting relatives)
D.E.	Black, Latino	Cis-gender female	United States
G.H.	African American	Female	United States
J.K.	African	Woman, female	Kenya United States (only supporting relatives)
M.N.	Black	Woman, female	United States
Y.Z.	Black, African American	Female	United States
V.W.	Black, Mixed	Female	United States
T.U.	African American, Black	Female	United States Jamaica (providing virtual

			support) Ghana (leading a doula training)
B.C.	Black, African American	Female	United States Ghana (as a non-birth work educator)
H.I.	Black Woman in America	Woman	United States
E.F.	Black	Cis-woman	United States Guam (as a birth work educator)
K.L.	Black Lady, African American	“Assigned female at birth. I'm cis gender, so I identify as female. And gender, yeah, woman,”	United States

		(she/her pronouns)	
N.O.	African American	Woman	United States Tanzania
S.T.	Black	Woman	United States
Q.R.	“I'm of Palestinian, Lebanese origin. I came to Australia when I was two”	Woman	Australia Japan China Taiwan United States India

Recruitment

One participant was recruited from a doula training attended by the researcher. One participant was referred to the researcher by a different doula. All other participants were randomly selected through mass outreach over email and Instagram to doula and birth worker

databases. Keywords such as “doula,” “midwife,” “birth worker,” and country names were used to search for participants. All participants were contacted between January 1, 2025, and April 21, 2025, with the only requirement that they are a doula, midwife, or birth worker. No participant incentives were provided. The greatest barriers to further collaborating with doulas and birth workers across the globe were language, distance, costs, and time.

Data Type and Tools

Each person was individually interviewed, with each interview ranging from 45 minutes to 1 hour and 30 minutes.[16] Semi-structured interviews were conducted using a set list of broad questions to elicit the participant’s experiences. Depending on the participants’ response, the researcher asked follow up questions that were distinct for each interview.

Ethical Considerations

This research was conducted under the University of California, Los Angeles IRB and verbal consent was obtained from all interview participants.

Research Approach

Reflexive thematic analysis (RTA) was used to analyze the interviews because of its ability to identify and analyze patterns and themes (Perry, Meissel, & Hill, 2022). The following phases developed by Braun and Clarke were used in sequential order: (1) becoming familiar with the dataset, (2) coding, (3) creating an initial list of themes and patterns, (4) theme development, (5) creating a final list of themes, and (6) completing a written piece in the following format: development and analysis of the HBW-GS (University of Auckland, n.d.).

[16] One doula was interviewed twice for one hour each time.

RTA was used to analyze all interview transcripts, develop a codebook with memos for each codeword, and develop themes. RTA allowed for the direct involvement of community voices through the centering of doula and birth worker perspectives in the findings and deliverables of the paper. Therefore, the research study themes were developed with the important perspectives of sixteen doulas and birth workers, alongside deep positionality work by the author, Leila Chiddick.

The in-depth interviews and the meaningful quotes from each doula and birth worker are a form of storytelling. Although seen as illegitimate by traditionalists in the research space, "storytelling is defended by many critical race theorists who regard it as exceedingly useful and undeniably powerful in its effect" (Ross, 2020). The voices of the doulas and birth workers have shaped all of this work, and the outcome would not have been the same without their willingness to share their stories with Leila. They have changed the entire trajectory and purpose of the research. It is critical that international organizations use similar or more in-depth methods to produce community-driven guidance, policy, and recommendations. In particular, for future contextualization of the HBW-GS, the WHO should especially collaborate and center the voices of the people and women in this work. We cannot do this work without them.

Positionality

Leila Chiddick is a cisgender, straight, Black, upper-class woman who is a United States citizen. She does not have the lived experience of being a mother or a birthing person. Black maternal and perinatal wellbeing has always been an interest of hers, and she was influenced by her own mother's birth stories and the United States' medical failure of Black women and birthing people. She has co-researched one reflexive thematic analysis paper with a team of

experienced mixed-methods researchers on survivors of sexual violence. Because of this experience, she has a strong foundation in the reflexive thematic development process, reflecting on positionality, and developing themes and patterns in qualitative research. Furthermore, prior to conducting her research, she was not knowledgeable about maternal and perinatal health beyond the United States and held the assumptions that: (1) doctors and medical systems in the US are biased against Black patients and cause them further harm by ignoring their pain, (2) racism impacts medical care in the US, (3) more holistic birth support methods are used in Sub-Saharan Africa compared to North America, (4) doulas are more common in Sub-Saharan Africa than in North America, and (5) obstetricians were the primary people attending births in all countries. From research experience for and with survivors, Leila understands the importance of researching with directly impacted communities. Therefore, this research will continue to shift and is always open to community feedback.

Limitations and Future Research

Leila has faced limitations, such as being unable to involve community members in the development of research questions, methods, and analysis. Therefore, this research does not fall under the community-engaged research framework. Regardless, because of community feedback, Leila has made multiple shifts to the research questions, healing focus, and development of the HBW-GS. For example, her work did not initially engage community members, and she shifted to include doulas and birth workers in her research process after taking a doula training and becoming a part of the birth work community. After speaking with doulas and birth workers, she changed her research question from weighing the benefits and constraints of globally regulating doulas to condemning the regulation of birth work. She made this shift specifically because of

conversations with doulas and birth workers about the harm that regulation can have on their ability to provide holistic support. Instead, she has shifted to create a standard, as recommended by multiple doulas and birth workers. The HBW-GS allows for contextualization while still addressing broad issues in the birth work space.

For future research, she hopes to engage participants through more than just data collection, review of analysis and writing, and evaluation and feedback. It should be all-encompassing. In addition, she would broaden her scope to speak to midwives and participate in doula trainings outside of the United States. She spoke to mostly African American doulas and birth workers and hopes to expand the scope of her research to more Black, African, Afro-Caribbean, and Indigenous doulas, midwives, and birth workers from all over the world to understand more nuanced perspectives and experiences. Leila also acknowledges the importance of paying birth workers for their time and, unlike her current interviews, would secure funding to provide payment to doulas, midwives, birth workers, and translators who support the live and written transcription process.

Development and Analysis of A Global Standard

What is the Holistic Birth Work Global Standard?

The Holistic Birth Work Global Standard (HBW-GS) developed in this paper is a guide to the holistic care and practices of doulas and birth workers. Therefore, it provides guidance on how their holistic practices can be used to center mothers and birthing people. This general and expansive standard creates a baseline for implementing holistic care in different countries, communities, and contexts. The contextualization of the HBW-GS to any country, community, and context through community-engaged research, centers the voices of doulas, midwives, and

birth workers. The HBW-GS is intended to change and be a living and breathing document, meaning it should be expanded to include the perspectives of midwives and community birth workers while including more perspectives from doulas, birth workers, women, and birthing people.

The HBW-GS' foundation is created with the vast, in-depth perspectives, recommendations, and evaluations from doulas and birth workers interviewed during the research process alongside community members' evaluation of the unpublished draft.[17] Each doula and birth worker shared personal stories and their passion for keeping mothers and birthing people safe, centered, and whole. Furthermore, many of them spoke about the challenges of intersecting race and gender in their work and keeping Black families safe from additional barriers and harms. Author Leila hopes the HBW-GS will change how maternal and perinatal health is globally addressed and shift the future of how the World Health Organization creates global guidance.

What is the purpose of the Holistic Birth Work Global Standard?

The HBW-GS specifically critiques and revises existing WHO guidance on maternal health, requesting that changes are made to center community voices on maternal and perinatal health and wellbeing with the goal of improving holistic support to mothers and birthing people. A common issue in the global maternal health space is the victimization of communities and the identification of community challenges without the involvement of community members (Oni-Orisan, 2023). The HBW-GS intends to change how global maternal and perinatal health research and support victimizes communities by creating community-generated

[17] Community members are only involved in evaluating a full draft of the research to provide feedback and recommended changes. These members include doulas and birth workers from Leila's doula trainings, along with Leila's research mentors and peers.

recommendations to increase holistic support for women and birthing people throughout the perinatal process.

Using a broad term like "holistic birth" allows room for the vast and flexible nature of the prenatal, birth, and postpartum process; it also allows birthing people to be centered and feel autonomous while seeking support and care. It paints a picture of what holistic birth can look like through the lens of doulas and birth workers, with room for expansion if this research expands in the future. Although it is critical to look at this work for all women and birthing people, Black women, birth people, and birth workers across the world are often left out of conversations about their maternal and perinatal health. When specifically addressing maternal and perinatal health for Black, African, or Afro-diasporic communities, they should be directly involved.

Findings

Five key themes were developed from the interview and RTA analysis process: (1) the Medicalization of Birth, (2) the Colonization of Birth, (3) Doulas Can Co-create Safe Spaces, (4) Healing Rather than Death, and (5) the Importance of Context-Specific Education and Support.

The **Medicalization of Birth** undermines birth as an innate, intuitive process that does not require medical intervention or support. However, in many countries, modern, allopathic medical systems have been pushed to the forefront. Medical spaces, specifically hospitals, are often described as survival spaces. Medical providers, ranging from physicians, midwives, and nurses, have different roles in the medicalization of birth, depending on context or country. Patterns of violating consent, lacking trauma-informed care, and treating birth as a business have arisen from critical conversations about existing in medical spaces as a doula, birth worker, or

birthing person. These patterns have revealed the hierarchical nature of modern, allopathic medical systems globally, creating dissonance between provider and patient. Just because medical or hospital protocol is safe does not mean it feels safe; birthing people know what feels good to them, and they know when something in their body feels wrong. However, modern, allopathic medical providers often disregard the nuances around safety and existence in medical spaces, let alone around birth. This causes a key perspective shift, where the birthing person must shift from "wanting to have their birth a certain way" to "preventing certain interventions, examinations, or things from happening to them." Often, this is the case in hospitals, further reinforcing why hospitals are survival spaces. One doula in the United States shared:

> *But if you think about [it] from a very, very early stage of life, four, three, two, even, one, right? You go to the pediatrician, and the pediatrician is talking to the adult, and so it's already telling our kids that this pediatrician is the hierarchy. They are the ones that are in charge. I no longer have a voice to tell you what's wrong with me because you're asking somebody else to use their words instead of asking me. So until we start to change that- that dynamic and teach our kids to speak up, the trend will continue. We will allow things to happen to us and not for us, and that's what happens in labor. You're super vul- vulnerable, you're in pain, and the doctor says 'We're going to do this.' And you say, 'Okay,' because you think they have your best interests, not recognizing that you have options. (T.U., United States, Jamaica, Ghana)*

The **Colonization of Birth** specifically impacts women and birthing people of color and is closely connected to the Medicalization of Birth. Black communities, in particular, have historically been impacted, and are currently being impacted, by the long-lasting impact of slavery and/or colonization in a climate where neocolonialism is on the rise. The greatest impact

of slavery and colonization is institutional racism, which is embedded into social, economic, and government systems across the globe, including in International Organizations. Institutional racism exists and presents itself in different contexts, making it less apparent in countries with populations that are predominantly Black people. However, all Black communities are still impacted, still othered, and still treated as monoliths. These impacts affect Black maternal and perinatal health and wellbeing, especially because maternal and perinatal health extends beyond birth to comprehensive sex education, menstrual health, mental and physical wellness, and meeting basic needs. Acknowledging and atoning for historical wrongdoings requires a change to structural systems that not only support Black mothers and birthing people but Black families and communities as a whole. One doula shares a passionate sentiment, emphasizing the healing and care that Black people deserve:

> *And so if I could change the narrative and keep saving lives, Black women and Black babies, specifically, and I mean that wholeheartedly, this is my aim, then I'm gonna keep doing the work, and Imma keep holding the spaces, and I'm going to keep holding the women and the babies until I can't anymore. (H.I., United States)*

Doulas can Co-Create Safe Spaces. Safe spaces extend beyond the spaces someone is in, but to the people there to support them in said spaces. Doulas can provide support to mitigate harm and increase autonomy, personal decision-making, and connection, creating a space where they are a safe resource and can co-create a safe environment for the birthing person. The presence of a doula can allow for a deeper connection to oneself and to the doula, as they provide consistent care and support. However, doulas are not the sole solution to critical problems emerging from the Medicalization and Colonization of Birth. Furthermore, each doula has a different answer to the question, “Why are you doing this work?” Passion-driven responses are important to birth

worker communities and birthing people. However, doulas are typically unregulated, receiving various trainings or certifications, which leads to some doulas centering birth as a business rather than co-creating a holistic, intuitive experience. Although not all doulas are supportive or in birth work for the right reasons, the profession is still important in providing holistic care to mothers and birthing people. One birth worker beautifully shares the importance of having consistent care:

> *Who would you feel comfortable walking with you? And very few people would we feel comfortable with. But we are flung into a hospital system or a medical system, and you get what you get, and you're lucky if who you got supported you and listened to you and loved you through; and this is the crying shame every single day. Women are being robbed in birth; of walking [a] path of a spiritual, sacred, ceremonial initiation. (Q.R., Australia, et al.)*

Pregnancy, birth, and postpartum should be more than survival. It is imperative that narratives focus on **Healing Rather than Death**. However, within medical spaces, pregnancy, birth, and postpartum are often framed as something that just happens to women and birthing people rather than being an autonomous, informed, and self-centering process supported by a consistent community. Although "healing" is often used to describe recovery from trauma, its definition and application extend beyond trauma and to the entire pregnancy process. Healing for each birthing person and each of their pregnancies is unique and changes based on how much they feel they are being listened to, being respected, feeling centered in the perinatal process, and having full autonomy over the perinatal process. Although "healing" can move beyond trauma, it includes recovery from trauma, whether it is trauma from a previous birth, generational birth trauma, trauma from sexual violence, or trauma from birth while in postpartum. It is a malleable

term that can be adjusted to center the needs of the birthing person and what healing means to them. By shifting perspectives to focus on pregnancy, birth, and postpartum as healing, maternal death narratives are deconstructed. One doula talks about fear-mongering and why people might be scared to give birth:

> *What we hear all the time is, just as you said, a lot of fear-mongering. People come to me and they're scared. They're scared. They're scared they're gonna die. Partners are scared they're gonna lose you know their wives, or you know their- their partners, or their sisters because of everything that we hear on- on the TV, and what the real stats say. (K.L., United States)*

Context-Specific Education and Support have a deeply profound role in birth work, impacting guidance, policy, and law of maternal and perinatal healthcare; how someone is holistically supported during pregnancy, birth, and postpartum based on their cultural beliefs and needs; or the dissemination of information in various formats that make information about maternal and perinatal health accessible. Community-engaged research, specifically using community-identified concerns, community-generated recommendations, implementation, and evaluation, set the foundation for creating context-specific education and support. However, community-engaged research typically does not include an analysis of the harm that research institutions have historically caused or continue to perpetuate, including their positionalities. Without acknowledging the history of communities at the center of research and acknowledging personal and institutional positionality, community-engaged research does not center the context-specific messaging, practices, and perspectives of people working with and within said communities, particularly Black communities. One doula shares the importance of knowing and reclaiming one's body before getting pregnant:

And something else that I've seen too is just, we have to start this education and this like reclamation of like- our bodies are ours before people get pregnant. Because what I see like, right? It's not just like, Oh, you're pregnant. All of a sudden now the doctors are being rude to you, or they're not getting your informed consent or explaining what- like, right? Like that doesn't start during pregnancy. (D.E., United States)

The Holistic Birth Work Global Standard

The HBW-GS aligns with the developed themes and is guided by direct quotes, recommendations, and feedback from doulas and birth workers. It is also influenced by the literature review and the researcher's participation in doula trainings. The HBW-GS expands on the holistic practices of doulas and midwives and the importance of their community-based practices.

The Holistic Birth Work Global Standard

[Contextualized to *'Country Name'* by
'*Community Member Organization Names*']

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Statement of Purpose

The Holistic Birth Work Global Standard (HBW-GS) provides guidance on supporting someone holistically through pregnancy, birth, and postpartum. It is important to emphasize that the HBW-GS is not a means to regulate or further regulate the work of birth workers. However, it does emphasize that regulation without community-driven perspectives can harm their holistic practices. Furthermore, it is intended to be contextualized, as community-generated recommendations are critical to ensuring that any version of the published HBW-GS aligns with community needs.

Overlapping and interconnected, there are five standards: (1) Supporting Birth as An Innate Process, (2) Acknowledging Histories of Dispossession, (3) Increasing Awareness and Access to Holistic Care, (4) Creating Maternal and Perinatal Healing Spaces, (5) Contextualizing the Holistic Birth Work Global Standard in Collaboration with Community Birth Workers. They expand on the importance of all birth workers engaging in holistic care when supporting pregnant people.

Disclaimer: The quotes and community-generated recommendations listed under each of the five standards are not an exhaustive list of the stories, personal reflections, and community-engaged perspectives included in the HBW-GS.

1 | Supporting Birth as An Innate Process

Birth is an intuitive process that is medicalized with the increasing presence of obstetric care and medical facilities. However, medical systems approach pregnancy and birth as a medical condition, de-centering women and birthing people from the perinatal process. Shifting to holistic models of care, such as the midwifery model of care, can change how medical providers support women and birthing people.

1.1 | Patient-Centered Care Models Can Replace Existing Allopathic Medical Models

Hierarchy in allopathic medical systems is learned. Medical providers function within hierarchical systems between each other but also between themselves and patients. This de-centers patient perspectives, questions, and concerns. Doulas can notice demeanor changes in medical providers when they are present or when physicians or doctors are questioned. In addition, doulas' advocacy is often mistaken for pushback because of learned beliefs that medical providers should not be questioned or are authority figures. Moving away from and removing hierarchy in medical spaces requires systematic shifts in medical providers' education and training. In particular, teaching patient-centered and holistic care models, like the midwifery model of care, promotes birth as "normal and safe," limiting the use of medical intervention unless needed or requested (Barnawi, Richter, & Habib, 2013). In addition, it centers patient-provider relationships as a means of building trust to provide the best care and support for the mother or birthing person (World Health Organization, 2024, p. x).

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the importance of centering women and birthing people in their care:

- [In Kenya] "And some doctors don't like us because they're like, Oh, you're making the client question- miss too much, or you're, you know, like, in all those things. So they don't allow us to practice there. Some hospitals are okay. Some are not. Some we have to go and just not say you- just say you are a friend"..."But doctors, I think they feel like you're trying to- so in Kenya, we are very patriarchal, and we grew up knowing the doctor says it all. Like people don't argue with doctors in this country. So the doctors actually grow- The most doctors in Kenya have that sense of like, what I say is what goes and so as a doula, I'm supposed to help my client make informed decisions, so they ask questions, and doctors don't like that. So some doctors. We have some who are great" (J.K., Kenya).

1.2 | Teaching Medical Providers Holistic Care Models that Center Consensual Trauma-Informed Care and Practices

As aforementioned, the midwifery model of care centers women and birthing people. However, a key issue is the need for medical providers to be further trained in providing consensual and trauma-informed care. Women and birthing people's autonomy is often overlooked for the sake of emergencies or medical intervention. However, medical providers can still uphold a birthing person's autonomy through informed consent and clear explanations. It is problematic that medical providers do not understand the baseline for providing consensual care (Hakimi et al., 2025). Furthermore, in medical spaces, often there is no physical evidence of harm or violation of consent if it does occur, which can be harmful and invalidating for the birthing person. By learning and upholding the importance of consent and trauma-informed care, medical providers can allow women and birthing people to have autonomy in their care and positive birth experiences.

The following quote from doulas and birth workers influenced the creation of this standard and emphasizes the importance of teaching and upholding consensual and trauma-informed care:

- [In the United States] The maliciousness of the medical system ultimately did not harm a mother because of the support of a doula: "And so when I have families that have cesareans, we work very hard to work mentally with the family around and that's supporting them, because they've never heard of a VBAC [Vaginal Birth After Cesarean]. Usually they think that that child is nuts. Okay, so you can easily discourage a mom that has that as a goal. And then there are medical providers that are kind of quietly laughing at you like, oh yes, she's not getting her VBAC. I literally heard nurses at the nurses station say that"..."And I was walking up to get my charger from a birth previously at, you know, the week before, and I was going to the unit Secretary [to] say, 'Hey, did I leave my charger?' But as I'm walking up, I hear [the nurses] say, 'Oh yeah, room so and so is here with the doula, and she wants a VBAC, and she's- She laughs, says, yeah, she's not getting that VBAC.' And I'm walking up, and I say, 'why not? Why not?' And and turns beet red and does not answer. 'I'm her doula. I'm the doula that you were just speaking about. And I want to know, why not? You haven't even checked her. You haven't- you haven't even evaluated her at all. You have no idea how dilated she is. You have no idea where she is mentally. But you're saying she's not going to get it. Why not?' No one answers me. So eventually they never say anything. So I just walk on to the unit secretary and ask 'Where's my charger?' And she got her VBAC. I didn't- I never told her what happened too [until] like, a month or two later, and I never told her about the interaction until later, and at that point, I was determined. And I told her I was like, if you need to go back home because you haven't made enough progress, we're going home" (S.T., United States).

1.3 | De-centering the Medical Institutions Involvement in Birth

For midwifery models of care to become the standard for providing care, the structure of modern, allopathic medical systems must change. Both modern, allopathic medical systems and holistic-based medical and non-medical systems can exist simultaneously. However, birth is a business for many hospitals, and many births are rushed or labeled as failed because of money, space, or pressure from insurance companies. A perspective shift occurs in medical spaces, especially hospitals, when a birthing person does not have autonomy over their birth. Their perspective shifts from wanting something to happen to preventing something from happening. For example, a mother shifts from wanting to have a birth as naturally as possible to trying to have a birth without medical intervention as much as possible. Without changing modern, allopathic medical institutions' influence on birth, mothers and birthing people will continue to be harmed by institutional failure.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the importance of de-centering medical institutions from birth:

- One doula expands on the detrimental effect of labeling labor as a failure or pressuring birthing people to labor faster: "Her body was doing the best it can, but they make it seem like it's not enough in enough time. Hearing that created fear in her and really shifted things. She went from wanting to have a labor as natural as possible to having pitocin and an epidural. Those medications are there to help if it's extremely needed, not to use just to speed things along because it doesn't fit their needs" (Y.Z., United States).
- [In the United States] Birth as a business is exemplified by one doula: "But everyone's lying in the hospital. And so yeah, I've pushed that, yeah, the issues, yeah, sometimes they- you get ones that are great and they're beautiful, and it's usually if it's more of an urban area and the nurses are Black and the midwives are Black, they're like, Yeah, let's go with this. We're gonna be calm. We're gonna be chill. And sometimes you'll get a non-Black one that's great, that listens, that understands that all this stuff isn't great, and they're not looking at you like $1 sign, but nine times out of 10, it's all money. And so no matter what happens, no matter how much they smile and talk and you guys agree and [are] on the same page, it's really the push for the money, you know? And so, yeah, man, we're gonna be working with the hospital crews shit most of the time, unless they're all on board, and that's rare, right?" (H.I., United States).

2 | Acknowledging Histories of Dispossession

Global, national, and local institutions must acknowledge the histories of dispossession experienced by Black people and the nuanced impact on each Black community. These institutions must acknowledge these histories to improve Black maternal health and birth outcomes and better support their wellbeing. [The following standard can be shifted to acknowledge the histories of dispossession of any group of persons, regardless of their race, ethnicity, gender, sexuality, or religion.]

2.1 | The Importance of Acknowledging Black Communities Beyond the Maternal Death Narrative

Black people deserve to be heard, seen, and recognized not only for their survival through mass genocide, forced labor, generational harm, and occupation but for thriving, creating families, creating futures, and connecting with each other and ourselves despite these challenges. Western states and international organizations often forget to remember, recognize, and atone for the past and celebrate the existence and presence of Black communities and people across the world. These forgotten histories impact how maternal and perinatal health is researched and explained, often centering the maternal death narrative and stereotypes about Black communities. Through the recognition of colonialism, slavery, and racism and the centering of personal stories and perspectives, maternal death narratives can shift to maternal and perinatal healing narratives.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the importance of acknowledging Black communities beyond the maternal death narrative:

- [In Kenya] One doula shares their feedback with Leila about the term "maternal healing spaces" sharing:[18] "So I think in creating spaces that are healing, it also creates- it also still automatically reduces the mortality rate. So instead of just concentrating on mortality rate, let's make these spaces friendly and safe and helping the mothers just have this space where they feel like I am respected and I am I am- I- The people who are treating me, they have compassion and they understand, and I feel safe; then it automatically, yeah, solves the issue of mortality as well. Yeah" (J.K., Kenya).

2.2 | Racism is Embedded into Institutional Systems

Birth work has been colonized and shifted to fit modern, allopathic medical recommendations, allowing for the medicalization of birth. Moving away from traditional birth workers, specifically midwives, birth work has shifted to a regulated process often occurring within medical or hospital settings (Musie et al., 2022). The role of traditional birth workers slowly fades as modern, allopathic medicine takes over. [The history of traditional birth workers, gynecology and obstetrics, and institutional harm in relation to race can be further contextualized in this section.]

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize racism's role in institutional systems:

- [In the United States] One doula shared their discomfort with hospitals: " it took me a long time to be comfortable to work as a doula in a hospital because of the history of institutional racism, the history of where our- what has- what has happened to Black,

[18] At the time, the term was not expanded to 'maternal and perinatal healing spaces.'

Black people, and not just Black people, people of color, right? Like it's- like it's been- and so I feel like, you know me- it took me a while to be like, okay, comfortable with saying I work as a doula in a hospital as well" (M.N., United States).

- [In the United States] Another doula shared: "It's not always like this huge, giant production where they're like being overtly racist. It's like very subtle, very like, microaggressions that just kind of build up over time of like, you know, not asking your client for consent before touching them, in insisting that they need to do this intervention or their baby's going to die, telling them that, you know, like, oh, a healthy baby is what's most important. Yes, a healthy baby is important, but so is a healthy mom or birthing person. So is a not traumatized mom or birthing person. Those things are all equally important" (E.F., United States).

2.3 | Birth as an Ancestral and Generational Practice

Ancestral, communal, and generational knowledge is passed down through listening to and working with communities and their elders. Generational knowledge is often knowledge that is learned through community and family. Traditional birth workers often learn and train others through communal knowledge and apprenticeship (National Museum of African American History & Culture, n.d.). Furthermore, alongside generational knowledge, generational trauma is passed down within Black communities as a result of histories of dispossession. [The passing down of ancestral, communal, and generational knowledge and practice can be further contextualized in this section.]

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize birth as an ancestral and generational practice:

- [In the United States] "They took breastfeeding from us because we were wet fucking nurses for them, and that's why there's the scarring with us- in Black women not being able to breastfeed. That's centuries of our babies dying, you know, so that we could feed their babies. And so it's like, How dare a lot of them tell us that stuff like this isn't a problem, but it's also, how dare we be surprised still. I guess the jokes on us for thinking that the bones of this place would change; yeah, and it can't. How could something built on blood, sweat and racism and the hatred of us…How could that change?" (H.I., United States).
- One doula shares how ancestral and generational knowledge has impacted her: "as much as I may have knowledge and wisdom and experience doing these things, what I really stand on is like the shoulders of my grandma and my mother, right?" (G.H., United States).

3 | Increasing Awareness and Access to Holistic Care

Access to holistic care, typically provided by doulas and midwives, varies from country to country. By increasing awareness of and access to doulas and midwives, along with their

holistic practices, women and birthing people can be given more support throughout the perinatal process. [The following standard can be contextualized to specifically address access restrictions and regulations around birth work.]

3.1 | The Harm of Regulation for Birth Workers

Midwives have been regulated in different ways by many countries (International Confederation of Midwives, n.d.). In some countries, the regulation of midwives has changed how they function, typically in medical systems, preventing them from practicing certain methods under the midwifery model of care. Their regulation has made other birth workers weary of regulation, especially as it is often created and enforced by institutions and people not involved in birth work. For doulas, as non-medical professionals, there is a strong consensus against regulation because each of them can uniquely meet the needs of the women and birthing people they work with. However, birth workers acknowledge that regulation will continue to occur regardless. Therefore, regulation that is implemented must include birth workers and their critical perspectives in the process.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the harm in regulating birth workers without their perspectives:

- The following quote is an example of how de facto regulation through insurance in the United States negatively impacts women and birthing people: “I will say, with my private clients, I can go to their- their baby showers. I can, you know, I can go to their home. I can make dinner. I can, like, do things that you can't- I can't do hospital wise, like working for the hospital. I can't go to my client's dinners like I can't I can't go- like my client today, she has no support system. 21 years old, no support, but her boyfriend, he's a truck driver, and, you know, she was talking to me about how she lost a lot- she's very young, so she lost a lot of those friends where, you know, they're going out and they're doing all the things, and then now her support system has shifted, and so I find myself as a doula filling that gap of, you know, a person who doesn't have friends, who doesn't have family, and it was so hard today because I'm like, dang, like, I can't say, oh, let me come over and sit with you and let's watch a movie together. Let's learn, you know, like, those types of things. And so when we talk about regulation, I think that's one of the things, being the person who's kind of in the middle, I find it to be difficult, because one of the problems I have, in general with America is very- we have a very, you know, the way our system is, is very colonized”(M.N., United States).
- Another birth worker explains the challenges of being a midwife in allopathic medical systems that sometimes require physician or doctor oversight: “Why does she have to have, like, a go between? Why does she have to have this doctor when everywhere, it's just like she's a medical professional. This is her license. This is her reputation, and again, I don't know people's motivations for doing any of the things that they do, so I can't say that, Oh, everybody is teaching 100% practical and all of those things, but

having a backup doctor doesn't automatically save someone from something" (N.O., United States, Tanzania).

3.2 | Doulas and Birth Workers Do Not Need Official Titles

Similar to lay, traditional, and community midwives, doulas do not need official titles, training, or certification to be qualified to do their work. Learning through apprenticeship and community is integral to the generational practices passed down by Black birth workers across the globe. What is more important is "*Why is someone doing birth work?*" This is an important guiding question for birth workers, but especially for doulas, as anyone can hold the official title of doula. However, being a doula does not mean a person is equipped to support a mother or birthing person through contextualized, centered, and autonomous care.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the importance of "Why" someone is doing birth work:

- One birth worker shares their experience: "so I had already been a doula without [the] label doula. I had been sisterly support to my friends in [redacted location] at their home births for about four years, and in that capacity, we were just connected in the heart. I as a sister with my friend giving birth. So that's how we always saw birth support or sacred, midwifery, yeah" (Q.R., Australia, et al.).
- The same birth worker also shares: "This is deep, sacred work. What does that mean to you outside of your professional role? (Q.R., Australia, et al.).
- Another doula shares: "it really has to be passion work. It has to come from within. You just can't get [a] certificate and just say, Okay, I'm going to be a doula now. You really have to have some kind of connection with it, because you're not going to wake up at two and- two in the morning when a baby's coming. And if you're not really connected to the work" (T.U., United States, Jamaica, Ghana).

3.3 | The Importance of Expanding the Care Team

Doulas face access issues to medical spaces, particularly hospitals, as they are not designated as members of the care team, limiting their ability to provide holistic care. Women and birthing people must have access to doulas, as they provide consistent care through pre-existing trust and communication. Medical providers often cannot provide consistent care as they constantly shift and change, preventing connection, safety, and trust. More holistic care can be achieved with medical providers and doulas present as a team of care providers.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize why care teams need to be expanded to include doulas:

- "And they can get in the way of the goals that you have because they're taught that they are the end all be all, just being very honest like you know, you came to me so I can

make those decisions for you when it's not true. You don't even know me. This culture now you rotate physicians every time you go see an OB, you don't even see the same one anymore,"..."They say, 'Oh, well, whoever's on call, you will have met them at least once.' How does that make me comfortable?"..."How does that make me comfortable? And I'm supposed trust y'all when I've only met all of y'all barely one time, you know? Um, yeah, so that there's, that's an example. That's an example, right there" (S.T., United States).

4 | Creating Maternal and Perinatal Healing Spaces

Maternal and perinatal healing spaces are safe spaces where women and birthing people can find healing, autonomy, and support at any stage of the pregnancy process. They can be created with the support of birth workers, family members, or partners to center the woman or birthing person. Furthermore, maternal and perinatal healing spaces extend to include integral support systems such as access to safe housing, food security, and general wellbeing.

4.1 | Mitigating and Removing Fear from Birth

People are scared to give birth. Why and how fear shows up in birth changes depending on the context. However, fear in the actual birth process is not helpful and can lead to more stress and pain, then increasing risks and intervention use. Maternal and perinatal healing spaces can mitigate fear because they ensure that women and birthing people feel supported through access to community support, feel empowered in the decisions that they are making, and are centered throughout the entire pregnancy and postpartum process.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize why mitigating and removing fear from birth is important for women and birthing people:

- Another doula shares: "And so I think that we're going to start to see a decline in younger people having kids for that reason. They're scared. The pros don't weigh- don't outweigh the cons, right?" (T.U., United States, Jamaica, Ghana).
- "I think it's just the fear-mongering right there, because the doctor's like, your baby's small, it's not gonna make it, you're gonna die today. [unintelligible] everybody's panicking" (H.I., United States).

4.2 | Cultivating Safe Spaces by Centering Women and Birthing People

Creating spaces where mothers and birthing people feel respected and are being treated with compassion makes them feel safe. In turn, that creates healing spaces that will hopefully lower maternal mortality rates in tandem with increasing positive birth outcomes and experiences. Regardless of where or how someone gives birth, the most important message is that it not only is safe but feels safe and grants the mother or birthing person full

autonomy and centering. It can change the trajectory of how they see birth, view their body, and connect with their child. By centering their needs, they have the opportunity to have a fulfilling, safe, informed, autonomous, and healing birth experience.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the importance of cultivating safe spaces that center women and birthing people:

- One birth worker shares: “We could change it in a generation if we respected birth and women and these new souls coming to the world in gentle, harmonious, wise, conscious birth- way- birthing ways” (Q.R., Australia, et al.).
- Centering the mother and birthing person is a way of honoring, respecting, nurturing them as explained by one doula: “ and I'm centering her and the baby so that she can feel safe, so that she can feel heard, so she can feel honored, nurtured, respected, all of those things” (N.O., United States, Tanzania).

4.3 | Maternal and Perinatal Wellbeing Should be More than Survival

Birth is an innate process. So why are people surviving birth? Hospitals are survival spaces. They are specifically intended to be spaces that are always available in case a person is in need of care for “acute and complex conditions” (World Health Organization (d), n.d.). Hospitals are correlated to intervention, often prompting doulas to recommend birthing people to stay out of hospitals for as long as possible until they are in active labor (Reitsma et al., 2020). Birth is not a medical condition, but it is treated as such. Black women and birthing people, in particular, have to survive in hospital spaces. They deserve to have a safe birthing process where their pain is believed, and any complications immediately addressed. By creating maternal and perinatal healing spaces, women and birthing people’s concerns are addressed, and their autonomy is prioritized in hospitals.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the need for maternal and perinatal wellbeing to be more than survival:

- “Yeah, they're doing something right. And so even when you look at, oh, going to the hospital doesn't guarantee- it doesn't- it doesn't guarantee that everything's going to be perfect, or that there's not going to be any complications for- that the mom's life and or her baby's life is going to be saved every time” (N.O., United States, Tanzania).
- [In the United States] “I'm like, how do we live in a society that lets pregnant people be homeless, that lets children, that really lets anyone be homeless, right?” (D.E., United States).
- [In the United States] “Who's making it this way? Ask where the gentrification is- that? Ask why you're buying these people out of their homes? You know. Ask that- why you're making these people homeless and sleep in tents? You get me. Why is there no

housing? Why is there no homeless help and no more shelters? Why do we have vans for fentanyl needles and da ba de ba dah? Why should we all carry Narcan? Look at the priorities in this bitch" (H.I., United States).

5 | Contextualizing the Holistic Birth Work Global Standard in Collaboration with Community Birth Workers

The HBW-GS must be contextualized to specific countries, communities, or contexts to effectively support the expansion of holistic care for women and birthing people. By contextualizing the standard with birth workers, local, regional, and national policy on maternal and perinatal health can shift to better center women and birthing people.

5.1 | The Importance of Community-Engaged Research in Global Maternal and Perinatal Health

Community-engaged research allows community members to have a direct role in the development, execution, and evaluation of public health concerns and change (Vázquez, 2024). Community-engaged research can vary depending on the study, but regardless, it allows for essential relationship and trust building (University of California Riverside School of Medicine Center for Healthy Communities, n.d.). It is important to do this research in a community-driven way. Even doulas and birth workers cannot do their work without their communities. Oftentimes, there are disconnects between what the community members need versus what people think they need. Therefore, the WHO should engage with community members and people working directly from a supportive, holistic lens to ensure that birth is not just survivable, but also a positive and meaningful experience.

The following quotes from doulas and birth workers influenced the creation of this standard and exemplify the importance of community-engaged research with birth workers:

- [In Ghana] One doula shares: "even though all- there's so many different cultures and backgrounds and things like that, we all come from a place of like, you know, you have to show respect in order to get it, and there's a certain protocol that you need to follow in order to engage. So we're never going to go to a space and just go there to take or to be like we know better than you all. We go to, you know, engage ourselves in the customs and like, learn from the people who are there also, while sharing what we know and making sure that our curriculum is relevant to the struggles that they face as a community. Because we all have different struggles based on, you know, where we live or our backgrounds, our culture. So yeah, we always take the approach of, you know, meeting people where they're at and like learning and like tailoring what we do to suit them" (E.F., United States).

5.2 | Providing Context-Specific Support to Minority Communities

Global guidance and policy are more effective when co-created by the communities they support (University of California Riverside School of Medicine Center for Healthy Communities, n.d.; Han et al., 2021). Using community-engaged research to identify problems, recommendations, and preferred language, specific community needs can be centered in global guidance and policy. Furthermore, providing context-based education can address critical questions like: How do you work with women and birthing people in a trauma-informed way? and How do you work with women and birthing people who do not share the same identities as you? For example, racism presents itself differently to Black cis-gender parents versus Black transgender parents, and ensuring that support methods can cater to the needs of all parents is critical to ensuring quality care.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the need for context-specific support for minority communities:

- "I try to make sure that my language is inclusive, because, again, I never know and and sometimes people might not tell me because they're scared, and so I do ask, like my first thing is- intake is, how do you identify? How do you want me to identify you? And what pronouns do you use? And then- what you know, what can we talk- How can I best serve you in this space?" (M.N., United States).
- [In the United States] "But what I probably did say is that the healthcare system is racist. If you want me to take that back I'm not taking that back."..."Exactly. And I kid you not. He was like, 'Well, we're not racist. We have photos of Black families.' Oh, that's nice. Also, 'I mark all of my Black women high risk, just so we can take better care of them.'"..."'And why do you have to do that?' I said. You really think you're doing us a favor. He sat there, he said, 'Maybe I'm speaking from a place of privilege'. I said, 'You are,' then I let him continue to speak. But he's like 'I feel like whenever someone's high risk, we pay more attention.' I said, 'So why don't you just pay attention to everybody?' I said, 'Why do you have to put that stamp on us, and now we can hardly make decisions for ourselves, just for you guys to pay more attention to us?' He's like 'Well that- I hadn't think of it like that. That's not why I did it.' I said, 'You're putting the nail in the coffin for so many moms that go in that want to have a birth a certain way, and because that they're marked high risk, nobody [is] sitting down having a conversation. Because we rotate physicians, they don't get a chance to make any decisions. And then they're immediately set up for induction. They're immediately set up for a planned cesarean. They are advised that they shouldn't breastfeed.' I said, 'You're not helping us. You're making things worse, and you're further proving my point,'"..."he said, 'Well, maybe I should stop doing that.' I said, 'Yeah, yeah, maybe you should.' He's like, 'Well, can we have lunch and you talk to our staff?' I said, 'I'm not going to talk to your staff how to not be racist,'"..."'You have to create that culture.' I said, 'I can't, I can't help you with that.' Said, 'you have to pay me,' yeah,

and I still won't come. No, no, absolutely not. You want me to tell you how to treat people who don't look like you? You're a grown ass, man" (S.T., United States).

5.3 | Improving Context-Specific Education on Maternal and Perinatal Health

Context-specific education requires acknowledgment of historical harms and prioritizing healing from generational harm. It can also expand to ensure that medical terminology and information are more accessible, especially because having clinical knowledge can help women and birthing people maintain their autonomy in medical spaces. Furthermore, comprehensive sex education (or an equivalent) must be expanded and contextualized to specific communities, teaching people about their bodies, menstrual health, pregnancy, and holistic care from a young age. It is difficult for someone to learn about and advocate for their body while also going through pregnancy. Knowing what their body can do and needs can change how they ask for medical care.

The following quotes from doulas and birth workers influenced the creation of this standard and emphasize the need for context-specific education on maternal and perinatal health:

- Medical providers use education as a blockade to receiving care, which is explained one doula: "And you know, I- when I would decline something, people would get very upset and ask me what they- they would literally ask me, 'What makes you think we have the right to tell me no,' or instead of saying that, they would get very upset and they would just flat out ask, 'What's your educational background?' I got tired of being asked that, walking you off, asking me that. And they said, 'You know, a young, single lady your age usually only ask[s] these five questions whenever they have higher education.' And I'm like, 'Huh,' okay, got it, you know. And basically they also thought that my fiance is like a figment of my imagination, you know, or that [he] was maybe in prison" (S.T., United States).

Closing Statement

The HBW-GS should be changed, revised, and altered to center the specific communities that birth workers support. Each of the five standards is guided by the perspectives and feedback of birth workers interviewed by researcher Leila Chiddick. Although it highlights the importance of supporting Black communities from a global lens, the HBW-GS can be adapted to support the needs of any community, particularly marginalized communities.

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Conclusion

Creating maternal and perinatal healing spaces allows women and birthing people to find healing, autonomy, and support at any stage of the pregnancy process. Having a safe and fulfilling birth experience is something that mothers remember for the rest of their lives, impacting their postpartum experience and their children. By creating maternal and perinatal healing spaces, mothers and birthing people are provided safe spaces to have joy, possess autonomy, and have the ability to make decisions in their perinatal experience. Creating safety extends beyond physical safety and to feeling safe during all stages of pregnancy. Furthermore, ensuring that mothers and birthing people have a short-term (e.g., doulas) and long-term (e.g., friends, family, partners, community members) community to rely on throughout the perinatal

process, especially in postpartum, is essential to allowing them to feel supported through the pregnancy process.

For this work to be meaningful and to create change, uncomfortable and often hidden conversations and perspectives about Blackness, racism, and inequity must come to the surface and be acknowledged in order to create maternal and perinatal healing for Black communities. For Black communities, maternal and perinatal wellbeing and healing extends beyond general health, safety, and comfort; it extends to comprehensive sex education, menstrual health, mental and physical wellness, and meeting basic needs.

The holistic support and healing that mothers and birthing people deserve are long-term solutions that can continue to shift with community needs. The creation of the HBW-GS shares doula and birth worker feedback and insights to emphasize the need for more long-term holistic maternal and perinatal care on a global scale. Its broad nature, allowing it to be contextualized, will allow it to change to meet the needs of different communities across the globe. Furthermore, the HBW-GS hopefully encourages international organizations, like the World Health Organization, to engage in community-engaged research where doulas, midwives, and birth workers are positioned as experts in their own communities. This work is so important, and doing it ***alongside*** birth workers and their communities, rather than on their behalf, makes a difference.

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