

The Florida Maternal and Infant Health Crisis



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Acknowledgments

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Glossary of Key Terms and Abbreviations

ACA	Affordable Care Act
ACOG	American College of Obstetricians and Gynecologists
California’s Family PACT	California’s Family Planning, Access, Care, and Treatment
CAT	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CAT Committee	Committee Against Torture, monitoring implementation of CAT
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEDAW Committee	Committee on the Elimination of Discrimination against Women, monitoring implementation of CEDAW
CERD	Committee on the Elimination of Racial Discrimination, monitoring implementation of ICERD
CESCR	Committee on Economic, Social and Cultural Rights, monitoring implementation of ICESCR
CMS	Centers for Medicare and Medicaid Services
CRC	Convention on the Rights of the Child
DCF	Department of Children and Families
DOH	Department of Health
Doulas	Trained birth companions who provide continuous physical and emotional support during labor and help individuals meet psychological and socioeconomic needs pre- and post-partum
Expansion States	States that have opted into Medicaid Expansion under the ACA
Family PACT	Family Planning, Access, Care, and Treatment
Family Planning	The practice of controlling the number of children in a family and the intervals between births through practices such as artificial contraception.
FHJP	Florida Health Justice Project
FPL	Federal Poverty Level
FPOS	Family Planning Only Services
FSU	Florida State University
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
Human Rights Committee	Monitors implementation of ICCPR

ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
Midwives	Nurses trained to provide maternal and newborn care and assist during childbirth
NFPRHA	National Family Planning and Reproductive Health Association
Non-Expansion States	States that have not opted into Medicaid Expansion under the ACA
OB	Obstetrician
OECD	Organization of Economic Cooperation and Development
OHCHR	Office of the High Commissioner of Human Rights
Peripartum	Before, during, and immediately after giving birth
Post-Partum	Following childbirth
PPD	Postpartum Depression
Pre-Partum	Prior to childbirth
PTSD	Post-traumatic stress disorder
Reproductive Age	Ages 19-44 in the U.S.
Section 1115 Waivers	State-determined Medicaid eligibility for a limited scope of services or for a specific population.
SMM	Severe Maternal Morbidity
SOBRA	Sixth Omnibus Budget Reconciliation Act
STD	Sexually Transmitted Disease
UDHR	Universal Declaration of Human Rights
UN	United Nations
U.S.	United States
Waiver Program	Family Planning Waiver Program
WHO	World Health Organization
Wisconsin's FPOS	Wisconsin's Family Planning Only Services

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I. INTRODUCTION

Despite spending more than any other developed nation in the world on healthcare, the United States (U.S.) is battling a maternal and infant health crisis and has the highest rate of infant and maternal mortality¹ of any developed country.² Counter to international trends, pregnancy-related deaths have astonishingly increased from 7 deaths per 100,000 live births in 1987 to 17 deaths per 100,000 live births in 2016.³ The U.S. is the only developed country in the world where maternal mortality rates have increased from 1987 to 2016; in that time, doubling the rate of pregnancy-related deaths.⁴ Currently, the U.S. ranks 60th in the world in maternal mortality deaths, with its rate being eight times that of Iceland, the country with the lowest maternal mortality rate.⁵ Moreover, the crisis is worsening. American women⁶ are disproportionately afflicted with severe maternal morbidity (SMM), pregnancy complications that may result in maternal mortality if not caught and addressed.⁷ From 2006 to 2015, severe maternal morbidity (SMM) hospitalization rose by 45%.⁸

The U.S. likewise suffers from an infant health crisis. The current average U.S. infant mortality rate is two times the average of the other Organization of Economic Cooperation and Development (OECD) countries, ranking 33 out of the 38 OECD nations with even the top U.S. state ranking poorly among the other countries.⁹ For infants, or children younger than the age of one, the most common cause of death cited by the Centers for Disease Control and Prevention (CDC) are

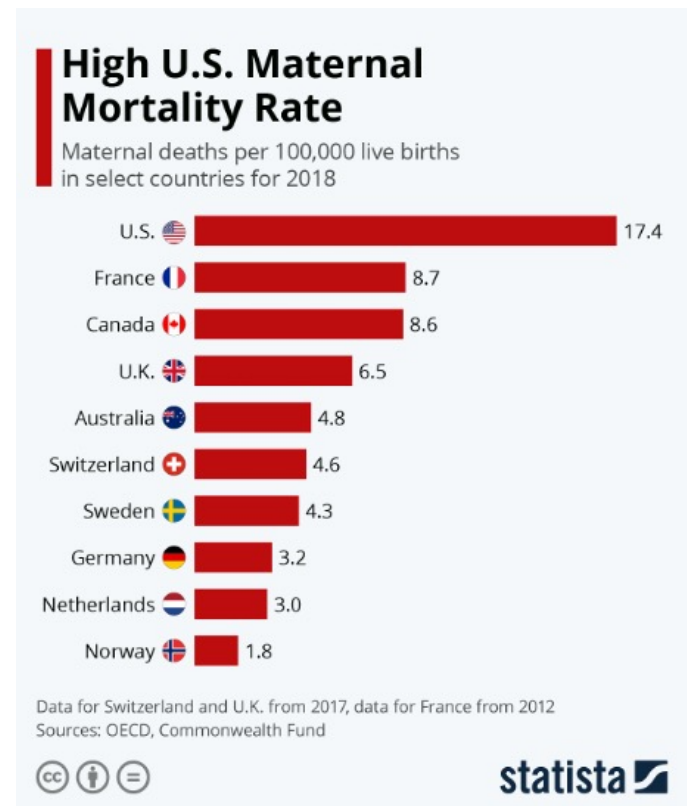


Photo Courtesy of Statista

¹ The mortality rates are determined by the number of deaths divided by the number of live births multiplied by 1,000, serving as a measure of infant and maternal death risk and is used to indicate infant and population health. See http://www.floridahealth.gov/diseases-and-conditions/infant-mortality-and-adverse-birth-outcomes/data/_documents/racial-disparities-infant-mortality-rates-2007-2018.pdf.

² Jessica Brown, *The Fight for Birth: The Economic Competition That Determines Birth Options in the United States*, 52 U.S.F. L. REV. 1, 1 (2018).

³ Center for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*. <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>.

⁴ National Partnership for Women & Families (NPWF), *Improving Our Maternity Care Now: Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies*, 1, 14 (2020).

⁵ Brown, *supra* note 2, at 6.

⁶ **It is important to note that while we refer to childbearing individuals as women in this document, we recognize that childbearing individuals are generally, but not always women. The analysis here also applies to other childbearing individuals.**

⁷ Taylor Platt and Neva Kaye, National Academy for State Health Policy (NASHP), *Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid*, 1, 1 (2020).

⁸ NPWF, *supra* note 4, at 14.

⁹ United Health Foundation, *America's Health Rankings, 2022 Annual Report: Featuring COVID-era data and insights*, 25 (2022).

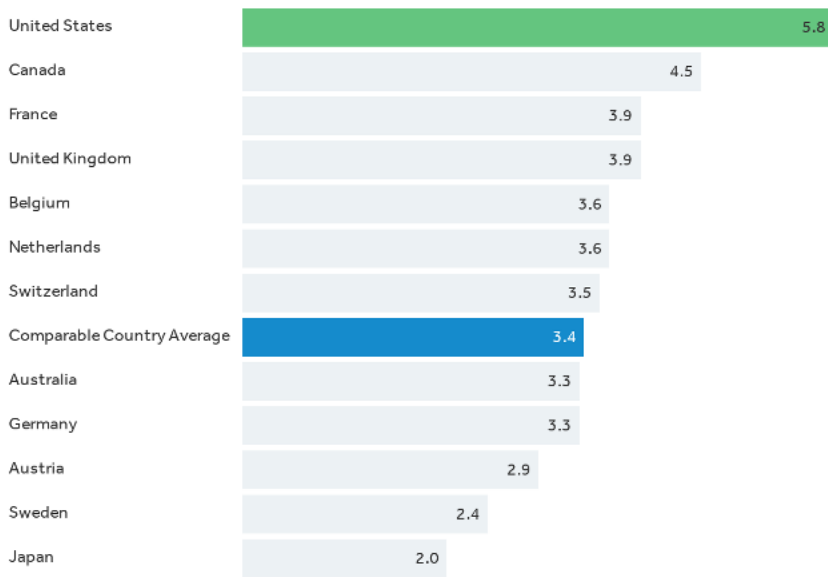
birth defects, preterm birth and low birth weight, maternal pregnancy complications, sudden infant death syndrome, and injuries.¹⁰ In 2018, more than 21,000 infants died from one of these five causes.¹¹

The maternal and infant health crisis in Florida is similarly dire. From 2013 to 2017, Florida ranked 32nd in the U.S. in terms of highest maternal mortality rates.¹² From 2015 to 2018, more than one in every ten new mothers were uninsured, with over half being Latina women, and about two-thirds living in America’s South.¹³ In 2019, Florida had an infant mortality rate of 6.01 for every 1,000 live births, ranking 30th in the U.S.¹⁴ Comparatively, New Hampshire¹⁵ has a rate of 3.7, ranking as the second-lowest rate in the country, whereas Mississippi has a rate of 9.07, making it the highest state in the

country.¹⁶ As of 2018, the top five leading causes of infant death in Florida were congenital malformations, deformations, and chromosomal abnormalities; other undistinguished cause of death; disorders pertaining to short gestation and low birth weight; unintentional injuries; and maternal complications from pregnancy.¹⁷

Moreover, the maternal and infant health crisis disproportionately impacts marginalized populations in the U.S., such as Black, Native American, and other communities of color; rural communities; and low-income individuals.¹⁸ According to the CDC, Black women are about four times more likely to die from pregnancy-related issues than white women,¹⁹ and Native American women are

Infant mortality per 1,000 live births, 2017



Note: 2016 data shown for Japan

Source: KFF analysis of OECD data • Get the data • PNG

Peterson Kaiser
Health System Tracker

Photo Courtesy of Health System Tracker

¹⁰ Center for Disease Control and Prevention, *Reproductive Health, Infant Mortality* (June 22, 2022), available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>.

¹¹ Esther Jean-Baptiste, *Racial Disparities in Infant Mortality Rates for Florida Compared to All Other States Combined 2007-2018*, Florida Health, Bureau of Family Health Services, Jan. 28, 2020.

¹² America’s Health Rankings, *Health of Women and Children, Florida*, United Health Foundation, (2021).

¹³ Stacey McMorro, et al. *Uninsured New Mothers’ Health and Health Care Challenges highlight the Benefits of Increasing Postpartum Medicaid Coverage*, 10, Urban Institute Health Policy Center (May 2020).

¹⁴ Center for Disease Control and Prevention, *Infant Mortality Rates by State* (Mar. 12, 2021), available at https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

¹⁵ Center for Disease Control and Prevention, *Infant Mortality Rates by State* (Mar. 12, 2021), available at https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm. Please note that New Hampshire ranks No. 2, only to fall behind Vermont (No. 1) with a calculation of 15 deaths, which the CDC has determined as an unreliable statistic.

¹⁶ Center for Disease Control and Prevention, *Infant Mortality Rates by State* (Mar. 12, 2021), available at https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

¹⁷ Esther Jean-Baptiste, Florida Health, Bureau of Family Health Services, *Racial Disparities in Infant Mortality Rates for Florida Compared to All Other States Combined 2007-2018* (Jan. 28, 2020).

¹⁸ NPWF, *supra* note 4, at 14-16.

¹⁹ Centers for Disease Control and Prevention, *Reproductive Health, Pregnancy-Related Deaths* (Feb. 26, 2019), available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm>.

more than twice as likely to die due to pregnancy related issues in comparison to white women.²⁰ Black women are further more than twice as likely to experience SMM than white women at the time of delivery.²¹ Rural residents have a 9% greater risk of mortality and SMM compared to urban residents²² due to the fact that more than a third of U.S. counties are “maternity care deserts” without a hospital maternity unit, obstetrician-gynecologists or certified nurse-midwife.²³

Maternal Mortality Rates in the United States per 100,000

New data from the Centers for Disease Control and Prevention shows a spike in maternal mortality between 2020 and 2021. The increase was largest for Black women.

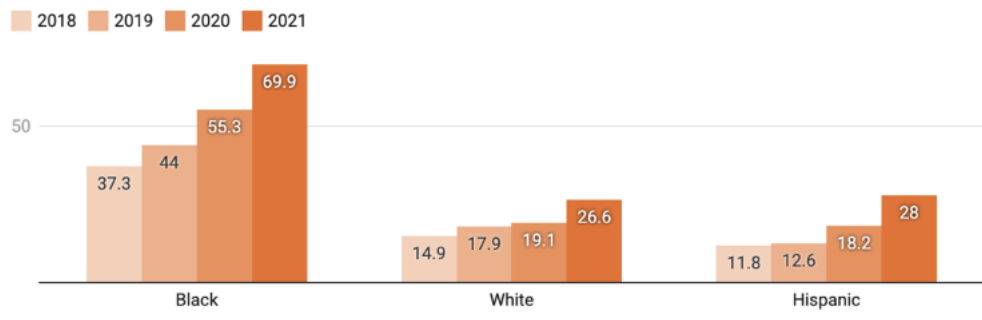


Chart courtesy of Margo Snipe; Data from Center for Disease

These trends are similar in Florida. In 2016, 41% of Floridians who died of pregnancy-related complications were Black, despite making up just 16% of the state’s population.²⁴ Moreover, Black Floridian mothers were three times more likely to die from pregnancy-related complications and two times more likely to experience infant mortality compared to their white counterparts.²⁵ Risk factors such as poverty, lack of education, and preexisting health conditions do not fully explain the discrepancies, and these populations, particularly Black women, face unique risks for poor maternal health outcomes, including institutional and individual bias.²⁶ Furthermore, in 2018, black infants had a 2.4 times greater risk of incurring infant mortality compared to their white counterparts.²⁷

Additionally, women frequently experience abuse and coercion during their child birthing experience.²⁸ While most families’ birthing experience results in a physically healthy mother and baby, many women report low satisfaction with giving birth in American hospitals.²⁹ As obstetrician and researcher Neel Shah writes, “In our intense focus on mortality rates, we often overlook the obvious fact that childbearing women have goals other than emerging from birth alive and unscathed.”³⁰ Additionally, 28% of women

²⁰ Kiley Warren, *Native American Women Tackle High Rate of Maternal Mortality* (Dec. 17, 2019), available at <https://www.usnews.com/news/best-states/new-mexico/articles/2019-12-17/native-american-women-tackle-high-rate-of-maternal-mortality>.

²¹ Gianna Melillo, American Journal of Managed Care, *Racial Disparities Persist in Maternal Morbidity, Mortality, and Infant Health* (2020), available at <https://www.ajmc.com/view/racial-disparities-persist-in-maternal-morbidity-mortality-and-infant-health>.

²² NPWF, *supra* note 4, at 14.

²³ NPWF, *supra* note 4, at 16. This causes rural childbearing individuals to drive more than a half-hour to the nearest hospital for maternity services.

²⁴ Leticia Hernandez and Angela Thompson, Florida Department of Health, *Issue brief: Florida’s Pregnancy-Associated Mortality Review 2016 Update* (May 2018), available at http://www.floridahealth.gov/statistics-and-data/PAMR/_documents/pamr-2016-update.pdf; United States Census Bureau, *U.S. Census Bureau QuickFacts: Florida* (2022), available at <https://www.census.gov/quickfacts/fact/table/FL/RH1225219>.

²⁵ Florida Department of Health, *Maternal & Child Health, FLHealthCHARTS Data Viewer* (2023), available at <https://www.flhealthcharts.gov/charts/MaternalAndChildHealth/default.aspx>.

²⁶ Cristina Novoa and Jamila Taylor, Center for American Progress, *Exploring African Americans’ High Maternal and Infant Death Rates*, 6 (2018).

²⁷ Esther Jean-Baptiste, *Racial Disparities in Infant Mortality Rates for Florida Compared to All Other States Combined 2007-2018*, Florida Health, Bureau of Family Health Services, Jan. 28, 2020.

²⁸ Elizabeth Kukura, *Obstetric Violence*, *The Georgetown Law Journal* 106(3) 721, 724 (2018).

²⁹ Kukura, *supra* note 28, at 721, 724.

³⁰ Shah, Neil, *The Conversation, Both the US and India fall short on care of women during childbirth* (2017).

birthing in hospitals experienced mistreatment.³¹ Up to 34% of women describe their birthing experience as “traumatic,”³² and women frequently speak of the violations of their dignity.³³ Nearly 20% of women report postpartum post-traumatic stress disorder (PTSD) symptoms.³⁴ The abuse, coercion, and disrespect women face while giving birth is coined “obstetric violence” by Latin American advocates.³⁵ Marginalized populations are more likely to incur obstetric violence in addition to an increased risk of maternal and infant mortality.³⁶ One study found that disrespect and abuse were nearly four times more likely among women with low socioeconomic status.³⁷ Both the healthcare disparities and obstetric violence trends are exacerbated by intersecting discrimination based upon multiple aspects of identity (e.g., disability or sexual orientation).³⁸

However, Florida can turn the maternal and infant crisis around. According to the CDC, over 80% of pregnancy-related deaths are preventable.³⁹ Part I of this memo focuses on three approaches Florida should take to address the current maternal and infant health crisis and improve access to critical healthcare services. The first approach is to opt into the expansion of Medicaid under the Affordable Care Act to provide access to healthcare prepartum, intrapartum, and postpartum. The second approach presents ways to strengthen the Medicaid Family Planning Waiver Program, which provides access to family planning services to underserved families. The third approach seeks to increase access to midwives—nurses who provide maternal care—and doulas—providers of continuous, non-clinical support during labor, enabling holistic maternal care that meets patients’ individual physical, emotional, and social needs. Collectively, these approaches can revolutionize maternal and infant health outcomes. Part II then provides an analysis of international human rights standards and interpretations relevant to maternal care, and part III provides recommendations for specific steps the state of Florida should take to move forward with each of the approaches.

³¹ Saraswathi Vedam et al., *The Giving Voice to Mother Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 *REPROD. HEALTH*, 1, 8 (2019).

³² Debra Creedy, Ian Shochet, and Jan Horsfall, *Childbirth and the Development of Acute Trauma Symptoms: Incidence and Contributing Factors*, *Birth* 27(2), 104-111 (2000).

³³ Kukura, *supra* note 28, at 754.

³⁴ Johanna Soet and Gregory Brack, Colleen Dilorio. *Prevalence and Predictors of Women’s Experience of Psychological Trauma During Childbirth*, *Birth*, 30(1): 36-46 (2003).

³⁵ Kukura, *supra* note 28, at 724.

³⁶ Hum. Rts. Council, Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. ¶ 43, U.N. Doc. A/HRC/74/50 (2019).

³⁷ *Id.*

³⁸ Hum. Rts. Council, Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. ¶ 45, U.N. Doc. A/HRC/74/50 (2019).

³⁹ Center for Disease Control and Prevention, *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019* (2022).

II. GAPS IN FLORIDA LAW AND POLICY

A. Expanding Medicaid Can Address the Maternal and Infant Health Crisis

Medicaid plays a key role in maternal and infant health, financing more than two out of every five births in the U.S., and half of all births in Florida.⁴⁰ However, Florida has opted out of Medicaid expansion, denying coverage to many women. This lack of coverage has had dire consequences for both maternal and infant health, all too often resulting in mortality. According to the World Health Organization (WHO), a majority of maternal deaths are preventable through effective and timely management during all stages of pregnancy.⁴¹ Further, the American College of Obstetricians and Gynecologists (ACOG) recommends women have access to continuous healthcare in order to increase preventive care and reduce maternal mortality rates.⁴² In fact, both maternal and infant mortality rates have declined for states that have opted into Medicaid expansion.⁴³ As a result of Florida's health policy, women and infants in Florida, especially from marginalized groups, are experiencing higher rates of maternal and infant mortality.⁴⁴ The failure to expand Medicaid has further exacerbated racial disparities and has had negative economic impacts.

The Affordable Care Act (ACA) provides for Medicaid expansion that would enable increased healthcare coverage. The ACA was introduced with the aim of increasing access to affordable health insurance for individuals without insurance and to make health insurance affordable for individuals already insured.⁴⁵ The ACA thus expanded the Medicaid program to extend eligibility for uninsured adults between the ages of 19-64, with incomes up to 138% of the Federal Poverty Level (FPL).⁴⁶ Medicaid access covers a large portion of maternal healthcare including specific services related to pregnancy, infant health such as pediatric care, chronic disease management, breastfeeding, contraception, mental health and substance use disorder screening, and other maternal related health.⁴⁷ However, in *National Federation of Independent Business v. Sebelius*, the Supreme Court effectively left the decision of Medicaid expansion to the states, making it optional.⁴⁸ Subsequently, most states in the U.S. decided to enact the ACA expansion of Medicaid.

Florida has opted not to take advantage of the ACA's provision for expanded Medicaid, leading

⁴⁰ Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to Congress on Medicaid and CHIP, Chapter 5: Medicaid's Role in Maternal Health* (June 2020), available at <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf>; see also Florida Department of Health, Bureau of Vital Statistics, *Births Covered by Medicaid*, available at <https://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=595>.

⁴¹ World Health Organization, *Maternal Health* (2023), available at https://www.who.int/health-topics/maternal-health#tab=tab_1.

⁴² Adam Searing and Donna Cohen Ross, Georgetown University Health Policy Institute Center for Children and Families, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*, 8 (May 2019).

⁴³ Chintan B Bhatt and Consuelo M Beck-Sagué, *Medicaid Expansion and Infant Mortality in the United States*, *American journal of public health* 108 (4), 565-567 (Apr. 2018); see also Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, *Women's Health Issues* 30, 3 (Feb. 25, 2020).

⁴⁴ Robin Bravender, Florida Phoenix, *'It's not fine.' Black mothers and babies are dying in Florida* (Jan. 30, 2020), available at <https://floridaphoenix.com/2020/01/30/its-not-fine-black-mothers-and-babies-are-dying-in-florida/>.

⁴⁵ Congressional Research Service, *Overview of the ACA Medicaid Expansion*, Version 9, (June 9, 2021).

⁴⁶ Kaiser Family Foundation, *Who Could Get Covered Under Medicaid Expansion? State Fact Sheets* (Feb. 10, 2021), available at <https://www.kff.org/medicaid/fact-sheet/uninsured-adults-in-states-that-did-not-expand-who-would-become-eligible-for-medicaid-under-expansion/>.

⁴⁷ Searing and Ross, *supra* note 42, at 8.

⁴⁸ *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

to gaps in healthcare coverage. Florida remains 1 of 12 states that has opted out of expanding Medicaid for its constituents and sets rigorous eligibility standards for Medicaid.⁴⁹ Florida's eligibility standards require adults to have: (1) a dependent child; and (2) an income less than a third of the poverty level – estimating \$7,000 in a family of three.⁵⁰ However, single adults do not qualify for Medicaid, regardless of the income they earn.⁵¹ As of April 2020, Medicaid eligibility standards for children and women who are pregnant require: (1) children up to the age of 1: 206% of the federal poverty level (FPL); (2) children between ages 1-5: 140% of the FPL; (3) children between ages 6-18: 133% of the FPL; (4) pregnant women: 191% of the FPL; or (5) adults with dependent children: 27% of the FPL.⁵² Uninsured individuals who are ineligible for Medicaid are also ineligible for tax subsidies to assist them with access to private health insurance because individuals with incomes between 100% and 138% of the FPL fall into the coverage gap which would place them within Medicaid eligibility if Florida were to opt into expansion.⁵³

While a majority of Floridians rely on their workplace for health insurance,⁵⁴ this leaves many uninsured. In 2019, 13% of Florida's population remained uninsured.⁵⁵ During the COVID-19 pandemic, over 5.4 million Floridians lost their jobs, also losing their access to insurance.⁵⁶ Between February and May of 2020, the uninsured non-elderly population increased to 25%.⁵⁷ Currently, about 400,000 adults in Florida, who would become eligible for Medicaid under expansion, remain in the coverage gap.⁵⁸ The decision not to expand Medicaid has left Florida with the second highest national rate of uninsured individuals who would be eligible for Medicaid with expansion, right behind Texas.⁵⁹

The coverage gap is significant for families and pregnant women. In Florida, the coverage gap consists of 66% of families with at least one individual employed, 25% of parents with children at home, and 31% of women of reproductive age.⁶⁰ In 2021, 1 in 6 women between the ages of 15- and 44 in Florida, were uninsured.⁶¹ In 2020 an estimated 28,000 children would have gained coverage in Florida if Medicaid expansion was adopted.⁶²

⁴⁹ Kaiser Family Foundation (KFF), *Status of State Medicaid Expansion Decisions: Interactive Map* (Nov. 19, 2021), available at <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁵⁰ Florida Voices for Health, *Urge Congress to Close the Coverage Gap*, available at <https://www.healthyfla.org/closethegap>.

⁵¹ *Id.*

⁵² Louise Norris, *Florida and the ACA's Medicaid Expansion* (Sep. 8, 2020), available at <https://www.healthinsurance.org/medicaid/florida/>.

⁵³ *Id.*

⁵⁴ US Census Bureau and Kaiser Family Foundation, *Health insurance status distribution of the total population of Florida in 2020* (Nov. 2021).

⁵⁵ *Id.*

⁵⁶ Stan Dorn, *The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History* (Jul. 13, 2020), available at <https://familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/>.

⁵⁷ *Id.*

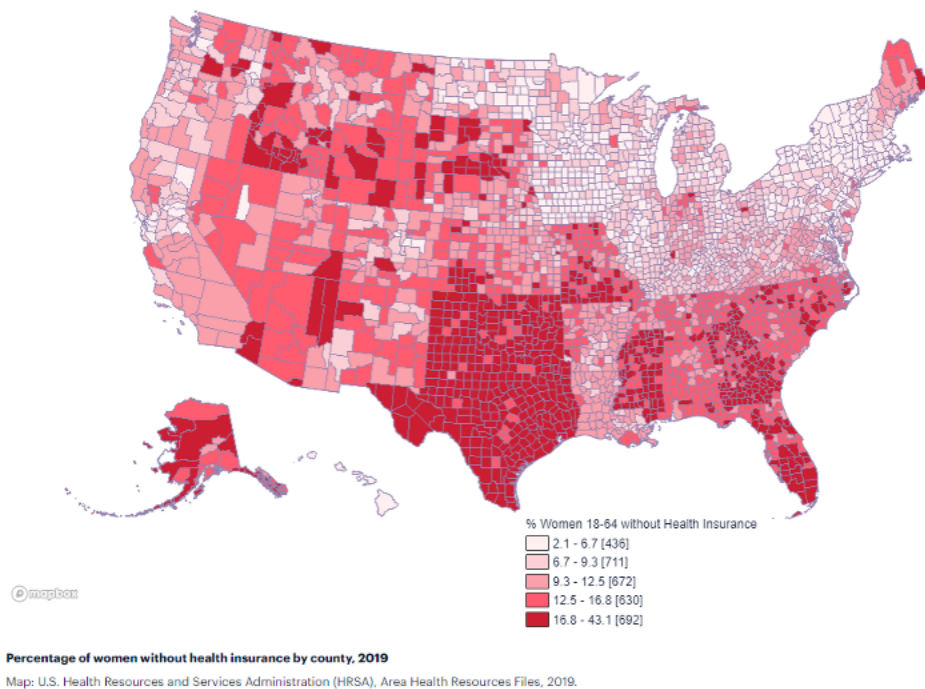
⁵⁸ Center on Budget and Policy Priorities, *The Medicaid Coverage Gap in Florida* (Jul. 8, 2021), available at <https://www.cbpp.org/research/health/the-medicaid-coverage-gap>.

⁵⁹ Louise Norris, *Florida and the ACA's Medicaid Expansion* (Dec. 8, 2021), available at <https://www.healthinsurance.org/medicaid/florida/>.

⁶⁰ Center on Budget and Policy Priorities, *The Medicaid Coverage Gap in Florida* (Jul. 8, 2021), available at <https://www.cbpp.org/research/health/the-medicaid-coverage-gap>.

⁶¹ March of Dimes, *A Profile of Prematurity in Florida* (2022), available at <https://www.marchofdimes.org/peristats/assets/s3/reports/prematurity/PrematurityProfile-Florida.pdf>.

⁶² Center on Budget and Policy Priorities, *The Medicaid Coverage Gap in Florida* (Jul. 8, 2021), available at <https://www.cbpp.org/research/health/the-medicaid-coverage-gap>.



[Photo](#) Courtesy of Salud America

Moreover, lack of coverage is particularly severe for women of color. In Florida 58% of people of color make up the coverage gaps.⁶³ As of April 2019, over 20% of Black women were uninsured in Florida.⁶⁴ The lack of access to healthcare correlates with greater maternal and infant mortality.⁶⁵ In 2018, Florida experienced 36 pregnancy-related deaths, with 48.6% of these deaths among non-Hispanic Black women.⁶⁶ The rate for infant deaths was twice as high for Black infants.⁶⁷ Not only would closing the coverage gap save lives, but it is one of the most effective ways to reduce racial disparities in coverage and health outcomes.⁶⁸

Women who are pregnant have the ability to obtain coverage through Medicaid’s eligibility requirements and remain covered from 60 days to 12 months postpartum. While Florida has recently with bipartisan support taken the positive step of enacting SB 2518, extending postpartum coverage to 12 months,⁶⁹ this does not resolve the maternal and infant health crisis. Preventive care and continuous coverage are needed to address preconception health risk factors which contribute to maternal mortality, such as obesity, diabetes, and heart disease, as well as improve the timeliness of prenatal care.⁷⁰ Uninsured women have a higher prevalence of

⁶³ *Id.*

⁶⁴ National Partnership for Women & Families, *Black Women Experience Pervasive Disparities in Access to Health Insurance* (Apr. 2019), available at <https://www.nationalpartnership.org/our-work/resources/health-care/black-womens-health-insurance-coverage.pdf>.

⁶⁵ *Id.*

⁶⁶ Hernandez and Thompson, *supra* note 24.

⁶⁷ *Id.*

⁶⁸ Center on Budget and Policy Priorities, *The Medicaid Coverage Gap in Florida* (Jul. 8, 2021), available at <https://www.cbpp.org/research/health/the-medicaid-coverage-gap>.

⁶⁹ Issac Morgan, Florida Phoenix, *FL moms have gotten expanded Medicaid coverage following childbirth, but not many people knew it* (Sep. 29, 2021), available at <https://floridaphoenix.com/2021/09/29/fl-moms-have-gotten-expanded-medicaid-coverage-following-childbirth-but-not-many-people-knew-it/>; Renzo Downey, *Gov. DeSantis approves Medicaid extension for new moms*, Florida Politics.com (June 3, 2021).

⁷⁰ Eliason, *supra* note 43; Simply Healthcare Plans and Clear Health Alliance, *Medicaid postpartum coverage extension, postpartum optimization, and promoting birth equity* (June 2021), available at https://provider.simplyhealthcareplans.com/docs/gpp/FL_SMH_CHA_PU_HealthCareBillcomeseffect.pdf/.

preconception health risk factors, as well as a lower prevalence of health-promoting indicators.⁷¹ This means uninsured, pregnant women are more likely to have pregnancy risk factors and, thus, higher rates of maternal morbidity and mortality.⁷² Fluctuations in access to healthcare can disrupt and exacerbate existing health conditions, negatively impacting health outcomes and ultimately increasing the cost of care.⁷³ Moreover, pregnancy does not guarantee automatic enrollment in Medicaid. When women who fall within the coverage gap do become pregnant, the process of applying for and enrolling in Medicaid may delay care, though timely access to prenatal care is essential to good pregnancy outcomes.⁷⁴

Access to peripartum care is vital in addressing the maternal and infant health crisis, and the expansion of Medicaid is a key factor in increasing access to healthcare. In fact, if Florida were to opt into Medicaid expansion, research from the Georgetown University Health Policy Institute Center for Children and Families estimates more than half of pregnancy-related deaths for women would be preventable.⁷⁵ Additionally, according to the Center for American Progress, if non-expansion states would opt into Medicaid expansion, they would avert 141 infant deaths per year.⁷⁶

Studies consistently show that ACA Medicaid expansion has resulted in improved preconception coverage for women who are pregnant, as well as a significant reduction in the infant mortality rate.⁷⁷ While maternal mortality rates continue to rise in the U.S., there is a clear divergence in trends between expansion states and non-expansion states, with maternal mortality rates rising less in expansion states than in non-expansion states.⁷⁸ In expansion states, the rate of uninsured new mothers fell by 56%.⁷⁹ In 2016, rates of uninsured women in non-expansion states versus expansion states was more than double, with 17.9% compared to about 7%.⁸⁰ A study of collective data from 1999 to 2016 found that in expansion states, Medicaid's supplementary assistance reflected 1.6 fewer maternal deaths per 100,000 women.⁸¹ The expansion of Medicaid has led to improved prenatal nutrition and prenatal care because women are obtaining better healthcare prior to pregnancy.⁸² Further, fluctuation in access to healthcare can disrupt and exacerbate existing health conditions, making them more expensive to later address.⁸³ Expansion states have also enjoyed overall improved health outcomes, which may further benefit maternal health, including reductions in low-income adults screening positive for depression, and fewer premature deaths among older adults, improved control of diabetes and hypertension.⁸⁴

⁷¹ Eliason, *supra* note 43.

⁷² MACPAC, *supra* note 40.

⁷³ Searing and Ross, *supra* note 42, at 8.

⁷⁴ Judith Solomon, Center on Budget and Policy Priorities, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), available at <https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health>.

⁷⁵ Searing and Ross, *supra* note 42, at 8.

⁷⁶ Jamila Taylor, et al., Center for American Progress, *Eliminating Racial Disparities in Maternal and Infant Mortality A Comprehensive Policy Blueprint* (May 2, 2019), available at <https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/>.

⁷⁷ Eliason, *supra* note 43.

⁷⁸ *Id.*

⁷⁹ Taylor, *supra* note 76.

⁸⁰ *Id.*

⁸¹ Searing and Ross, *supra* note 42, at 7.

⁸² *Id.*

⁸³ *Id.* at 7-8.

⁸⁴ Center on Budget and Policy Priorities, *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion* (Oct. 21, 2020), available at <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion>.

Failure to expand Medicaid further increases the risk of hospital closure, which would further undermine maternal and infant health. States that have not opted into Medicaid expansion have seen higher rates of rural hospital closures.⁸⁵ Whereas in expansion states, the likelihood of hospital closures considerably declined and also significantly declined in rural areas.⁸⁶ Hospital closures increase barriers to care and result in additional travel time for needed services, negatively impacting maternal and infant health, and at times, places lives in peril.⁸⁷ Low-income women and women of color are particularly disadvantaged.⁸⁸

Medicaid can further play a key role in addressing racial disparities in maternal and infant health. As discussed above, maternal and infant mortality in Florida disproportionately impacts women and children of color. Studies reveal that states that have adopted the expansion of Medicaid expansion saw a greater decline in infant mortality rates, especially among Black infants.⁸⁹ Thus, Medicaid expansion would address structural racism inherent in current uneven access to care, undermining maternal and infant health.⁹⁰

Moreover, Medicaid expansion is important for the mental health of women. Access to

healthcare coverage is vital in all stages of a woman's pregnancy and can help in detecting Postpartum Depression (PPD). PPD is a common condition that is undertreated, underdiagnosed, and can interfere with a woman's ability to function, as well as negatively impact the mother-child relationship.⁹¹ After pregnancy, women often experience a phenomenon known as the "baby blues," which subsides around two weeks post pregnancy without treatment.⁹² However, PPD lingers and causes women to have intense feelings of anxiety, sadness, and despair.⁹³ These feelings do not necessarily surface immediately after pregnancy and can occur within the first year of giving birth.⁹⁴ Thus, it becomes difficult for women to disclose or recognize their symptoms.⁹⁵

The burden of PPD is carried mainly by women of color, and low-income women, who do not receive the adequate services and support for early recognition and treatment.⁹⁶ The Florida Department of Health last reported in 2010 that 58% of new mothers suffered from PPD.⁹⁷ This report also revealed that PPD was higher among Black mothers and mothers with annual incomes of less than \$15,000.⁹⁸

Continuous access to healthcare is critical for addressing PPD. When women have continuous access to healthcare after their pregnancy, they

⁸⁵ Taylor, *supra* note 76.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ L.J. Sherman, M.M. Ali, Diagnosis of Postpartum Depression and Timing and Types of Treatment Received Differ for Women with Private and Medicaid Coverage, *Women's Health Issues* 28:6 524, 524 (2018).

⁹² *Id.* at 525.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.* at 524.

⁹⁷ Florida Department of Health Division of Disease Control and Health Protection, Chronic Disease Epidemiology Surveillance and Evaluation, Pregnancy Risk Assessment Monitoring Systems, *Postpartum Depression* (2010), available at http://www.floridahealth.gov/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/_documents/reports/depression2010.pdf.

⁹⁸ *Id.*

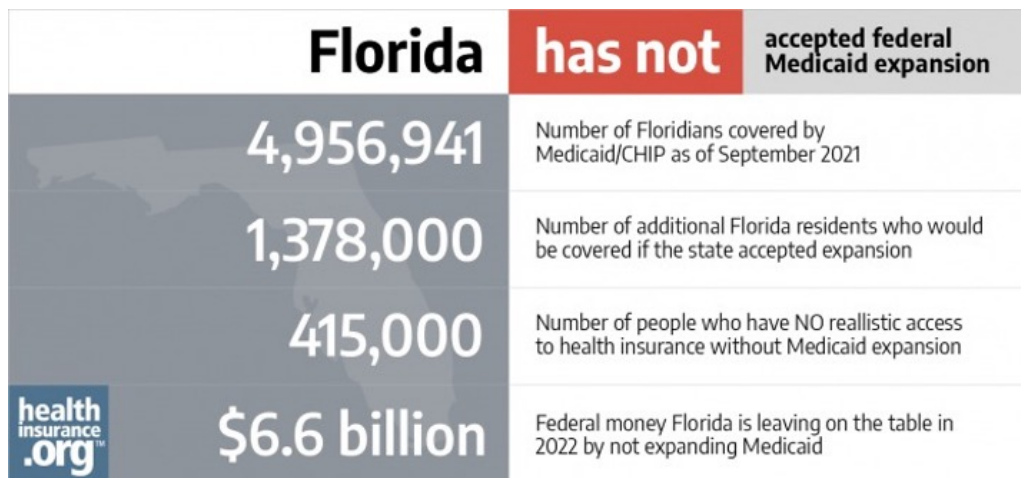


Photo Courtesy of HealthInsurance.org

have access to screenings for their postpartum visits, which prevents undertreatment of this mental health experience.⁹⁹ Undertreatment of PPD is often caused by the transition period from a woman switching from the OBGYN to her primary care provider, causing a disconnect between the patient relationship.¹⁰⁰ The frequency of visits a new mother has with her healthcare provider decreases substantially compared to her visits during her pregnancy, which creates a gap in receiving necessary follow-up care.¹⁰¹ This requires a change in treatment from healthcare providers to following depression screening guidelines laid out by ACOG.¹⁰² With continuous access to healthcare, women would be encouraged to keep their postpartum appointments. Florida has notably extended Medicaid coverage to a year postpartum, providing new mothers the ability to attend their postpartum checkups, allowing their care providers to screen for depression as an early intervention method.

Additionally, Medicaid expansion would have important economic benefits. Along with the rest of the country, Florida is in need of fiscal recovery from the consequences of the COVID-19 pandemic as Floridians are struggling from unemployment, while the state struggles from a significant budget deficit of about \$2 billion, as of March 2021.¹⁰³ By expanding Medicaid, the federal government covers 61% of the state Medicaid budget, which Florida taxpayers already pay for but do not currently reap the benefit from.¹⁰⁴ As a result of Florida's decision to not expand Medicaid, since 2014, Florida has lost out on \$66.1 billion in Medicaid funding, more than any other state.¹⁰⁵ In the state of Montana, for example, Medicaid expansion led to an addition \$600 million to the state's economy, each year since expansion.¹⁰⁶ Moreover, opting into Medicaid expansion would create an estimated 135,000 jobs in Florida, a majority of which would be in healthcare, but other sectors such as construction, insurance, retail, and

⁹⁹ Usha Ranji, et. al., *Expanding Postpartum Medicaid Coverage Issue Brief*, FirstFocus (May 2019), available at <https://firstfocus.org/wp-content/uploads/2019/11/Issue-Brief-Expanding-Postpartum-Medicaid-Coverage.pdf>.

¹⁰⁰ Sherman, *supra* note 91, at 527.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Florida Voices for Health, *Medicaid Expansion in the 2021 Florida Legislative Session*, available at <https://www.healthyfla.org/single-post/medicaid-expansion-in-the-2021-florida-legislative-session>; Florida Policy Institute and Florida Health Justice Project, *Florida Medicaid Basics*, Health Care for Florida, available at <https://www.healthcareforfla.org/basics>.

¹⁰⁴ Jacob Wentz, University of South Florida News, *Medicaid Expansion Could Help Florida Overcome Budget Deficit Advocate Says* (Mar. 3, 2021), available at <https://wusfnews.wusf.usf.edu/health-news-florida/2021-03-03/medicaid-expansion-could-help-florida-overcome-budget-deficit-advocate-says>.

¹⁰⁵ Louise Norris, *Florida and the ACA's Medicaid Expansion* (Sep. 8, 2020), available at <https://www.healthinsurance.org/medicaid/florida/>.

¹⁰⁶ Matthew Buettgens, Urban Institute, *Medicaid Expansion Would have a Larger Impact Than Ever during the COVID-19 Pandemic*, 9 (Jan. 2021), available at https://www.urban.org/sites/default/files/publication/103536/medicaid-expansion-would-have-a-larger-impact-than-ever-during-the-covid-19-pandemic_0.pdf.

finance would also be available.¹⁰⁷ The Florida Policy Institute estimated that opting into Medicaid expansion would save Florida around \$3.5 billion and would eventually further reduce healthcare premiums as the cost of uncompensated care at hospitals would be reduced.¹⁰⁸

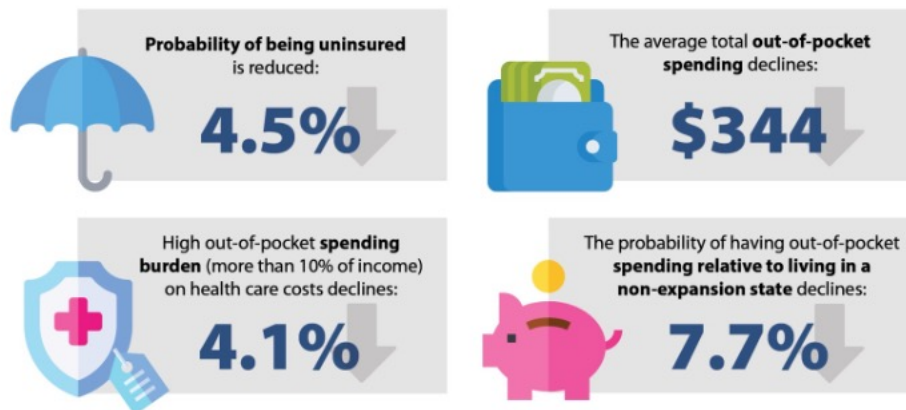
Increased Medicaid access would further improve economic security at an individual level. People with healthcare coverage are less likely to leave bills unpaid, borrow money for medical care, or face catastrophic medical costs.¹⁰⁹ In expansion states, Medicaid has reduced medical debt, improving quality of life and decreasing the risk of eviction.¹¹⁰ For example, studies in Arkansas and Kentucky revealed that Medicaid expansion in both states reduced the debt sent to third-party collection agencies by about \$1,140 per enrollee; which ultimately reduces their unpaid bills and

improves their credit, thus, lowering interest for their mortgage, car, and loans.¹¹¹

Unfortunately, Medicaid expansion has become politicized with health the casualty of political rivalry. Arguments against Medicaid expansion lack any real substance. Opponents of expansion claim that Medicaid should be only reserved for the most vulnerable and that expansion would be too costly,¹¹² However, the Federal government covers the majority of Medicaid expansion,¹¹³ and currently, Floridian tax dollars are allocated towards Medicaid spending without benefiting state residents.¹¹⁴ The Governor of Florida, Ron DeSantis, himself acknowledged that federal money for Medicaid is “free money” being turned away.¹¹⁵

Moreover, Medicaid expansion would be in line with the post-partum extension, achieved through

Medicaid expansion helps keep out-of-pocket costs down for low-income patients.



Source: Health Affairs

Photo Courtesy of Salud America

¹⁰⁷ Carol Davis, *Expanding Medicaid In All States Would Boost Coverage, Economics, and Jobs* (May 20, 2021), available at <https://www.healthleadersmedia.com/strategy/expanding-medicare-all-states-would-boost-coverage-economics-and-jobs>.

¹⁰⁸ *Id.*; see also Taylor, *supra* note 76.

¹⁰⁹ Center on Budget and Policy Priorities, *The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion* (Oct. 21, 2020), available at <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicare-expansion>.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Gray Rohrer, Orlando Sentinel, *Florida unlikely to expand Medicaid for 800,00 residents, despite offer of more federal money* (Mar. 17, 2021), available at <https://www.orlandosentinel.com/politics/os-ne-florida-medicare-expansion-20210317-uxyqvh3trjgvthw4qxoba52syy-story.html>.

¹¹³ *Id.*

¹¹⁴ Florida Policy Institute and Florida Health Justice Project, *Medicaid Expansion: Florida's Big Opportunity*, Health Care for Florida (2023), available at <https://www.healthcareforfl.org/medex4fl>.

¹¹⁵ Rohrer, *supra* note 114.

bipartisan support.¹¹⁶ Both parties have indicated that they care about addressing maternal health. However, support for maternal health requires more than just healthcare after pregnancy. Rather, as discussed above, pre-pregnancy preventive care is critical since a woman's entire health history comes to bear on pregnancy outcomes. To truly address the current maternal and infant health crisis and meet the goals of both political parties, would seem to point to Medicaid expansion.

Florida currently suffers from a maternal and infant health crisis. Consistent access to healthcare would help address this crisis. Florida has been presented with the opportunity to expand access to healthcare to its constituents through the expansion of Medicaid; this would effectively expand healthcare access to women who are currently uninsured. Access to healthcare coverage, which would be provided through the expansion of Medicaid, would not only reduce the maternal and infant mortality rate in Florida, but also address racial disparities and provide important economic benefits.

B. Strengthening Florida's Family Planning Waiver Program

Florida's Family Planning Waiver Program (the "Waiver Program"), also known as the Family Planning Medicaid for Today's Women, was established in 1998 for women and families who did not otherwise have access to the provided healthcare related services.¹¹⁷ The Waiver Program was introduced to address a lack of access to family planning services in Florida, particularly for marginalized communities with inadequate financial access to healthcare.¹¹⁸ According to the Department of Health & Human Services, the objectives of the Waiver Program are to (1) increase access to family planning services, (2) reduce the number of unintended pregnancies, (3) increase child spacing intervals through contraception, and (4) reduce costs by reducing unintended pregnancies by women who would be eligible for Medicaid pregnancy related services.¹¹⁹ This section describes the Waiver Program and how it functions, as well as discusses its benefits and current gaps.

1. Waiver Program Description

The Waiver Program has successfully provided Floridian women with improved access to family planning-related services and supplies. The services available through the Waiver Program include sexually transmitted disease testing and treatment; breast cancer and colposcopy screening; medications, antibiotics, supplies, and

pregnancy tests; contraception and birth control supplies; physical exams, such as a pap smear, breast exam, or STD testing, and counseling; and education.¹²⁰ All services are confidential.¹²¹ With few exceptions, the Waiver Program provides access to these services for women and families up until pregnancy.¹²²

¹¹⁶ Renzo Downey, Florida Politics, *Gov. DeSantis approves Medicaid extension for new moms* (June 3, 2021), available at <https://floridapolitics.com/archives/433437-gov-desantis-approves-medicaid-extension-for-new-moms/>.

¹¹⁷ Florida Agency for Health Care Administration (AHCA), *Medicaid Family Planning Waiver Program* (2023), available at https://ahca.myflorida.com/medicaid/family_planning/index.shtml.

¹¹⁸ The United States Department of Health and Human Services, *FL FPW Evaluation Design Approval Letter* (Jul. 13, 2020) available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl-fl-family-planning-ca.pdf>.

¹¹⁹ *Id.*

¹²⁰ Florida Department of Health, *Medicaid Family Planning Waiver Program* (2023), available at <http://www.floridahealth.gov/programs-and-services/womens-health/family-planning/fp-medicaid.html>.

¹²¹ *Id.*

¹²² *Id.*

Studies have demonstrated several benefits to the utilization of family planning services, including a decrease in the share of children and adults living in poverty.¹²³ In a 2014 study on family planning programs across the country, an association was found for individuals born after federal family planning programs began and a decreased likelihood of living in poverty in childhood and adulthood.¹²⁴ Additionally, the implementation of Medicaid family planning programs has been found to lower average annual birth rates in all states.¹²⁵ A 2007 study found that a reduction in births on average in income-based Medicaid expansion programs that incorporate family planning services.¹²⁶

Moreover, family planning services are imperative to the health and well-being of families. Family planning allows individuals and couples to avoid unintended pregnancies,¹²⁷ attain their desired number of children, and determine the spacing and timing of their births.¹²⁸ Family planning further reduces the spread of sexually transmitted diseases, as well reduces rates of infertility, in part by treating sexually transmitted diseases.¹²⁹ Access to contraception has a number of

important benefits, such as reducing the need for unsafe abortions and with proper medical care, preventing HIV transmission from mother to child,¹³⁰ and protecting girls and women from risky pregnancies.¹³¹ Avoiding unintended pregnancies further enables girls and women to benefit from education and employment opportunities.¹³²

Family planning services within the Waiver Program are financed and organized by the Medicaid Program.¹³³ Over twenty years ago, states began establishing special demonstration programs as Section 1115 waivers, which allowed them to offer Medicaid eligibility for a limited scope of services or to a specific population.¹³⁴ This gave states the flexibility to waive certain Medicaid rules to design new systems to expand and improve their Medicaid programs.¹³⁵ All state Medicaid programs must offer some level of family planning benefits¹³⁶ as family planning is classified as a “mandatory” benefit.¹³⁷ Furthermore, healthcare providers and pharmacies are not permitted to charge cost-sharing for family planning services.¹³⁸ The Federal Government matches state family planning contributions to all participating

¹²³ Martha J. Bailey, et al., *Do Family Planning Programs Decrease Poverty? Evidence from Public Consensus Data*, CESifo Econ Stud. 60(2): 312-337 (2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/pdf/nihms602597.pdf>.

¹²⁴ *Id.*

¹²⁵ Richard C. Lindrooth and Jeffrey S. McCullough, *The Effect of Medicaid Family Planning Expansions on Unplanned Births*, *Women's Health Issues* 17: 66–74 (2007), available at <https://www.shepscenter.unc.edu/wp-content/uploads/2013/07/The-Effect-of-Medicaid-Family-Planning-Expansions-on-Unplanned-Births.pdf>.

¹²⁶ *Id.*

¹²⁷ Institute of Medicine (IOM) Committee on a Comprehensive Review of the HHS Office of Family Planning Title X Program, *A review of the HHS Family Planning Program: Mission, Management and Measurement of Results* (2009), available at <https://www.ncbi.nlm.nih.gov/books/NBK215219/#:~:text=Family%20planning%20serves%20three%20critical,helps%20reduce%20rates%20of%20infertility>.

¹²⁸ World Health Organization, *Contraception*, https://www.who.int/health-topics/contraception#tab=tab_1.

¹²⁹ IOM, *supra* note 129.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ Usha Ranji, et al., Kaiser Family Foundation (KFF), *Medicaid and Family Planning: Background and Implications of the ACA* (Feb. 3, 2016), available at <https://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy/>.

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

providers at 90%, which is a higher rate than that offered for other services.¹³⁹ While all state programs must cover family planning, states have considerable discretion in identifying the specific services and supplies that are included in the program.¹⁴⁰ Moreover, no formal definition of family planning exists in Medicaid.¹⁴¹

Eligibility for the Waiver Program extends to women of general childbearing age who are citizens of Florida in need of financial assistance to access family planning services. A woman qualifies for the Waiver Program if she is between the ages of 14 and 55, has lost Medicaid coverage within the past two years, wants access to family planning services, is not pregnant, has not had a hysterectomy or sterilization, and has an income at or below 191% of the federal poverty level.¹⁴² As stated by the Centers for Medicare and Medicaid Services (“CMS”), eligibility for “the [Waiver Program] section 1115(a) Medicaid demonstration...is limited to a period of up to 24 months following the loss of Medicaid coverage, . . . to provide transitional coverage for those losing Medicaid eligibility. Women may become eligible for a new two-year period of transitional family planning coverage upon each subsequent loss of

Medicaid eligibility.”¹⁴³ While the Department of Children and Families (“DCF”) is responsible for most Medicaid eligibility determinations,¹⁴⁴ an exception is the Waiver Program, which is determined by the Department of Health (“DOH”).¹⁴⁵ The Waiver Program’s eligibility process is integrated with the process used for other Medicaid eligibility determinations.¹⁴⁶ Eligible women have either lost or are losing Florida Medicaid State Plan eligibility and are not otherwise eligible for Medicaid, Children’s Health Insurance Program, or health insurance coverage that provides family planning services.¹⁴⁷ Moreover, recipients losing Sixth Omnibus Budget Reconciliation Act (“SOBRA”) eligibility, which provides pregnancy services through Medicaid, will have passive enrollment during the first 12 months of losing Medicaid.¹⁴⁸ Non-SOBRA women will have to actively apply for the first year of benefits at their local county health department.¹⁴⁹

Florida’s Waiver Program can be nationally compared to other states that provide access to a waiver program alternative to Medicaid. Both California and Wisconsin provide family planning waiver programs to Medicaid and have

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* The clinical context of family planning has evolved to include a broader array of services, such as health education and promotion, testing and treatment for STDs, and services that facilitate fertility preservation.

¹⁴² Florida Agency for Health Care Administration (AHCA), *Florida Medicaid Family Planning Waiver Section 1115 3rd Quarter Report* (2017), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Medicaid-Family-Planning-Waiver/fl-family-planning-qtrly-rpt-jan-mar-2016.pdf>.

¹⁴³ Department of Health and Human Services, *FL FPW Evaluation Design Approval Letter* (Jul. 13, 2020), available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-family-planning-ca.pdf>.

¹⁴⁴ Florida Administrative Code & Florida Administrative Register, *59G-1.058 Eligibility*, 59G-1 (myflorida.com).

¹⁴⁵ Florida Agency For Health Care Administration (AHCA), *Annual Monitoring Report* (2020), available at https://ahca.myflorida.com/medicaid/family_planning/pdf/DY22_Q4_and_Annual_Report_Final.pdf. By March 2022, the process for the Program’s eligibility will be transitioned from the DOH to the DCF. The objectives for this transition will include automatic enrollment for those who lost Medicaid coverage and an increase in the consistency and accuracy of enrollment and eligibility. These objectives will seek to ensure availability and continuity of family planning services, as well as reduce administrative burdens on eligible recipients, as they will only have to engage if additional information is needed by the DCF. *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ Florida Agency for Health Care Administration (AHCA), *Medicaid Family Planning Waiver Program* (2023), available at https://ahca.myflorida.com/Medicaid/Family_Planning/index.shtml.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

similar eligibility requirements and available services with slight deviations. California’s Family Planning, Access, Care, and Treatment (“Family PACT”) has almost identical eligibility requirements to the Waiver Program,¹⁵⁰ except for a few differences that Florida could implement. The Family PACT’s website explicitly addresses COVID-19 information and resources related to family planning.¹⁵¹ In some areas, the Family PACT is more comprehensive with resources and services than the Waiver Program. However, Florida overall seems to provide a more extensive range of services for family planning. Similarly, Wisconsin’s family planning waiver program, the Family Planning Only Services (“FPOS”), provides men and women with certain

family-planning related services and supplies to assist with maternal health and prevent unplanned pregnancies.¹⁵² Again, Florida’s Waiver Program appears to have largely similar intentions to Wisconsin’s FPOS, with slightly different variations in available services.

An international comparison is less applicable because healthcare coverage is free in many developed countries, particularly in Europe, so no waiver is necessary, and there are no special eligibility requirements. For example, in the United Kingdom, programs such as the Family Planning Association¹⁵³ and the Family Planning Clinic London¹⁵⁴ provide similar services to Florida’s program at no cost.

2. Waiver Program Benefits

The Waiver Program’s evaluation process is part of a three-year contract with Florida State University (“FSU”), the most recent of which began in 2020.¹⁵⁵ The Waiver Program is evaluated using Medicaid eligibility and claim files, Florida birth certification and Health Start Pre-Natal risk screening data, and qualitative survey completed by DOH staff.¹⁵⁶ The evaluation plan was revised in June of 2020 to focus more on how enrollees utilize covered health services while maintaining budget neutrality.¹⁵⁷ This revised plan monitors performance improvement. The plan focuses on objectives including: (1) increasing access to family planning services; (2) reducing the number of unintended pregnancies in Florida; and (3) reducing Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.¹⁵⁸ The plan assesses how well the Waiver Program is meeting assigned objectives.

¹⁵⁰ California Department of Health Care Services, *Am I Eligible for Family PACT* (2023), available at <https://familypact.org/am-i-eligible/>. To qualify for the Family PACT, individuals must be a resident of California, have a medical need for family planning, be at or below 200% of the federal poverty income guidelines, and have no other healthcare that covers the relevant family planning needs. Family PACT’s services include: (1) various birth control methods, such as long-acting, reversible contraceptives, emergency contraception, and sterilization; (2) family planning counseling and education; (3) STD testing and treatment; (4) HIV testing; (5) cervical cancer screening; (6) limited fertility services. Coverage does not include emergency room visits or in-patient services for pregnant women, breast health services, and healthcare needs not related to family planning. *Id.*

¹⁵¹ California Department of Health Care Services, *Family PACT COVID-19 Updates* (2023), available at <https://familypact.org/covid-19-updates/>.

¹⁵² Wisconsin Department of Health Services, *Family Planning Only Services* (April 13, 2023), available at <https://www.dhs.wisconsin.gov/fpos/index.htm>. To qualify for FPOS, eligible individuals must: (1) live in Wisconsin; (2) be a U.S. citizen or have qualifying immigration status; (3) be of childbearing or reproductive age; (4) have an income at or below \$3,284.39 per month; (4) not be enrolled in Wisconsin Medicaid or BadgerCare Plus. *Id.* Covered services include contraceptives with a prescription, natural family planning supplies, pap tests, routine preventive, family planning-related primary services, STD tests and treatment, and voluntary sterilizations for women and men. Non-covered services with FPOS include hysterectomies, in-patient hospital services, mammograms, vaccinations, and other services provided during a family planning-related visit that are not family planning-related. *Id.*

¹⁵³ The Family Planning Association (FPA), *Our Mission Statement* (2023), available at <https://www.fpa.org.uk/about-fpa/>.

¹⁵⁴ Broadgate GP, *Family Planning Clinic London* (2023), available at <https://www.broadgategp.co.uk/family-planning-clinic-london/>.

¹⁵⁵ Florida Agency for Health Care Administration (AHCA), *Florida’s Family Planning Waiver (FPW) Program Evaluation Design* (Nov. 25, 2019), available at https://ahca.myflorida.com/Medicaid/Family_Planning/pdf/Revised_Evaluation_Design_Final_TOC_cover.pdf.

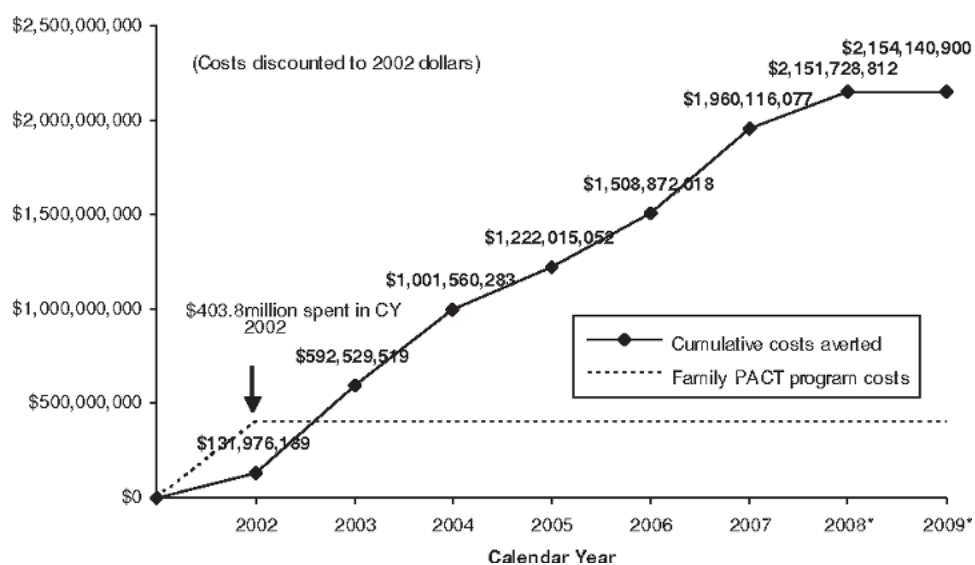
¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

The 2021 Evaluation Report of the Waiver Program found program success in three key areas: the total proportion of eligible women enrolled in the Waiver Program increased from the year prior, the proportion of enrolled women who utilized any service increased from the year prior, and the vast majority of women who were surveyed after using any Waiver Program services indicated satisfaction with those services and found them easily accessible.¹⁵⁹

The Evaluation Report found several improvements, as well as several key areas of the Waiver Program still in need of improvement. The interbirth interval—the time between the birth of one child and the next—was slightly longer for the Waiver Program’s enrollees with an average of 16.8 months, as compared to eligible women who did not enroll with an average of 14.2 months.¹⁶⁰ Waiver Program enrollees experienced slightly lower rates of “low birth weight” and “pre-term births” compared to non-enrollees.¹⁶¹ In addition, estimated cost savings increased to approximately \$89.5 million.¹⁶² However, the Waiver Program has neither reduced the number of women dissatisfied with the timing of their pregnancy nor the number of unintended pregnancies among Waiver Program enrollees as compared to non-enrollees.¹⁶³ Moreover, when women who were eligible for the Waiver Program’s services but did not enroll were asked for reasons, nearly all women responded that they were not aware of the Waiver Program.¹⁶⁴ When women who were enrolled but did not participate were asked for reasons, nearly all women provided that they were not aware they were enrolled or not aware of the full range of services offered.¹⁶⁵



[California Family PACT Program Costs v. Savings.](#)

¹⁵⁹ *Id.*

¹⁶⁰ See Florida Agency for Health Care Administration (AHCA), *Florida Medicaid Family Planning Waiver Program: Family Planning Waiver DY 22 (SFY2019-2020) Evaluation Report* (Dec. 7, 2021), available at https://ahca.myflorida.com/Medicaid/Family_Planning/pdf/Final_Evaluation_Report_2020.pdf.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* Approximately 13% of women enrolled in the Waiver Program utilized at least one service – approximately 5% were tested for an STD and 2% obtained a cervical cancer screening. Florida Agency for Health Care Administration (AHCA), *See Medical Care Advisory Committee Meeting* (Jan. 25, 2021), available at https://ahca.myflorida.com/medicaid/mcac/docs/2021-01-25_Meeting/MCAC_January_2021-Meeting_Presentation.pdf.

A 2015 study on family planning waiver programs by the Guttmacher Institute found the following results for 49,800 adolescent participants (aged 13-18): 7,070 unintended pregnancies, 2,430 abortions, and 3,720 Medicaid births were averted; \$37,472 was saved from Medicaid births averted; \$9,840 expenditures on expansion services was saved; a total of \$27,631 was found for net savings.¹⁶⁶ These findings demonstrate the impact that services like Florida’s Waiver Program can have on local communities when utilized properly.

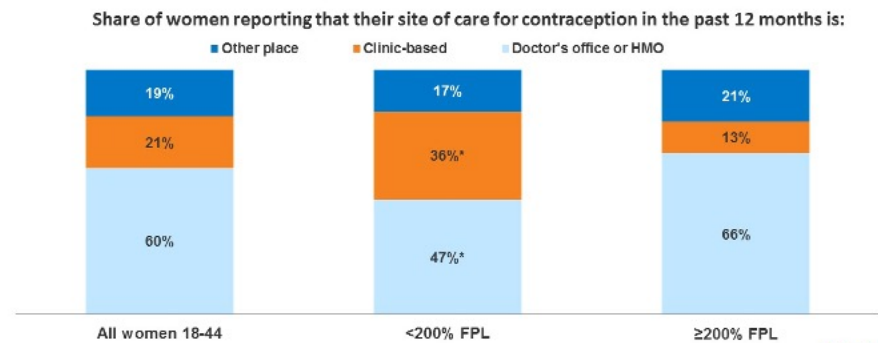
3. Waiver Program Gaps

While the Waiver Program has demonstrated significant benefits, it suffers from several key gaps. This includes low service utilization and failure to adapt quickly to COVID-19, as well as a lack of clarity in family planning that leaves out essential services and service gaps with regards to sex education, abortion, and mental health.

First, low service utilization is a critical issue that the Waiver Program needs to address. According to the FSU evaluation process, a very small number of eligible people utilize the services provided to them by the Waiver Program.¹⁶⁷ For example, from 2019 to 2020, just 13% of individuals enrolled in the Waiver Program utilized at least one service.¹⁶⁸ Of those, approximately 5% were tested for an STD and approximately 2% obtained a cervical cancer screening.¹⁶⁹ These numbers could and should be elevated through increased education and advertising of the available services.

Figure 1

One in Three Low-Income Women Who Use Birth Control Obtain It From a Safety-Net Clinic



NOTES: Among sexually active women ages 18-44 who had used any birth control within the past 12 months. The Federal Poverty Level (FPL) was \$20,420 for a family of three in 2017. *Clinic-based* includes community health centers, Planned Parenthood and other family planning clinics, and school-based clinics. *Other place* includes drugstores and other unspecified sites. *Indicates a statistically significant difference from ≥200% FPL, p<.05. SOURCE: Kaiser Family Foundation, 2017 Kaiser Women's Health Survey.



[Photo](#) Courtesy of Kaiser Family Foundation

Finally, the Waiver Program must evolve to incorporate lessons learned during the COVID-19 pandemic. Florida waived the requirement that Florida Medicaid providers be licensed in-state and

¹⁶⁶ Adam Sonfield, et al., Guttmacher Institute, *Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update* (Jan. 2011), available at https://www.guttmacher.org/sites/default/files/report_pdf/medicaid-family-planning-2011.pdf.

¹⁶⁷ AHCA, *supra* note 147.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

enacted a quicker enrollment process,¹⁷⁰ which greatly improved accessibility for eligible participants to the Waiver Program during critical months. The National Family Planning and Reproductive Health Association (“NFPRHA”) curated a collection of resources to support patient care during COVID-19 that include Health Center Operations, Online Clinical Guidance, Virtual information on billing and coding, Telehealth, Virtual Medicaid Assistance, and a focus on Health Equity during the pandemic.¹⁷¹ The Waiver Program should utilize NFPRHA’s model to, for example, increase accessibility via telehealth and other forms of virtual communication. Across the nation, publicly funded family providers are rapidly expanding the use of telehealth to deliver family planning and sexual care.¹⁷² By eliminating transportation and child care barriers, improved access to virtual resources would greatly benefit the eligible participants of the Waiver Program.

The lack of clarity as to what family planning entails results in a failure to provide essential services and resources including transportation, emergency room visits, and in-patient services.¹⁷³ While there are federally-specified covered benefits that are required to be included—access to contraceptives, screening services, and counseling¹⁷⁴—the vast majority of services that could fall under “family planning” are not set out since there is no official federal definition of “family planning.”¹⁷⁵ This ambiguity gives states, such as Florida, considerable discretion to determine the specific services covered under their programs.¹⁷⁶ The state should explore maximizing services offered to ensure healthy future pregnancies.

The Waiver Program, for instance, should cover at least basic mental health services. This could include access to medication, counseling services that specifically educate prospective families on how to handle the impact of pregnancy, preparation for children, and other unexpected situations that might occur in the process—such as a miscarriage, postpartum health, medical emergencies, and other occurrences. A new study by the Guttmacher Institute has found that women’s ability to use contraceptives and to control if and when to have children enhances their education and employment opportunities, as well as family stability, mental health, and overall well-being.¹⁷⁷ Coupling the inherent supports of family planning with mental health care is a logical extension in support of family health.

The current Waiver Program is set to expire on June 30, 2023,¹⁷⁸ providing the opportunity to address these gaps in its renewal. Addressing these gaps and increasing service utilization is not only important for maternal and infant health in Florida but would also result in budget savings.

¹⁷⁰ Florida Agency for Health Care Administration (AHCA), *Florida Medicaid Managed Medical Assistance Waiver: Combined Q3 and Annual Report* (2020), available at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Reports/FL_1115_DY14_Q3_Report.pdf.

¹⁷¹ National Family Planning and Reproductive Health Association, *Health Center COVID-19 Resources* (2023), available at <https://www.nationalfamilyplanning.org/covid-19-resource-hub>.

¹⁷² National Family Planning and Reproductive Health Association, *Telehealth for Family Planning Providers* (2023), available at <https://www.nationalfamilyplanning.org/telehealth>.

¹⁷³ Florida Agency for Health Care Administration (AHCA), *Medicaid Family Planning Waiver Program* (2023), available at https://ahca.myflorida.com/Medicaid/Family_Planning/index.shtml.

¹⁷⁴ *Id.*

¹⁷⁵ Jenna Walls, et. al., Kaiser Family Foundation (KFF), *Medicaid Coverage of Family Planning Benefits: Results from a State Survey* (Sep. 15, 2016), available at <https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/>.

¹⁷⁶ *Id.*

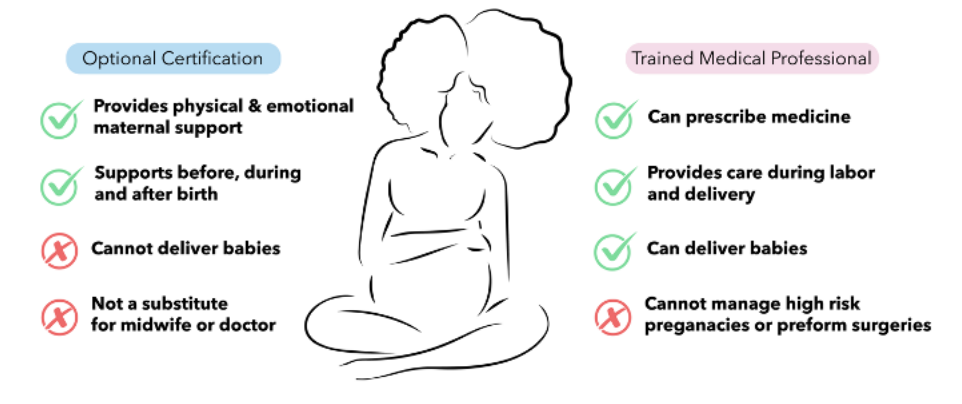
¹⁷⁷ United Nations Population Fund, *New Study Shows Benefits of Family Planning to the Well-Being of Women, Families, and Economies* (Mar. 21, 2013), available at <https://www.unfpa.org/news/new-study-shows-benefits-family-planning-well-being-women-families-and-economies>.

¹⁷⁸ AHCA, *supra* note 147.

C. Expanding Access to Midwives and Doulas

Midwives and doulas offer a high-touch, low-tech approach to maternity care that empowers birthing individuals and emphasizes health-promoting practices.¹⁷⁹ A midwife is a health professional who cares for birthing individuals and newborns around childbirth and can assist births in a hospital, birthing center, or patient’s home.¹⁸⁰ All midwives are trained to identify when higher levels of more specialized care are needed, and may consult, share care, or transfer when deemed appropriate.¹⁸¹ Doulas, originating from the Greek word meaning “women who serve,” are specially-trained birth companions who provide continuous physical and emotional labor support.¹⁸² Doulas do not perform any medically-related tasks or give or make any medical advice to their clients.¹⁸³ Significantly, evidence from other developed countries suggest midwife-assisted and doula-assisted childbirth—both in the hospital and at home—improves numerous outcome measures and is cost-effective.¹⁸⁴ Accordingly, expanding access to high quality midwifery care and doula services is an effective strategy to rapidly expand access to effective maternity care services.¹⁸⁵

Doula versus Midwife



[Photo](#) Courtesy of: UNC Media Hub

Currently, access to midwives and doulas is extremely limited due to the overmedicalization of childbirth and the dominance of the medical model of childbirth over the physiological model. This overmedicalization is buttressed by economic interests, the legal framework, and gaps in education, making up our current maternal medicolegal system.

¹⁷⁹ NPWF, *supra* note 4, at 23.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² DONA International (DONA), *Position Paper: The Birth Doula’s Role in Maternity Care*, 2 (2022), available at <https://www.dona.org/wp-content/uploads/2020/02/DONA-Birth-Position-Paper-2022.pdf>; Amy Chen, National Health Law Program (NHLP), *Routes to Success for Medicaid Coverage of Doula Care*, 1 (2018), available at <https://healthlaw.org/wp-content/uploads/2018/12/NHeLP-PTBi-Doula-Care-Report.pdf>.

¹⁸³ DONA, *supra* note 184, at 1.

¹⁸⁴ NPWF, *supra* note 4, at 7; Brown, *supra* note 2, at 2.

¹⁸⁵ NPWF, *supra* note 4, at 25.

1. The Overmedicalization of Childbirth

Childbirth is highly medicalized in the U.S. Of the four million births that occur each year in the U.S., 98.6% occur within hospitals, with the vast majority attended by physicians.¹⁸⁶ In comparison, in Europe, where maternal and infant mortality rates are lower than America, 70% of women have a midwife-assisted hospital birth, and for low-risk pregnancies, midwives were the only caregivers European women see.¹⁸⁷ Currently in the U.S., obstetricians (OBs), trained surgeons, provide most prenatal care.¹⁸⁸

Other countries with better maternal health outcomes follow a different model than the U.S. There are two prevailing approaches to childbirth: the medical model prevalent in the U.S, and the physiological model prevalent in Europe and other regions. The medical, U.S.-utilized model approaches birth as a potentially pathological state that requires hospitalization, medical supervision, and frequent intervention to manage perceived risks.¹⁸⁹ It is technologically-driven and doctor-centered.¹⁹⁰ Significantly, in the medical model, safety is prioritized, but narrowly defined and typically centered around fetal wellbeing.¹⁹¹ Meanwhile, the physiological model approaches birth as a normal physiological process, seeks to minimize technological interventions, and emphasizes the birthing individual's autonomy to make decisions.¹⁹² Moreover, unlike the medical model's prioritization of fetal wellbeing, the physiological model treats the fetus and pregnant person as an "interdependent" whole, and takes a holistic approach; supporting the dyad's physical and psychosocial health and safety.¹⁹³

While the medical approach is currently the dominant approach in the U.S., this was not always the case. For much of human history, women globally have been giving birth in the presence of at least two other women: midwife and doula, in today's parlance.¹⁹⁴ In the U.S., most women, particularly Black women,

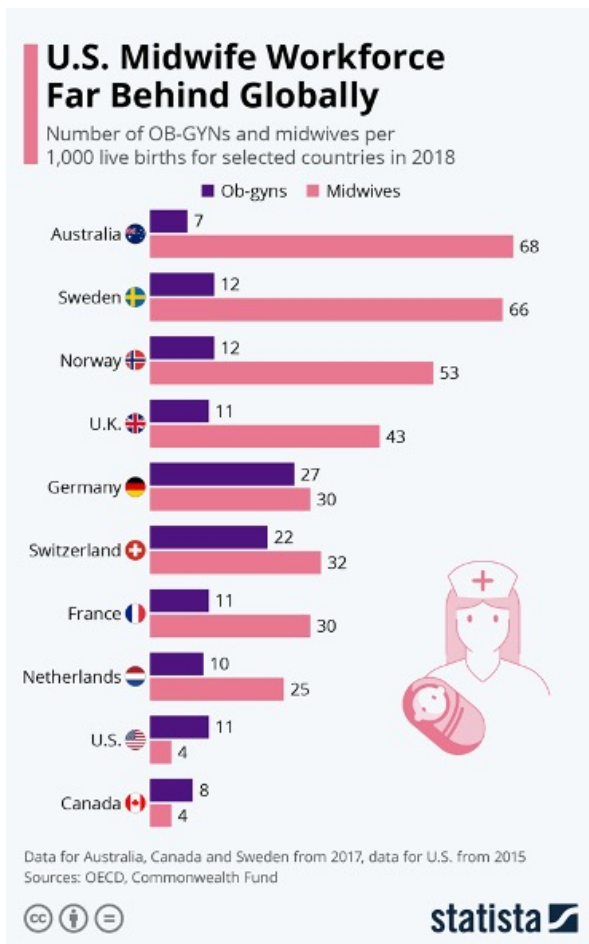


Photo Courtesy of Statista

¹⁸⁶ Brown, *supra* note 2, at 5 & 8.

¹⁸⁷ Brown, *supra* note 2, at 6-7.

¹⁸⁸ *Id.* at 5.

¹⁸⁹ The Legal Infrastructure of Childbirth, 134 HARV. L. REV. 2209, 2210 (2021).

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 2211.

¹⁹² *Id.* at 2211.

¹⁹³ *Id.* at 2211.

¹⁹⁴ DONA, *supra* note 182, at 1.

continued to give birth nearly exclusively at home until 1930, delivered by midwives, many of whom were Black, Indigenous, or immigrants.¹⁹⁵ However, physicians, fueled by economic interests, misogyny, and racism, used their social influence to denigrate midwifery, effectively eradicating access to midwives for underserved communities of color. In the mid-1700s, the field of obstetrics was introduced in America and by the early 1800s, white male obstetricians began to largely replace the role of the midwife, particularly among upper and middle-class white Americans.¹⁹⁶ Beginning in the early 1800s, due

to physician outcry and lobbying, many states created laws that prohibited lay midwives.¹⁹⁷ Accordingly, predominately white, male OBs and their white counterpart policymakers openly advocated for the elimination of midwives.¹⁹⁸ Successful racist and misogynistic smear campaigns, cleverly designed for political persuasion and to achieve legal reform, described Black midwives as unhygienic, barbarous, ineffective, non-scientific, dangerous, and unprofessional.¹⁹⁹ Physicians explicitly revealed their motivations in undermining midwifery: the desired financial gains, recognition, and a



[Photo](#) Courtesy of ACLU (see footnote 198)

¹⁹⁵ Brown, *supra* note 2, at 2; Kennedy Austin and Lynn Freedman, Columbia Public Health, *End Racial Disparities in Maternal Health, Call a Midwife* (2020), available at <https://www.publichealth.columbia.edu/news/end-racial-disparities-maternal-health-call-midwife>. When Europeans brought enslaved African people to the U.S. in the early 1600s, there were among them African women who trained and practiced as midwives, and who continued to do so and train others to do while enslaved. During slavery and colonial times, midwives were the primary source of maternal care and African midwives served both Black and white women in birth. The terms midwife, granny-midwife, and granny were used to describe traditional Black midwives, who were well respected by their community and who still attended up to 75% of births in the 1940s in the Southeastern United States. Cara Terreri, Lamaze International, *Black History Month: The Importance of Black Midwives, Then, Now and Tomorrow* (2019), available at <https://www.lamaze.org/Connecting-the-Dots/black-history-month-the-importance-of-black-midwives-then-now-and-tomorrow-1#:~:text=As%20slavery%20grew%2C%20African%20midwives,and%20middle%2Dclass%20white%20Americans>

¹⁹⁶ Terreri, *supra* note 197.

¹⁹⁷ *Id.*

¹⁹⁸ Michele Goodwin, American Civil Liberties Union, *The Racist History of Abortion and Midwifery Bans* (July 2020), available at <https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/>.

By the early 1900s, physicians and health officials across the country published articles linking midwifery to high rates of infant and maternal mortality, blaming Eastern European and Black women for public health emergencies and associated midwifery with “illiteracy, carelessness and general filth.” *Id.* Male gynecologists claimed midwifery was a degrading means of obstetrical care, viewing themselves as elite members of a trained profession with tools and other technologies, and the modern convenience of hospitals, which excluded Black and Indigenous women from practice within their institutions. *Id.* Dr. Joseph DeLee, a preeminent 20th century obstetrician and fervent opponent to midwifery, stated in a much-quoted 1915 speech, “Progress Toward Ideal Obstetrics”: “The midwife is a relic of barbarism. In civilized countries the midwife is wrong, has always been wrong . . . The midwife has been a drag on the progress of the science and art of obstetrics. Her existence stunts the one and degrades the other. For many centuries she perverted obstetrics from obtaining any standing at all among the science of medicine . . . Even after midwifery was practiced by some of the most brilliant men in the profession, such practice was held opprobrious and degraded.” *Id.* Not surprisingly, the movement to delegitimize midwifery rose alongside immigrant quotas and Jim Crow laws. *Id.*

¹⁹⁹ *Id.*

monopoly.²⁰⁰ In 1921, Congress passed the Sheppard-Towner Act requiring all midwives to undergo health safety training, effectively banning midwives from hospitals.²⁰¹

From the mid-1800s to the mid-1900s, all lay midwives, including Black granny-midwives, were systematically ousted from practice until there were none left at all. By the 1930s, physicians, notably predominantly male at the time, recommended women give birth in hospitals.²⁰² With the shift to physician-assisted births, women lost access to midwives and doulas.²⁰³ As hospitals became more desirable places to give birth due to medical advances, midwifery and homebirth remained common in, and became associated with, high-poverty, low-education, minority communities.²⁰⁴ By the 1960s, physicians monopolized maternity care.²⁰⁵

U.S. obstetricians have gained significant economic, political, and social power, and have at times used this power to less the power of midwives.²⁰⁶ ACOG has a political action committee (PAC) that lobbies Congress, as well as state PACs that lobby every state legislature.²⁰⁷ These political groups significantly influence the national maternal care system. For example, ACOG recommended women give birth in

hospitals attended by obstetricians.²⁰⁸ In contrast, the United Kingdom's National Institute for Health and Care Excellence (NICE) recommends that women with low-risk pregnancies undergo a homebirth or a midwife-assisted hospital birth.²⁰⁹ This difference in the utilization of midwives in the U.S. and the United Kingdom reflects, in part, the powerful effect the lobbying organizations have on maternal care provision.

Yet, despite the shift toward medicalization of birth, the medical model has not produced superior outcomes to the physiological, midwife-based model.²¹⁰ The largest flaw of the medical maternal care model is the resulting overuse of potentially harmful practices and underuse of beneficial practices, which ultimately results in worsened health outcomes and increased cost as compared to midwifery models.²¹¹ Overuse occurs when a medical practice has no clear benefit in a particular context, and yet has associated complications that may cause harm.²¹² Underuse, in contrast, happens when safe, beneficial, health-enhancing practices are underutilized.²¹³ Worse, overmedicalization is cyclic; as one medical intervention during childbirth increases the chance of complications and the need for additional medical

²⁰⁰ *Id.* Skilled Black midwives represented both real competition for white men who sought to enter obstetrics and were viewed as a threat to obstetricians' monopoly on childbirth. As Dr. DeLee wrote in a 1916 article published in the *American Journal of Obstetrics & Disease of Women & Children*, "There is high art in obstetrics and that it must pay as well for it as for surgery. I will not admit that this is a sordid impulse. It is only common justice to labor, self-sacrifice, and skill." This emphasizes their motive to have men paid, and not women, particularly Black women.

²⁰¹ Austin and Freedman, *supra* note 197. Although the bill aimed to minimize lethal maternal health risks, advocates mapped race and ethnicity onto hygiene and inadequate healthcare systems, molding the midwife's image into that of a racist caricature. *Id.*

²⁰² Brown, *supra* note 2, at 3.

²⁰³ *Id.* at 4. This historical overrepresentation of men in medicine and particularly as obstetricians and gynecologists resulted in modern maternity care's reliance on the paternalistic, racist, and sexist views of male obstetricians from the 19th and 20th centuries. This paternalistic view rationalized the medicalized approach to childbirth on female weakness, dictating women required pain medication and other interferences with the body's natural labor process. Kukura, *supra* note 28, at 775.

²⁰⁴ Brown, *supra* note 2, at 4.

²⁰⁵ Brown, *supra* note 2, at 4.

²⁰⁶ Brown, *supra* note 2, at 13.

²⁰⁷ *Id.* at 13-14.

²⁰⁸ *Id.* at 7.

²⁰⁹ *Id.*

²¹⁰ The Legal Infrastructure, *supra* note 191, at 2211.

²¹¹ NPWF, *supra* note 4, at 19. Noting overused practices include labor induction, scheduled births, Cesarean birth, repeat cesarean birth, continuous electronic fetal monitoring, and healthier babies admitted to the neonatal intensive care units. Underused practices include planned labor after one or two cesareans, smoking cessation interventions for pregnant people, continuous support during labor, hand maneuvers to turn a fetus to headfirst position at term, intermittent auscultation with handheld device for fetal monitoring, being upright and mobile during labor, and screening for and treating perinatal depression.

²¹² NPWF, *supra* note 4, at 19.

²¹³ *Id.*

interventions.²¹⁴ The overmedicalization of childbirth also increases the chances of women's exposure to obstetric violence. Overmedicalization is demonstrated in the example of C-sections below.

Further, the overmedicalized maternal care system has inappropriately minimized the psychospiritual significance of physiological childbirth. Research indicates that physiological childbirth is a profound and transformative psychological experience that increases a woman's self-efficacy and has both short- and long-term effects.²¹⁵ Childbirth is typically a vivid, lifelong memory for women; the effects of a birthing experience can be positive and empowering, or negative and traumatizing.²¹⁶ The psychological benefits of childbirth are maximized through physical, emotional, and social support; increasing the birthing person's belief in their birthing abilities and autonomy in birthing options; and not performing unnecessary medical interventions.²¹⁷ Ignorance by providers of childbirth psychology increases the likelihood of a traumatizing birth.²¹⁸ The American maternal care system should recognize the empowering effects of the psychological experience of physiological childbirth.²¹⁹

Selected Examples of Overused and Underused Maternity Practices⁴⁰

OVERUSED PRACTICES

- Labor induction
- Scheduled births
- Cesarean birth
- Repeat cesarean birth
- Continuous electronic fetal monitoring
- Healthier babies admitted to neonatal intensive care units (NICUs)

UNDERUSED PRACTICES

- Planned labor after one or two cesareans
- Smoking cessation interventions for pregnant people
- Continuous support during labor
- Hand maneuvers to turn a fetus to a headfirst position at term
- Intermittent auscultation with handheld device for fetal monitoring
- Being upright and mobile during labor
- Screening for and treating perinatal depression

Photo from NPWF, *supra* note 4, at 19.

²¹⁴ *Id.*

²¹⁵ Ibone Olza, et al., *Birth as a neuropsychosocial event: An integrative model of maternal experiences and their relation to neurohormonal events during childbirth*, Public Library of Science (PLOS) ONE 15(7): 1 (2020); Ibone Olza, et. al., *Women's psychological experiences of physiological childbirth: a meta-synthesis*, British Medical Journal Open, 1 (2018).

²¹⁶ PLOS, *supra* note 217, at 2.

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

Overmedicalization Case Study: C-Sections

This country's approach to C-sections provides a vivid example of overmedicalization. The WHO (World Health Organization) recommends a country's C-section rate of 10% to 15% and recommends that it stay below 15%, given that a higher rate is not associated with better maternal or infant mortality rates.²²⁰ Across the U.S., C-section rates vary dramatically and change significantly depending on the chosen hospital, the time of the day, and the day of the week.²²¹ This suggests the choice to pursue a C-section is largely driven by the medical institution policy and the convenience of the hospital staff.²²² Currently, the national C-section rate is 32.2%, with at least half estimated to be performed unnecessarily.²²³ In Florida specifically, the C-section rate was even higher at 36.8% in 2018, down from 37.2% in 2017, but still significantly higher than the Healthy People 2020 target goal of 23.9%.²²⁴ In a fee-for-service model, medical institutions are incentivized to increase C-sections rates as they are more lucrative for both healthcare providers and hospitals.²²⁵ While there are complications related to childbirth that make C-sections necessary, the overutilization results in increased harm to mothers due to the risk of complications. In fact, over 20,000 U.S. women experience complications from C-sections annually.²²⁶

2. The Physiological Model of Childbirth

The physiological model of childbirth, which is complementary to the medical model, may take a few different forms including midwifery care in a hospital setting, midwifery care in a birth center or in the home, and community-led and community-based perinatal health worker groups. Doula support can occur in any of these settings. Ideally, a midwife and doula are available for support for any low-risk pregnancy, referred to here as integrative maternal care. Moreover, women, and especially women of color, are increasingly demanding access to integrated maternal care.

a. Midwifery Hospital Care

Most midwives attend births in hospitals.²²⁷ Hospital-based midwives have access to and can use epidural analgesia and other technologies not available in birth centers and at home, according to the birthing person's needs and preferences.²²⁸ Operating within the hospital arena, hospital-based midwives utilize more interventions than midwives practicing in birth centers and at home.²²⁹ States, as well as individual

²²⁰ World Health Organization, *Appropriate Technology for Birth*, 326 *Lancet* 403, 437 (1985); Brown, *supra* note 2, at 9.

²²¹ Brown, *supra* note 2, at 10.

²²² *Id.*

²²³ *Id.* at 9-10.

²²⁴ Florida Department of Health, *AHCA and FDOH Recognize 19 Hospitals in Florida for Achieving the Healthy People 2020 Low-risk, Primary C-section Goal* (October 25, 2019), available at <https://www.floridahealth.gov/newsroom/2019/10/102519-ahca-and-fdoh-recognize-19-hospitals-in-florida-for-achieving-the-healthy-people-2020-lowrisk-primary-csection-goal.pr.html>.

²²⁵ Brown, *supra* note 2, at 10.

²²⁶ *Id.*

²²⁷ NPWF, *supra* note 4, at 23.

²²⁸ *Id.*

²²⁹ *Id.*

hospitals, that more fully integrated midwifery care into hospital settings had better maternal and infant health outcomes.²³⁰

b. Midwifery Community Birth

Collectively, birthing centers and midwife-facilitated home birth are referred to as “community birth.”²³¹ Community birth is not appropriate for medically high-risk pregnancies requiring specialized care, a small proportion of all births.²³² Community births represent a very small, but rapidly growing fraction of births in the U.S., with rates rising by 85% between 2004 to 2017.²³³ Moreover, the COVID-19 pandemic spurred an increase in community birth.²³⁴

A birthing center is a non-hospital facility where midwives provide prenatal, labor and delivery, postpartum, and well-woman and newborn care.²³⁵ Often, these centers have a supervising or partnering obstetrician to whom midwives refer patients who need surgical or advanced medical care, and patients may be transferred to hospitals when deemed necessary.²³⁶ Birthing centers differ fundamentally from hospital settings in that the care is, by design, more home-like (with many operating out of converted homes).²³⁷ Further, care provided in the two settings is also quite different, with community visits generally much longer.²³⁸ This allows the patient more time to build relationships with and trust with their healthcare providers and to receive more support and education. Moreover, birthing centers offer additional care options not offered in hospitals.²³⁹ If needed, midwives manage first-line complications and consult or transport to the hospital as appropriate.²⁴⁰

Home birth both contrasts notably with hospital care and shares similarities with birthing center births. Eighty-five percent of home births are planned.²⁴¹ Given the familiarity with and control over one’s surroundings, home births provide maximum freedom and autonomy for physiological birth.²⁴² Midwives bring the needed tools and supplies to provide care.²⁴³ Researchers found community birth and hospital birth are equally safe in integrated systems with seamless transfer, ongoing risk assessment, and the proper selection for eligible and well-qualified providers.²⁴⁴ Moreover, community birth offers

²³⁰ *Id.* at 25. More integrated states, as measured by numerous indicators including the regulation of and the Medicaid reimbursement of midwifery services, and the degree to which regulations allow them to practice autonomously, were more likely to report higher rates of physiologic childbearing, lower rates of cesarean and other obstetric interventions, lower risk of adverse newborn outcomes, and increased breastfeeding postpartum. *Id.* Similarly, the availability of midwifery care at the hospital level has been associated with reduced rates of labor induction, medication to speed labor, and cesarean birth, and greater rates of vaginal birth, including vaginal birth after a cesarean, than hospitals with physician-only maternity services. *Id.*

²³¹ NPWF, *supra* note 4, at 32.

²³² *Id.*

²³³ *Id.* at 33.

²³⁴ *Id.* at 34.

²³⁵ Brown, *supra* note 2, at 15.

²³⁶ *Id.*

²³⁷ NPWF, *supra* note 4, at 32.

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ *Id.* at 33. The National Academic of Sciences, Engineering and Medicine’s “Birth Settings in America” report comprehensively details practices and precautions. *Id.*

²⁴¹ NPWF, *supra* note 4, at 38.

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.*

additional benefits to birthing people of color, allowing them to receive racially and culturally congruent care and avoid institutional racism regularly reported in connection with hospital care.²⁴⁵

c. Community Perinatal Health Worker Groups

Community-led or -based perinatal health worker groups are a newer, hybrid model of care that provides a wide range of birthing options, including a combination of midwifery care, community birth settings, and doula support, through the pre-partum and post-partum periods.²⁴⁶ They are often located in underserved communities and headed by women of color, and work to prioritize the community's needs and priorities, often by informally or formally assessing community members to identify unmet community needs.²⁴⁷ Accordingly, community-based perinatal health worker groups develop multi-functional programs that provide a wide range of non-clinical support services, like providing families long-term parenting support and addressing social determinants of health.²⁴⁸ Moreover, they often hire from within the community and provide workers with training to provide culturally-congruent and trauma-informed services and care.²⁴⁹ Additionally, these groups play a large role in community development, and leaders often become active in state or other jurisdictional policy development and community advocacy.²⁵⁰ Given their novelty, the effect on healthcare outcomes of community-based perinatal health worker groups has not yet been evaluated extensively enough to generate evidence-based recommendations.²⁵¹ However, given the well-studied effects of each of its respective components, their relative geographical and financial accessibility (services are typically provided on a sliding scale), and their personalized approach, we anticipate the synergistic effect of services provided and the context of their provision will result in strong outcomes.²⁵²

d. Integrated Maternal Care

Midwives and doulas together enable the provision of holistic maternal care, addressing women's physical, emotional, and needs. In fact, current medical authorities endorse the use of midwives and doulas, and ACOG has recommend increasing the number of midwives as an essential strategy to improving access to maternity care.²⁵³ ACOG provided affirmative support for doulas in their 2017 Committee Opinion Paper.²⁵⁴ This opinion was subsequently endorsed by the American College of Nurse-Midwives (ACNM).²⁵⁵ The Society for Maternal-Fetal Medicine (SMFM) and ACOG also published a joint statement highlighting the benefits of doula-supported labor.²⁵⁶ Incorporating this evidence-based, interdisciplinary team approach into maternal care will holistically help to meet families' physical, emotional, and other needs and provide individualized, respectful, trusted, relationship-based

²⁴⁵ *Id.*

²⁴⁶ *Id.* at 52.

²⁴⁷ *Id.* at 52.

²⁴⁸ *Id.* at 52.

²⁴⁹ *Id.* at 52-3.

²⁵⁰ *Id.* at 53.

²⁵¹ *Id.* at 52.

²⁵² *Id.* at 53.

²⁵³ *Id.* at 29.

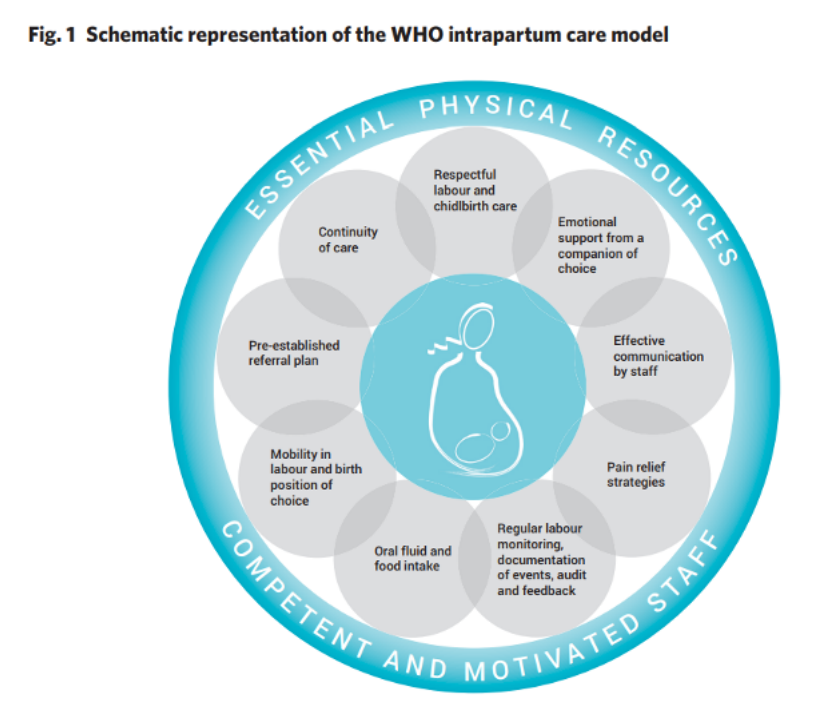
²⁵⁴ NHLP, *supra* note 184, at 4.

²⁵⁵ *Id.*

²⁵⁶ *Id.*

care that can revolutionize maternal healthcare outcomes and more generally, women’s health.²⁵⁷ This would comport with international human rights standards and WHO’s recommendations for childbirth care (See Figure 1).²⁵⁸

Fig. 1 Schematic representation of the WHO intrapartum care model



[Photo](#) Courtesy of World Health Organization

Each person involved in the care of the laboring woman has a role in improving maternal health care outcomes. Specifically, physicians focus on safety by assessing the risk of pregnancy complications and by diagnosing and treating complications if they arise.²⁵⁹ Midwives can care for and manage low-risk pregnancies through the prenatal, labor and delivery, and post-partum phases.²⁶⁰ Doulas help ensure non-medical needs are met and enhance communication between the birthing person, the family, and the healthcare staff.²⁶¹ Doulas provide continuous labor support and may help women meet their psychological, practical, and socioeconomic needs during the pre-partum and post-partum phases; even during abortions and miscarriages.²⁶² Doulas are well-versed in emotional adjustment and physical recovery and newborn development, care, and feeding. The doula’s goal is to help her client have a safe and satisfying childbirth as defined by the woman. To achieve this, doulas offer comfort measures.²⁶³ Moreover, the doula helps inform and empower the client throughout the pregnancy about their birthing options.²⁶⁴

²⁵⁷ NPWF, *supra* note 4, at 8; NHLP, *supra* note 184, at 4.

²⁵⁸ World Health Organization, *WHO recommendations: intrapartum care for a positive childbirth experience* (2018). See Figure 1: Schematic Representation of W.H.O.’s essential components of a maternal care system.

²⁵⁹ DONA, *supra* note 182, at 2.

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *Id.* at 1.

²⁶³ *Id.*

²⁶⁴ *Id.*

e. Women’s Interest in Integrated, Community Maternal Care

Currently, the demand for midwives and doulas exceeds availability.²⁶⁵ Fifty-four percent of women indicated some level of interest in midwifery care, seventeen percent indicated they “definitely wanted” midwifery care, and thirty-seven percent stated they would consider this type of care.²⁶⁶ The preferences for midwifery care were highest amongst Black women at sixty-six percent.²⁶⁷ The interest of women with Medicaid was equivalent to that of women with private insurance.²⁶⁸

3. The Maternal Medico-Legal System

The overmedicalization of childbirth is buttressed by (1) vested economic interests and Florida’s failure to utilize available federal funding to expand access to midwife and doula services; (2) the current legal framework; and (3) the lack of systemic support for and education surrounding and support of the physiological model of childbirth. Ultimately, this decreases women’s access to midwives and doulas, and decreases maternal health outcomes.

a. Economics of Childbirth

1) Childbirth Industry

In the U.S., childbirth is big business. In fact, prenatal, childbirth, and newborn care results in over \$111 billion of revenue each year.²⁶⁹ One-fifth of all healthcare expenditures in the U.S. are spent on maternity care.²⁷⁰ Economic pressures causing hospital consolidation, labor and delivery ward closures, and a shift from solo and small-practice obstetricians to large medical care facilities and hospital-based providers, has greatly influenced where and how maternity care is delivered.²⁷¹ The closure of entire maternity care wards has reduced women’s access to services and limited the options available for birth location and medical providers.²⁷² Ample research suggests that profit motives can drive clinical decision-making in hospitals and incentivize providers to recommend procedures without clear medical necessity.²⁷³

²⁶⁵ Brown, *supra* note 2, at 27.

²⁶⁶ NPWF, *supra* note 4, at 28.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ Brown, *supra* note 2, at 6.

²⁷⁰ *Id.*

²⁷¹ Kukura, *supra* note 28, at 766.

²⁷² *Id.*

²⁷³ *Id.* at 767.

Childbirth Industry Case Study: C-Sections

Organizational C-sections rates vary, and have been shown to be associated with the institutional profit orientation and the availability of increased reimbursement.²⁷⁴ Women with private, fee-for-service insurance are more likely to have C-sections than those covered by health management organizations, Medicaid or the uninsured, and risk-adjusted capitation for Medicaid patients was associated with lower cesarean rates.²⁷⁵ Moreover, for-profit hospitals are more likely to perform C-sections than not-for-profit hospitals.²⁷⁶ While high C-section rates may reflect a rational desire to maximize resources and profitability, the desire for efficiency feeds an urgency to expedite the labor and delivery process, ultimately resulting in poor maternal health outcomes, decreased patient satisfaction, and, at times, obstetric violence.²⁷⁷

2) Title V Maternal and Child Health (MCH) Block Grant Program

Florida has also failed to utilize the Title V Maternal and Child Health (MCH) Block grant to build capacity for midwife and doula services. Since 1935, the Social Security Act has administered grants to states via the Health Resources and Services Administration (HRSA) Title V MCH Block Grant.²⁷⁸ This program seeks to promote and improve the health and well-being of mothers, children, and their families via the creation of federal and state partnerships that support both access to quality health care, especially for people with low incomes and/or limited availability of care, and access to comprehensive prenatal and postnatal care for women, among other goals.²⁷⁹ States are granted flexibility to creatively use the funds to address the unique needs of their children and families.²⁸⁰ While Florida has utilized these funds to advance maternal and child health and prioritized perinatal health, none of the funds from 2021 were earmarked for expanding access to midwives and doulas, or generally, to improve the conditions surrounding childbirth.²⁸¹

b. The Legal Framework

Additionally, the existing legal framework supports the overmedicalization of childbirth and restricts access to midwives and doulas through the regulation of midwives and birthing centers, tort law, and criminal law. The legal framework surrounding childbirth gives rise to pregnancy exceptionalism, the idea that pregnancy is an exception to the principle that the state should not mandate specific health practices which are best decided between the individual and their provider.²⁸² It moreover reinforces fetal

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ NASHP, *supra* note 7, at 4.

²⁷⁹ *Id.*

²⁸⁰ *Id.* at 4.

²⁸¹ Health Resources and Service Administration, *Title V MCH Block Grant: Florida snapshot FY 2021 Application/FY 2019 Annual Report* (2020), available at <http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/title-v-mch-block-grant-fl-snapshot-fy-2021.pdf>.

²⁸² The Legal Infrastructure, *supra* note 191, at 2229.

primacy, the elevation of fetal interests over the birthing individual.²⁸³ In this framework, medical providers effectively become de facto law enforcers of hospital birth, equipped with numerous direct enforcement mechanisms.²⁸⁴ In doing so, medical providers may experience a conflict between their duty to the patient and compliance with the state law, potentially resulting in the subordination of patient health and privacy interest to state law.²⁸⁵

1) Restrictive Regulation and Licensure of Midwives, Doulas, and Birthing Centers

Florida fails to license all eligible midwives decreasing birthing individual's access to community birth. The U.S. has three nationally recognized midwifery credentials: (1) the certified nurse midwife (CNM), (2) the certified midwife (CM), and (3) the certified professional midwife (CPM). CNMs and CPMs are licensed to practice and reimbursed by Florida Medicaid.²⁸⁶ However, despite being qualified, unlike CNMs and CPMs, CMs are not legally recognized in Florida, nor reimbursed by Medicaid.²⁸⁷ Florida's restriction of CM's ability to practice in Florida decreases the number of midwives and unnecessarily restricts women's access to care options where often no services exist. Florida's restrictive licensure regime unduly decreases the number of midwives and unnecessarily restricts women's access to care options where often no services exist. Ultimately, women wanting community birth are forced to have birth in a hospital or find a midwife outside of the legal system.²⁸⁸ Nationally, the lack of access to midwives has also led to an increased demand for underground midwives willing to serve, who risking persecution in doing so.²⁸⁹

Midwifery and birthing centers are tightly regulated by law, with the result of restricting

women's birthing options. Florida, for instance, requires midwives to have physician supervision or written collaborative agreements with a physician every year to "perform acts of diagnosis, treatment, and operation."²⁹⁰ While collaboration between midwives and physicians may have an important purpose, the need for signed collaborative agreements between physicians and midwives has been opposed by key industry stakeholders, including the American College of Nurse Midwives (ACNM) and the National Council of State Boards of Nursing (NCSB).²⁹¹ These organizations oppose the signed collaborative agreement as a condition for licensure, reimbursement, hospital credentialing, clinical privileging, or prescriptive authority and emphasize that CNMs should be able to practice to the full extent of their education, training, and license, and that these requirements are overly burdensome and inefficient.²⁹² The Standards for the Practice of Midwifery dictate that midwifery care is based upon written practice guidelines that include consultation with, collaboration with, and referral to physicians, but the Standards do not require signed collaborative agreements.²⁹³ States without signed collaborative practice agreements more

²⁸³ *Id.* at 2230.

²⁸⁴ *Id.* at 2231-32.

²⁸⁵ *Id.* at 2232.

²⁸⁶ § 467, Fla. Stat. (2021); Fla. Admin. Code R. 64B24.

²⁸⁷ *Id.*

²⁸⁸ The Legal Infrastructure, *supra* note 191, at 2222-23.

²⁸⁹ *Id.*

²⁹⁰ 464.012(3), Fla. Stat. (2021); <https://floridasnursing.gov/standards-for-protocols-physicians-and-amps/>.

²⁹¹ Midwife Schooling, *States that Allow CNMs to Practice and Prescribe Independently vs those that Require a Collaborative Agreement* (2023), available at <https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states/#florida>.

²⁹² *Id.*

²⁹³ *Id.*

effectively facilitate relationships between healthcare professionals, allowing nurse-midwives and physicians to collaborate while still providing quality care that falls within their scope of practice.²⁹⁴

State law and regulations further impede the physiological model of childbirth. While state law prevents vaginal birth after C-section (VBAC) within birthing centers, it allows for VBAC at a homebirth.²⁹⁵ While VBAC is undoubtedly a relatively complicated clinical decision due to the relatively increased risk of complication, attempted VBAC results in a successful vaginal birth nearly 90% of the time.²⁹⁶ Many women are willing to accept the increased risk, particularly those who had a previous negative hospital experience.²⁹⁷ Thus, Florida's banning of VBAC in community birth settings restricts women's autonomy. Similarly, Florida's prohibition of midwifery care for women carrying multiples should be revisited to ensure autonomy is maximized while still preserving the public health.²⁹⁸ Ultimately, restrictive regulations result from and complicate the fact that midwives are often constrained by unequal power relations within healthcare systems, cultural isolation, unsafe accommodation, and low salaries and/or reimbursement rates.²⁹⁹

Birth centers have also systemically been excluded from the maternal care marketplace. A 2014 American Association of Birth Centers (AABC) report details the practices that have limited birth centers from the marketplace: (1) regulatory schemes that present significant barriers of entry into the marketplace and limit the scope of the services, (2) the organized efforts of hospital and physician groups to oppose birth centers, and (3) the exclusion of birth centers and midwives from participating in MCO provider panels by independent practice associations, health maintenance organizations, and the accountable care organizations.³⁰⁰ Moreover, hospitals, due to their direct competition with birthing centers, often are unwilling to enter into transfer or transport agreements with birthing centers.³⁰¹ Targeted regulation of birthing centers also prevents their proper utilization. While ACOG released guidelines dictating VBAC should be the patient's decision after informed consent in 2010, in the same year, Florida passed a law prohibiting women seeking VBAC from giving birth at a birth center.³⁰² These industry practices and regulations significantly reduce women's access to birth centers.³⁰³

²⁹⁴ *Id.*

²⁹⁵ The Birth Center of St. Pete, *Frequently Asked Questions* (2023), available at <https://www.bcofstpete.com/faqs>.

²⁹⁶ Cheyney et. al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, *J Midwifery & Women's Health* 59(1): 17, 18 (2014).

²⁹⁷ The Legal Infrastructure, *supra* note 191, at 2226.

²⁹⁸ The Birth Center of St. Pete, *supra* note 298.

²⁹⁹ World Health Organization, International Confederation of Midwives, and White Ribbon Alliance (WRA), *Midwives' Voices, Midwives Realities*, 2 (2016), available at http://www.who.int/maternal_child_adolescent/documents/midwives-voices-realities/en/.

³⁰⁰ Brown, *supra* note 2, at 15.

³⁰¹ *Id.*

³⁰² Isabella Chan, Emily Bronson, and Allison Cantor, *Vaginal Birth after Cesarean Section: Provider Perspectives and Maternal Decision Making*, *Florida Public Health Review* 12, 42 (2015); Fla. Admin. Code 59A-11.009(4) (2021).

³⁰³ Brown, *supra* note 2, at 16.

2) Tort Law

Tort law distorts childbirth by restricting the choice of birthing options for expecting mothers through its creation of a narrow standard of care, causing physicians to practice defensive medicine and providing legal and economic incentive to prioritize the fetus's safety over the birthing woman's.³⁰⁴ It also fails to hold OBs to an adequate standard for informed consent.³⁰⁵

Tort law enforces a narrow standard of care, restricting options available for expecting mothers.³⁰⁶ A medical malpractice negligence claim requires showing a violation of the relevant standard of care (SOC).³⁰⁷ Notably, only departing from the SOC—determined most typically by a physician medical expert that testifies to the prevailing national SOC—is a breach.³⁰⁸ However, the tort SOC is determined by physician custom, which is influenced by society's power dynamics between physicians and other healthcare childbirth providers.³⁰⁹ Due to the dominance of the medical model, physician's custom often dictates hospital birth despite community birth being a safe and cost-effective alternative.³¹⁰ Thus, tort law fails to uphold the practice of evidence-based medicine in childbirth.

The threat of malpractice liability leads physicians to practice defensive medicine—the usage of unwanted, unconsented, or non-evidence-based interventions to prevent the risk of a health outcome that will result in a malpractice claim.³¹¹ Obstetricians are sued more often than any other medical specialty; accounting for three-fourths of all malpractice insurance losses, with an average payment amount to the plaintiff of over \$1.1 million dollars.³¹² More than 75% of obstetricians in the U.S. have been sued at least once, and over half have faced three or more malpractice claims.³¹³ Further, 64% of obstetricians admitted making changes to their medical practice due to fears of medical malpractice claims, according to an ACOG survey.³¹⁴ Given the high frequency of claims, exorbitant malpractice premiums and the associated fear, obstetricians often practice defensive medicine.³¹⁵ In childbirth, this causes OBs to recommend women with low-risk pregnancies have a hospital birth out of fear of the rare case that complications occur if she chooses community birth.³¹⁶ Moreover, healthcare providers liability, and thus pass guidelines and institutional policies that restrict women's choice about delivery.³¹⁷

Tort law further elevates fetal primacy, increasing pressure on women to have a hospital birth.³¹⁸ Currently, the fetus is the dominant putative plaintiff in modern tort law.³¹⁹ While harms to the birthing person are both rare and small in magnitude, awards for damages for fetal harm are both more frequent

³⁰⁴ The Legal Infrastructure, *supra* note 191, at 2214.

³⁰⁵ *Id.* at 2220.

³⁰⁶ *Id.* at 2214.

³⁰⁷ *Id.*

³⁰⁸ *Id.*

³⁰⁹ *Id.* at 2215.

³¹⁰ *Id.*

³¹¹ Kukura, *supra* note 28, at 771.

³¹² *Id.*

³¹³ *Id.*

³¹⁴ *Id.* at 774.

³¹⁵ *Id.* at 772.

³¹⁶ *Id.*

³¹⁷ Farah Diaz-Tello, *Invisible Wounds: obstetric violence in the United States*, *Reproductive Health Matters*, 24, 60 (2016).

³¹⁸ The Legal Infrastructure, *supra* note 191, at 2210.

³¹⁹ *Id.* at 2215.

and larger in magnitude, at times with up to eight figure awards.³²⁰ Worse, courts appear to even treat pregnant persons' injuries as an acceptable harm to deliver a healthy baby, a phenomenon coined "maternal sacrifice."³²¹ This disparity in treatment and awards leads to distortions in medical care that incentivizes providers to dissuade women from having a community birth to limit their legal liability related to fetal harm.³²²

Insufficient informed consent also contributes to obstetric violence.³²³ Florida tort law fails to uphold truly informed consent.³²⁴ A physician must obtain consent prior to performing any medical procedure, with the law recognizing the disparities in power, knowledge and expertise between provider and patient.³²⁵ Florida, like other states, requires that physicians must disclose the material risks, benefits, and *alternatives to treatment*.³²⁶ However, this rarely occurs in the childbirth setting as women are often not informed of their other birthing options and of all the risks associated with hospital birth.³²⁷ Courts often dictate informed consent was sufficient, even when true informed consent never occurs.³²⁸ Florida's informed consent law is also problematic because the threat of liability, combined with fetal primacy, may cause providers to exaggerate or to misrepresent fetal risk level in their communications with patients and stress the importance of the more precautionous hospital birth.³²⁹ This pressure, sometimes involving obstetric violence, can cause women to accept hospital birth and related procedures against their will.³³⁰

In some cases, courts have gone so far as to dictate that patients' requests be overridden and enforce compliance with the prescribed hospital birth by court order.³³¹ In *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, while attempting to deliver vaginally at her home after physicians refused to deliver without a C-section, a Florida woman was seized from her home by law enforcement officers via court order.³³² The doctors had refused to assist a vaginal birth because Pemberton's prior C-section used a vertical incision instead of the more common horizontal incision, that was associated with an increased risk of uterine rupture.³³³ Studies since have shown no such increased risk.³³⁴ She was brought to a hospital, where a C-section was involuntarily performed.³³⁵ Demonstrating fetal primacy, the U.S. North District of Florida court held that "whatever the scope of Ms. Pemberton's personal constitutional rights, they did not outweigh the interest of the State. . .in preserving the life of the unborn child."³³⁶ A more

³²⁰ *Id.*

³²¹ *Id.*

³²² *Id.*

³²³ *Id.* at 2220.

³²⁴ *Id.* at 2214.

³²⁵ Kukura, *supra* note 28, at 779; The Legal Infrastructure, *supra* note 191, at 2215.

³²⁶ § 766.103, Fla. Stat. (2021); The Legal Infrastructure, *supra* note 191, at 2215; Kukura, *supra* note 28, at 780.

³²⁷ The Legal Infrastructure, *supra* note 191, at 2216.

³²⁸ See § 766.103, Fla. Stat. (2021). Florida adopts the reasonable person standard, and thus, the informed consent determinations turns on whether "a reasonable individual, from the information provided by the physician would have understood and consented given the information provided." § 766.103, Fla. Stat. (2021). Florida law makes it harder to win an informed consent case by providing that even if a jury concludes that the physician did not give the patient the information he should have, the jury should decide in the doctor's favor if the jury believes that the patient would have consented even if the patient had been given all the information. § 766.103, Fla. Stat. (2021). However, this is unhelpful for women who were not able to choose community birth because under the reasonable person standard, determinations become nearly entirely shaped by what most women do, and most birthing individuals rely on physician-driven decision-making that nearly always results in hospital birth.

³²⁹ The Legal Infrastructure, *supra* note 191, at 2216.

³³⁰ *Id.* at 2216.

³³¹ *Id.* at 2217.

³³² *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999).

³³³ *Id.*

³³⁴ The Legal Infrastructure, *supra* note 191, at 2217, footnote 74.

³³⁵ *Pemberton.*, 66 F. Supp. 2d at 1249.

³³⁶ *Id.* at 1251.

recent case outlined Florida’s test in these scenarios: “[t]he test to overcome a woman’s right to refuse medical intervention in her pregnancy is whether the state’s compelling state interest is sufficient to override the pregnant woman’s constitutional right to the control of her person, including her right to refuse medical treatment.”³³⁷ Court-mandated hospital birth directly restricts women’s ability to choose community birth. Further, a court order mandating hospital birth is just one tool providers have used to get force an unwanted hospital birth. Other methods include: (1) terminating care for the pregnant women, and (2) threatening to take children away via child protective services or court orders.³³⁸

3) Fetal Homicide Laws for Pregnant Women and Midwives

In addition to the inadequacies of the tort legal framework, a pregnant woman’s pressure to comply with a physician’s order is further heightened by fetal homicide laws. Florida law dictates that anyone who commits a criminal offense (i.e., violating a court order) that “causes bodily injury to or the death of an unborn child commits a separate offense.”³³⁹ Florida defines the unborn child as “a member of the species *Homo sapiens*, at any stage of development, whom is carried within the womb.”³⁴⁰ This has hurt women’s ability to make more conservative choices when considering birthing options to avoid criminal repercussions.³⁴¹ These statutes have led to the potential persecution of women if they suffer a miscarriage.³⁴² Midwives may also be sentenced to prison for fetal demise.³⁴³ Consequently, Florida’s fetal homicide laws also impact a pregnant woman’s right to choose childbirth interventions, especially during the final stages of pregnancy and birth.³⁴⁴

4) Insurance Coverage, Reimbursement, and Network Adequacy

Midwives and doulas are also burdened by challenges with inadequate insurance coverage and reimbursement. Inadequate insurance reimbursement for midwives creates insurmountable financial barriers for both

providers and underserved individuals.³⁴⁵ States that have laws mandating insurance coverage for midwifery services have found higher proportions of midwife-attended births.³⁴⁶ While Florida is one of the few states that mandates health

³³⁷ *Burton v. State*, 49 So. 3d 263, 266 (Fla. Dist. Ct. App. 2010).

³³⁸ The Legal Infrastructure, *supra* note 191, at 2220.

³³⁹ § 775.021, Fla. Stat. (2021).

³⁴⁰ § 775.021(5)(e), Fla. Stat. (2021).

³⁴¹ Erin K. Duncan, *The United States’ Maternal Care Crisis: A Human Rights Solution*, 93 OR. L. REV. 403, 427 (2014).

³⁴² *Id.* at 427.

³⁴³ Brown, *supra* note 2, at 21.

³⁴⁴ Duncan, *supra* note 346, at 428.

³⁴⁵ NPWF, *supra* note 4, at 38.

³⁴⁶ Brittany Ranchoff and Eugene R. Declercq, *The Scope of Midwifery Practice Regulations and the Availability of the Certified Nurse-Midwifery and Certified Midwifery Workforce, 2012-2016*, *Journal of Midwifery Women’s Health* 65, 119, 120 (2020).

insurers' plans must cover midwifery services and prohibits the outright ban of community births, ultimately the law allows insurers significant latitude.³⁴⁷ First, coverage of midwifery services is mandated for low-risk pregnancies, a provision that can result in non-evidence-based restrictions.³⁴⁸ Provided there is a sufficient review process, an insurance provider can rely on this section to deny coverage of midwifery services.³⁴⁹ In 2017, while just 3% of hospital births were paid out of pocket, 68% of home births were paid out of pocket.³⁵⁰ Moreover, reimbursement is discretionary and low, and payment of CPM services and for midwives practicing in community settings by private insurance and Medicaid is uneven.³⁵¹ In some instances, Medicaid reimbursements are so low that

midwives and birthing centers often struggle to remain financially viable.³⁵² Florida also places unnecessary restraints on the number of prenatal visits covered, covering only 10 visits, despite birthing centers consistent calling for a standard of at least 14 visits.³⁵³ Lastly, Florida requires midwives to carry malpractice insurance with expensive premiums that further decrease the financial viability of midwifery practice.³⁵⁴

Further, Florida managed care organizations (MCOs) routinely fail to provide sufficient information about accessing midwives, despite legal requirements to do so. To satisfy both federal and state law, an MCO must: (1) maintain an accurate and complete online provider directory, and (2) maintain a region-wide network

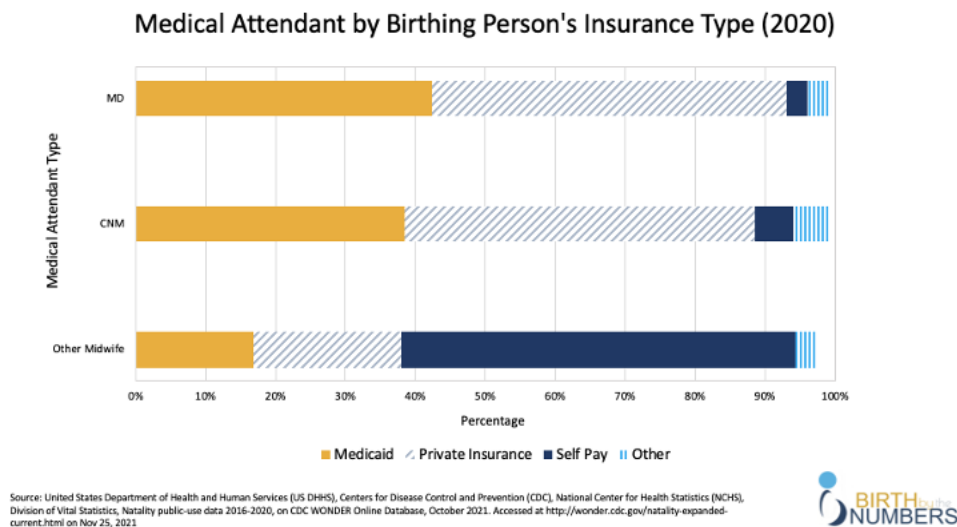


Photo Courtesy of Birth by the Numbers

³⁴⁷ § 627.6754(7)(1), Fla. Stat. (2021); <https://www.magnoliabirthhouse.com/cost-of-childbirth>.

³⁴⁸ *Id.* Florida law dictates that “[a]ny group, blanket, or franchise policy of health insurance that provides coverage for maternity care must also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.335.” § 627.6754(7)(1), Fla. Stat. (2021). It further prohibits insurance coverage from limiting the length of a maternity and newborn stay in a hospital or coverage for postdelivery care and dictates practitioners to follow the perinatal care guidelines of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists, by the treating obstetrical care provider or the pediatric care provider. § 627.6754 (2), Fla. Stat. (2021); § 627.6754(4), Fla. Stat. (2021). However, significantly, Florida also states “[t]his section *does not affect any agreement between an insurer and a hospital or other health care provider* with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this *section does not prohibit appropriate utilization review or case management by an insurer*[:]” ultimately giving the insurance more discretion on their maternal care coverage as long as there is a sufficient review. § 627.6754(3), Fla. Stat. (2021).

³⁴⁹ § 627.6754(3), Fla. Stat. (2021).

³⁵⁰ NPWF, *supra* note 4, at 38.

³⁵¹ *Id.*

³⁵² *Id.*

³⁵³ Brigitte Courtot, Ian Hill, Caitlin Cross-Barnet, and Jenny Markell, *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*, *Milbank Q.* 98(4): 1091, 1113 (2020).

³⁵⁴ O.M. Campbell, *Rural Health Quarterly, Might Midwives Help Fill Rural Maternity Care Gaps?* (2018), available at <https://ruralhealthquarterly.com/home/2018/07/09/might-midwives-help-fill-rural-maternity-care-gaps/>. The cost can be high — a fifth-year midwife working in Miami could pay \$30,000 a year for \$250,000 in coverage. <https://www.insurancejournal.com/news/southeast/2009/02/24/98080.htm>.

of providers in sufficient numbers to meet the network capacity and geographic access standards for services.³⁵⁵ However, a survey of Miami-Dade County found that many Medicaid managed care organizations (MMCOs) were violating these network adequacy standards.³⁵⁶ Only 45% of the midwifery facilities listed could be reached.³⁵⁷ Moreover, just 27% of midwives were accepting new patients.³⁵⁸ Furthermore, only 44% of midwives were in the plan's network.³⁵⁹ Accordingly, even when midwives are covered, patients may struggle to identify midwives whose services they can access.

Access to doula services is also subject to numerous payment barriers. Very few private insurers reimburse for doulas services, and when covered, payment often occurs retroactively after the patient has paid out-of-pocket.³⁶⁰ Accordingly, most clients must pay up front, with doula charges ranging widely.³⁶¹ Grant funding for doulas services is rarely available.³⁶² Subsequently, the most vulnerable and underserved populations often cannot afford to pay for doula care and trained professional doulas are often forced to volunteer or to waive fees to work with low-income women.³⁶³

No state mandate requires coverage of doula services by private insurers or Medicaid. Similar, but less burdens exists in the MMCO arena. While the Affordable Care Act mandates the coverage of maternal care services, it leaves states to have discretion of essential health benefits services covered; these are listed in states' benchmark plans.³⁶⁴ Yet, no state benchmark plan explicitly included coverage for doula services (or home births), including Florida.³⁶⁵ Florida's Agency for Healthcare Administration (AHCA) has included doula care as an expanded benefit that MMCO plans *can* include.³⁶⁶ Yet, while each MMCO has stated that it will cover doula services, the reality, according to Florida midwives and doulas, is a patchwork of different approaches with rates and requirements varying wildly across payers.³⁶⁷

Doula coverage is further complicated because doulas are not licensed providers. However, currently there are no formal mandatory licensure, certification, or accreditation requirements for doulas in the U.S.; despite over 100 independent organizations offering some form of doula training and certification.³⁶⁸ Accordingly, unlike midwives who have numerous credential mechanisms, doulas' lack of an official licensure or credentialing process creates considerable variability in the approach payers may take to coverage of doula services.³⁶⁹

³⁵⁵ § 409.967(2), Fla. Stat. (1973); 42 C.F.R. 438.68.

³⁵⁶ Florida Health Justice Project (FHJP), *Access to Midwifery Services*, 1, 10 (2020).

³⁵⁷ Florida Health Justice Project (FHJP), *supra* note 361, at 10.

³⁵⁸ *Id.* at 10.

³⁵⁹ *Id.* at 10.

³⁶⁰ NHLP, *supra* note 184, at 11.

³⁶¹ NHLP, *supra* note 184, at 11; DONA, *supra* note 182, at 4.

³⁶² DONA, *supra* note 182, at 4.

³⁶³ NHLP, *supra* note 184, at 2, 11.

³⁶⁴ Nora Ellmann and Jamille Fields Allsbrook, Center for American Progress, *States' Essential Health Benefits Coverage Could Advance Maternal Health Equity* (April 30, 2021), available at <https://www.americanprogress.org/article/states-essential-health-benefits-coverage-advance-maternal-health-equity/>.

³⁶⁵ *Id.*

³⁶⁶ Doula Series Footnotes, *Medicaid coverage of doula services in the United States* (2023), available at <https://doulaseriesfootnotes.com/national-overview.html>.

³⁶⁷ DONA, *supra* note 182, at 4; NHLP, *supra* note 184, at 11.

³⁶⁸ NHLP, *supra* note 184, at 6.

³⁶⁹ *Id.*

c. The Lack of Systemic Support for and Education on Midwives and Doulas

The lack of consistent, systemic support limits the supply of midwives and doulas.³⁷⁰ While Medicare provides funding for physician residency programs, for instance, midwives receive no comparable support.³⁷¹ This elevates costs for midwifery programs and increases tuition for midwifery students.³⁷² Consequently, there is a shortage of midwife educators to share their knowledge and approaches to maternal-newborn care with medical students and trainees, and nursing and other students.³⁷³ The Further Consolidated Appropriations Act of 2020 included \$2.5 million for this purpose, and included equity framing.³⁷⁴

The lack of awareness by healthcare providers and the general public of the services provided by both midwives and doulas also impedes their widespread utilization.³⁷⁵ As a result, distorted policy benefits doctors over consumers.³⁷⁶

³⁷⁰ NPWF, *supra* note 4, at 29.

³⁷¹ *Id.*

³⁷² *Id.*

³⁷³ *Id.*

³⁷⁴ *Id.*

³⁷⁵ NHLP, *supra* note 184, at 3.

³⁷⁶ Brown, *supra* note 2, at 14.

III. HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

The current laws and policies in Florida that perpetuate the maternal and infant health crisis are in violation of international human rights standards. This includes the fundamental rights to life and health, equality and nondiscrimination, physical integrity, and special protections for motherhood and childhood. In order to comply with international human rights law, Florida should adopt policy changes which address and minimize the impact of the maternal and infant health crisis. In this analysis, this section draws on the following key instruments for the basis of international human rights laws:

- The International Covenant on Civil and Political Rights (ICCPR), International Convention on Elimination of all Forms of Racial Discrimination (ICERD), and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). By ratifying these treaties, the U.S. is legally bound to implement them.³⁷⁷
- The Universal Declaration of Human Rights (UDHR), the foundational document of the human rights system; although the UDHR is not a treaty but a declaration, it has crucial normative status, as well as at least parts of it are customary international law.³⁷⁸
- The International Convention on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Convention on the Rights of the Child (CRC), which the U.S. has signed, but not yet ratified. While these treaties are not binding on the U.S., and it need not take any positive steps to comply with them, as a signatory, the U.S. is obligated to refrain from acts which would defeat their objective and purpose.³⁷⁹ Additionally, Miami-Dade County has joined the “Cities for CEDAW” movement³⁸⁰, and adopted an ordinance in 2015 aiming to “locally adopt the spirit underlying the principles of CEDAW.”³⁸¹
- The Constitution of the World Health Organization (WHO).

A. Rights to Health and Life

Florida policy fails to provide critical maternal and infant care in direct violation of the rights to health and life. ICESCR recognizes the right to enjoy the “highest attainable standard of physical

and mental health.”³⁸² The Committee on Economic, Social, and Cultural Rights (CESCR), responsible for monitoring implementation of the ICESCR, explains that the right to health

³⁷⁷ See Mariah McGill and Gillian MacNaughton, *The Struggle to Achieve the Human Right to Health Care in the United States*, 25 S. CAL. Interdisc. L.J. 625, 635 (2016). However, upon ratification the U.S. entered a declaration that the treaties are not self-executing, meaning they do on their own create a private right of action enforceable in U.S. courts. Catherine Powell, *Dialogic Federalism, Constitutional Possibilities for Incorporation of Human Rights Law in the United States*, 150 U. Pa. L. Rev. 245, 258–259 (2001). Nonetheless, they are legally binding and can be used by courts as an aid in interpretation, as well as in other advocacy. *Id.*

³⁷⁸ Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 Ga. J. Int'l & Comp. L. 287, 289 (1996).

³⁷⁹ Multilateral. Vienna Convention on the Law of Treaties. May 23, 1969, Article 18(a).

³⁸⁰ “Cities for CEDAW is a nationwide, grassroots effort to encourage local governments to support the [CEDAW] by way of local government proclamations, resolutions, and ordinances while at the same time lifting up the need to ratify the international women’s rights treaty.” United Nations Association of the United States of America, *Cities for CEDAW: Promoting Women’s Equality in Your Community Guidelines and Toolkit* (2021), available at <https://unausa.org/wp-content/uploads/2021/06/UNAWomenCEDAWToolkit.pdf?emci=05d81494-9cbc-eb11-a7ad-501ac57b8fa7&emdi=4a713dd8-70c5-eb11-a7ad-501ac57b8fa7&ceid=2749364#:~:text=Cities%20for%20CEDAW%20is%20a,need%20to%20ratify%20the%20international>.

³⁸¹ Women’s Intercultural Network, *About Us: Cities for CEDAW*, available at <http://citiesforcedaw.org/about-cedaw/>.

³⁸² International Covenant on Economic, Social, and Cultural Rights art. 12, signed Oct. 05, 1977, 993 U.N.T.S. 3 [hereinafter ICESCR]. Further, the UDHR acknowledges the human right “to a standard of living adequate for health and well-being” which has been understood as encompassing medical care “and the right to security in the event of sickness [and] disability.” Timothy Stoltzfus Jost, American Bar Association, *Health Care in the United States and the Affordable Care Act*, 43 HUM. Rts. (2018), available at https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/healthcare-in-us-aca/.

contains a right to healthcare that is available, accessible, acceptable, and of quality,³⁸³ as well as to the underlying determinants of health. The CRC similarly calls upon States to “recognize the right of the child to the enjoyment of the highest attainable standard of health. . . [and] to strive to ensure that no child is deprived of his or her right of access to such health care services.”³⁸⁴

Reproductive health is an integral component of the right to health under international human rights law. CESCR emphasizes “[a]ll individuals and groups should be able to enjoy equal access to the same range, quality and standard of sexual and reproductive health facilities, information, goods and services [...] without experiencing any discrimination.”³⁸⁵ Correspondingly, Article 12 of CEDAW “[r]equire[s] all health services to be consistent with the [other] human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.”³⁸⁶

Additionally, the current high rates of maternal and infant mortality violate the right to life, a core right protected in the UDHR³⁸⁷ and ICCPR.³⁸⁸ The Human Rights Committee (HRC), which monitors implementation of the ICCPR, has specifically interpreted this right to require States to “develop strategic plans for advancing the right to life by improving access to medical examinations and treatments designed to reduce maternal and infant mortality.”³⁸⁹

Moreover, in General Comment No. 36 of the ICCPR, the HRC interprets the right to life to include that “States provide effective access for women and men, and especially girls and boys, to both quality and evidence-based information and education on sexual and reproductive health.”³⁹⁰

While the ACA represents a breakthrough in the U.S. healthcare system,³⁹¹ U.S. citizens still do not fully enjoy the rights to health and life. More than a third of U.S. counties are maternity care ‘deserts,’ with no hospital maternity unit, obstetrician-gynecologists or certified nurse-midwife, causing rural expecting mothers to drive more than a half-hour to the nearest hospital for maternity services.³⁹² Moreover, Black, Latin, Indigenous, and other minorities groups face worsened outcomes and numerous barriers to accessing healthcare and to optimal care, including cultural and language barriers and institutional and individual bias.³⁹³ As a result, despite spending more money than any country, the U.S. maternal care system ranks below 59 other developed countries in maternal mortality, and this number likely represents underreporting of maternal deaths due to the lack of a comprehensive reporting and review protocol for maternal death.³⁹⁴ Moreover, the U.S. ranks thirty-third out of thirty-six developing countries in infant mortality.³⁹⁵ The ACA seeks to broaden healthcare coverage, but does not provide

³⁸³ Comm. on Econ., Soc., and Cultural Rts., General Comment No. 14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶ 12, U.N. Doc. CESCR/C/12/2000/4 (Mo. 05, 2000) [hereinafter CESCR General Comment No. 14].

³⁸⁴ Convention on the Rights of the Child art. 6, signed Feb. 16, 1995, 1577, U.N.T.S. 3 [hereinafter CRC].

³⁸⁵ Comm. on Econ., Soc., and Cultural Rts., General Comment No. 22: (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), ¶ 22, U.N. Doc. CESCR/C/12/GC/22 (Mo. 05, 2016) [hereinafter CESCR General Comment No. 22].

³⁸⁶ Convention on the Elimination of All Forms of Discrimination Against Women art. 12, signed July 17, 1980, 1249 U.N.T.S. 13 [hereinafter CEDAW].

³⁸⁷ Universal Declaration of Human Rights art. 3, G.A. Res. 217 (III) A, U.N. Doc. A/810 (Dec. 10, 1948) [hereinafter UDHR] (“Everyone has the right to life. . .”).

³⁸⁸ International Covenant on Civil and Political Rights art. 6, ratified Jun. 8, 1992, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR] (“Every human being has the inherent right to life.”).

³⁸⁹ Hum. Rts. Comm., General Comment No. 36: Article 6: right to life, ¶ 8, ¶26, U.N. Doc. CCPR/C/GC/36 (Mo. 09, 2019) [hereinafter HRC General Comment No. 36].

³⁹⁰ *Id.*

³⁹¹ Andrea Christopher and Dominic Caruso, *Promoting Health as a Human Right in the Post-ACA United States*, Am. Med. Assoc. J. of Ethics (Oct. 2015), available at <https://journalofethics.ama-assn.org/article/promoting-health-human-right-post-aca-united-states/2015-10>.

³⁹² NPWF, *supra* note 4.

³⁹³ FHJP, *supra* note 361 at 2.

³⁹⁴ Duncan, *supra* note 346, at 424.

³⁹⁵ United Health Foundation, *America’s Health Rankings, 2018 Annual Report: International Comparison* (2018), available at <https://www.americahealthrankings.org/learn/reports/2018-annual-report/findings-international-comparison>.

universal health coverage and is deliberately silent on the human rights to health and life. It instead reflects a narrow focus on insurance and the financing of healthcare.³⁹⁶ Moreover, experts predict Florida's recent six-week abortion ban will further increase maternal sickness and death, more than any other state with similar bans; many due to suicide.³⁹⁷

Moreover, Florida has failed to expand Medicaid under the ACA, which would greatly expand coverage for low-income residents, violating the rights to health and life of many mothers and infants. In Florida, too many expecting mothers lack access to key maternal services, in pre-partum, intra-partum, and post-partum, exacerbating racial, ethnic, and geographically based disparities.³⁹⁸ Without access to healthcare, Floridians lack continuous care and critical preventive measures. Continuous healthcare coverage can address preconception health risk factors which contribute to maternal mortality,³⁹⁹ and thus, these fluctuations in access to healthcare can disrupt and exacerbate existing health conditions, which ultimately increases the price tag of care delivered,⁴⁰⁰ and negatively impacts health outcomes.

In particular, the lack of access to midwives and doulas results in poor health outcomes, violating women's right to health and in some cases life.

The right to health requires quality healthcare that is evidence-based.⁴⁰¹ Evidence-based care entails a risk-based assessment of the harms and benefits for each procedure based on the best, most current evidence, giving "priority to care paths and practices that are effective and least invasive, with limited or no known harm."⁴⁰² Overmedicalized maternal care is not evidence-based. Systemic reviews, such as *Chalmer's Effective Care in Pregnancy and Childbirth*, have found that many routine obstetric practices are utilized without valid evidence of a clear benefit and nearly 25% of common hospital childbirth practices were being used with "unknown effectiveness."⁴⁰³ Moreover, systematic reviews have demonstrated the effectiveness and superior outcomes provided by hospital-based midwives, community birth, and continuous labor support.⁴⁰⁴ Community-based health workers can address non-clinic needs and provide culturally-congruent care that can dramatically improve healthcare outcomes.⁴⁰⁵ It is thus critical for women with low-risk pregnancies to have access to midwives and doulas, particularly for marginalized populations who experience increased infant and maternal morbidity and mortality.⁴⁰⁶ However, midwifery and doula services unduly benefit wealthy patients, and the lack of access to midwives and doulas is worse for marginalized populations due to cultural, socioeconomic, and geographic barriers.⁴⁰⁷

³⁹⁶ Andrea S. Christopher and Dominic Caruso, *Promoting Health as a Human Right in the Post-ACA United States*, AMA Journal of Ethics, Oct. 2015, <https://journalofethics.ama-assn.org/article/promoting-health-human-right-post-aca-united-states/2015-10>.

³⁹⁷ Elyssa Spitzer, Tracy Weitz, Maggie Jo Buchanan, The Center for American Progress, *Abortion Bans will Result in More Women Dying* (2022), available at <https://www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying/>; Regan McCarthy, National Public Radio, *Florida's abortion laws protect a pregnant person's life, but not for mental health* (2023), available at <https://www.npr.org/2023/04/19/1170553504/florida-abortion-life-of-the-mother-exception-mental-health-suicide-psychiatric>.

³⁹⁸ NPWF, *supra* note 4.

³⁹⁹ Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, Women's Health Issues 30, 3 (Feb. 25, 2020). Effective as of July 21, 2021, Florida has extended Medicaid coverage from 60 days postpartum to 12 months, this will allow for continuous access to healthcare but will not essentially close the coverage gap. Simply Healthcare Plans and Clear Health Alliance, *Medicaid postpartum coverage extension, postpartum optimization, and promoting birth equity* (June 2021), available at https://provider.simplyhealthcareplans.com/docs/gpp/FL_SMH_CHA_PU_HealthCareBillcomeseffect.pdf/.

⁴⁰⁰ Searing and Ross, *supra* note 42, at 8.

⁴⁰¹ Duncan, *supra* note 346, at 419; CESC General Comment No. 14, *supra* note 386, ¶ 43(f).

⁴⁰² Duncan, *supra* note 346, at 414.

⁴⁰³ *Id.* at 419-20.

⁴⁰⁴ NPWF, *supra* note 4. DONA, *supra* note 182, at 6.

⁴⁰⁵ NPWF, *supra* note 4.

⁴⁰⁶ Nora Ellmann, Center for American Progress, *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*, 1, 1-3 (2020).

⁴⁰⁷ *Id.* at 1-3.

The increased maternal and infant mortality experienced by women due to lacking access to key services like midwives and doulas, particularly for women of color, violates women’s right to life, the ultimate fulfillment of the right to health.⁴⁰⁸ These deaths are particularly egregious given many result from complications from medically-unnecessary interventions.⁴⁰⁹ Reducing complications from overmedicalization and promoting-evidence based maternal care inclusive of midwives and doulas will decrease maternal and infant morbidity and mortality, and

ultimately, help states fulfill women and infants’ rights to life and rights to health.⁴¹⁰

Additionally, to protect the right to health, the Florida Family Planning Medicaid Waiver Program should address both physical and mental health, core aspects of the right to health as defined by ICESCR.⁴¹¹ As such, the Waiver Program must be improved to recognize both types of health by incorporating services that support the mental health of expecting mothers. This includes counseling services to help them prepare for the mental and physical challenges that come with family planning and childbirth.

B. Right to Benefit from Scientific Progress

The overmedicalized maternal care system’s failure to properly utilize evidence-based options, like midwives and doulas, further violates the right to benefit from scientific progress. ICESCR sets out the right “[t]o enjoy the benefits of scientific progress and its applications.”⁴¹² Further, ICESCR recognizes the public must be able to enjoy benefits “from the encouragement and development of international contacts and co-operation in the scientific and cultural fields.”⁴¹³ The Special Rapporteur on Cultural Rights details this right is to be “understood as a right to be introduced to and informed about main scientific discoveries and their applications, regardless of frontiers[,]” “entails education instilling a spirit of scientific inquiry[,]” and must include “opportunities for all to contribute to the scientific enterprise[.]”⁴¹⁴ The report also details that “innovations essential for a life with dignity should be accessible to everyone, in particular marginalized populations.”⁴¹⁵ The right to science is a prerequisite for the realization of a number of other human rights and fundamentally link to the enjoyment of other human rights, including the right to health.⁴¹⁶ In recognizing this right, States have an obligation to take the steps necessary for the conservation, development, and diffusion of science.⁴¹⁷

Our overmedicalized maternal care system fails to objectively balance the benefits of hospital births with the benefits of the equally effective and less invasive community birth options like midwives and doulas.⁴¹⁸ The overmedicalization of maternal care is not evidence-based, but rather the result of

⁴⁰⁸ Duncan, *supra* note 346, at 423-24.

⁴⁰⁹ *Id.* at 425.

⁴¹⁰ *Id.*

⁴¹¹ Timothy Stoltzfus Jost, *Health Care in the United States and the Affordable Care Act*, 43 HUM. Rts. 60 (2018).

⁴¹² ICESCR, *supra* note 385, art. 15(1)(b). Accordingly, states must take all the steps necessary to facilitate “the development and the diffusion of science and culture” and “to respect the freedom indispensable from scientific research[.]” ICESCR, art. 15(2).

⁴¹³ ICESCR, *supra* note 385, art. 15(4).

⁴¹⁴ Hum. Rts. Council, Report of the Special Rapporteur in the field of cultural rights, ¶ 25-27, U.N. Doc. A/HRC/20/26 (2012) [hereinafter Special Rapporteur on cultural rights].

⁴¹⁵ Hum. Rts. Council, *supra* note 108, ¶ 29.

⁴¹⁶ Hum. Rts. Council, *supra* note 108, ¶ 23.

⁴¹⁷ Hum. Rts. Council, *supra* note 108, ¶ 45. Conservation refers to the identification and safeguarding of scientific knowledge. Development demands an explicit commitment to the development of science and technology for human benefit, typically by adopting programs that support and strengthen publicly funded research, developing partnerships with private enterprises, and promoting freedom of scientific research. Diffusion encompasses the dissemination of scientific knowledge and applications both within the scientific community and in society at large, and it is a prerequisite to public participation in decision-making, another important human right. Hum. Rts. Council, *supra* note 108, ¶ 45-48.

⁴¹⁸ Duncan, *supra* note 346, at 414, 419.

commercialization, effective lobbying, and the associated medicolegal framework. The right to benefit from scientific progress requires reevaluation of past medical practices for safety and the evaluation of new, promising alternatives, such as the community-based perinatal health worker groups, to ensure optimal care.⁴¹⁹ Indeed, strong empirical evidence indicates many routine obstetric practices are used without evidence of a clear benefit.⁴²⁰ Moreover, strong empirical evidence indicates midwife- and doula-assisted births provide equivalent safety to physician-assisted birth, while also providing more culturally-congruent and holistic maternal care.⁴²¹ These scientific efforts should be embraced by the medical community and public at large. Florida should draw on scientific evidence from the numerous countries that have effectively utilized midwives and doulas to deliver maternal care and to expand the maternal workforce.⁴²² The recognition of the value of midwives and doulas in the U.S. maternal care system will also help eliminate barriers to the provision of maternal care for underserved populations.⁴²³

C. Right to Work

The restrictive regulations on midwives and birthing centers, the lack of regulatory provisions and licensure trainings for doulas, and the excess power of physicians in hospitals over midwives violate the right to work.⁴²⁴ To enable a person to live with dignity, both the UDHR and ICESCR have provisions that guarantee “the right to work, to free employment, to just and favourable conditions of work and to protection against unemployment.”⁴²⁵ ICESCR Article 6(2) dictates that “the full realization of this right shall include technical and vocational guidance and training programmes” and States must take the appropriate steps to ensure the full realization for all to gain their living by work which they “freely choose[] or accept.”⁴²⁶ Accordingly, the right to work not only guarantees the opportunity to work, but also takes account of a person’s preference in how to earn a living. A UN Working Group report on discrimination against women and girls interpreted this provision to call on States to “[e]nsure the safety and decent working conditions of health-care workers in local communities, including midwives [and doulas], at all times and especially in situations of crisis, while promoting midwifery and other forms of community-based care and support.”⁴²⁷ Furthermore, during the COVID-19 pandemic, due to an uptick in the need for community birthing options, the UN-sponsored Partnership for Maternal, Newborn & Child Health (PMNCH) released information on the important role of midwives and the need to support them to provide quality maternal care.⁴²⁸

⁴¹⁹ *Id.* at 438.

⁴²⁰ *Id.* at 419-20.

⁴²¹ NPWF, *supra* note 4; DONA, *supra* note 184, at 6.

⁴²² In comparison, in Belgium, Denmark, Finland, France, Germany, Great Britain, Netherlands, Norway, and Sweden, where maternal and infant mortality rates are lower than the U.S., 75% of women had a midwife-assisted hospital birth, and for low-risk pregnancies, midwives were the only caregivers European women see. United Nations Population Fund, *The State of the World’s Midwifery 2021* (2021), available at <https://www.unfpa.org/sowmy>; Brown, *supra* note 2, at 6-7.

⁴²³ Ellmann, *supra* note 411, at 2.

⁴²⁴ Several international human rights instruments recognize the right to work. ICCPR, *supra* note 391, art. 8; International Convention on the Elimination of All Forms of Racial Discrimination art. 5, ratified Oct. 21, 1994, 660 UNTS 195, 212 [hereinafter ICERD]; *Id.* at art. 11; CRC, *supra* note 387, art. 32.; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Dec. 18, 1990, art. #, 2220 U.N.T.S. 93 [hereinafter Migrant Workers Convention]; *Id.* at art. 25; *Id.* at art. 26; *Id.* at art. 40; *Id.* at art. 52; *Id.* at art. 54.

⁴²⁵ UDHR, *supra* note 390, art. 23; ICESCR, *supra* note 385, art. 7.

⁴²⁶ ICESCR, *supra* note 385, art. 6(2).

⁴²⁷ Hum. Rts. Council, Report of the UN Working Group on discrimination against women and girls, ¶ 76 (d), U.N. Doc. A/HRC/47/38 (2021).

⁴²⁸ Partnership for Maternal, Newborn & Child Health, PMNCH for Women’s, Children’s, and Adolescent’s Health, *Pregnancy and Childbirth during COVID-19* (2023), available at <https://pmnch.who.int/resources/tools-and-toolkits/pmnch-covid-19-and-wcah-toolkits/maternal-and-newborn-health/pregnancy-and-childbirth>.

However, Florida's regulations limit women's access to midwifery care⁴²⁹ and fail to provide midwives and doulas with an adequate work environment. In Florida, certified midwives and direct-entry midwives are not able to seek a state licensure, limiting women's access to midwives, despite a state shortage of maternal care providers.⁴³⁰ Moreover, overregulation, such as the requirement for a collaborative agreement with a physician to practice, denies midwives a fair and appropriately autonomous work environment.⁴³¹ Women also struggle to access midwives due to the lack of enforcement of midwifery network adequacy standards.⁴³² This right to work violation is demonstrated by the fact that midwives nationally have brought suits in two contexts: (1) suits to combat statutes that bar home birth,⁴³³ and (2) suits against hospitals under antitrust theories.⁴³⁴ Birthing centers are also systematically excluded from the maternal care market place due to targeted regulations and industry practices.⁴³⁵ For doulas, there are no formal mandatory licensure, certification, or accreditation requirements, preventing them from receiving federal reimbursement for their services.⁴³⁶ Collectively, these practices bar midwives and doulas from working to the full scope of their abilities and from the training and resources necessary to develop within the maternal care arena.⁴³⁷

Ultimately, both midwives and doulas have the right to work within an enabling environment to provide quality care for women, newborns and their families.⁴³⁸ This entails ensuring midwives and doulas are recognized, valued, educated, and regulated to global standards, and facilitating their work to occur in supportive, safe and respectful working environments with sufficient resources for them to do their work effectively and to practice to their full scope.⁴³⁹

D. Right to Physical Integrity

The lack of sufficient access to midwives and doulas and to family planning education violates the human right to physical integrity. Several fundamental rights comprise the overarching right to physical integrity, including the rights to security of person, to privacy, and to freedom from torture and cruel, inhuman, and degrading treatment. Physical integrity is also a fundamental dimension of the right to

⁴²⁹ NPWF, *supra* note 4, at 29.

⁴³⁰ Midwife Alliance North America, *State-by-State* (2023), available at <https://mana.org/about-midwives/state-by-state#Florida>. Pursuant to federal law, a state needs only a rational basis to restrict the right to practice a profession, making it relatively easier for states to restrict women's access to midwives and doulas. The Legal Infrastructure, *supra* note 191, at 2222.

⁴³¹ Midwife Schooling, *supra* note 294.

⁴³² See FHJP, *supra* note 361, at 10.

⁴³³ Brown, *supra* note 2, at 496. In the Second and Third Circuits, midwives and prospective parents brought suits challenging state statutes that prevented midwives from providing home birth services, but both Circuits held that no fundamental right to a home birth existed under due process or right to privacy arguments. The courts held that the ability to select a health provider of choice to assist with birth was not a fundamental right and states can regulate homebirth accordingly. See *Lange-Kessler v. Dept. of Educ. Of the State of N.Y.*, 109 F.3d 137, 139 (2d Cir. 1997); See also *Sammon v. New Jersey Bd. Of Med. Examiners*, 66 F.3d 639, 640 (3d Cir. 1995).

⁴³⁴ Brown, *supra* note 2, at 496. See e.g., *Nurse Midwifery Associates v. Hibbett*, 918 F.2d 605, 607-608 (6th Cir. 1990), opinion modified on reh'g, 927 F.2d 904 (6th Cir. 1991). Two nurse midwives brought an anti-trust action against practicing obstetricians in three Nashville hospitals and a physician-controlled insurance company applying the Intra-corporate Conspiracy Doctrine. The midwives' claim alleged that obstetricians and insurers conspired to exclude midwives from hospitals. A lower court granted summary judgment on multiple anti-trust claims, and the Sixth Circuit reversed in part and remanded; See also, *Hospital Privileges for Nurse-Midwives: An Examination Under Anti-trust Law*, 33 AM. U.L. Rev. 959 (1984) (examining the denial of hospital privileges to nurse-midwives under antitrust law); de Courcy Hinds, *Midwives Seek Delivery From Discrimination*, N.Y. Times, Aug. 7, 1983, § 4, at E9, col. 1 (discussing the barriers faced by midwives seeking to operate independently of physicians).

⁴³⁵ Brown, *supra* note 2, at 494-495.

⁴³⁶ NHLP, *supra* note 184, at 6.

⁴³⁷ Moreover, like the effect of abortion restrictions in potentially endangering women, women seeking community birth will do it regardless, creating demand for underground midwifery practices, that pose legal issues for the midwife and safety issues for the expecting mother. The Legal Infrastructure, *supra* note 191, at 2222; International Confederation of Midwives, *International Confederation of Midwives Strategy 2017 – 2020* (2018), available at <https://www.internationalmidwives.org/assets/files/general-files/2018/04/final-copy-icm-strategy-2017-20-online.pdf>.

⁴³⁸ International Confederation of Midwives, *supra* note 437.

⁴³⁹ *Id.*

health.⁴⁴⁰ UDHR Article 3 and ICCPR Article 9 both state that everyone has “the right to liberty and security of a person.”⁴⁴¹ Article 12 of the UDHR and Article 17 of ICCPR both dictate that “no one shall be subjected to arbitrary interference with his privacy.”⁴⁴² The right to freedom from cruel, inhuman, and degrading treatment (CIDT) is articulated in Article 5 of the UDHR and Article 7 of ICCPR, which both dictate that “no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”⁴⁴³ Acts falling short of torture may constitute CIDT under Article 16 of CAT.⁴⁴⁴

1. Physical Integrity Violations through Inadequate Access to Holistic Maternal Care

Florida’s overmedicalized maternal care system violates women’s right to physical integrity by failing to ensure proper informed consent and to provide women information to make educated decisions around childbirth. Ensuring informed consent is fundamental to the right to physical integrity. As the Special Rapporteur on the Right to Health sets out, informed consent requires a voluntary and sufficiently informed decision regarding a medical intervention.⁴⁴⁵ However, as the Special Rapporteur observed, informed consent is frequently compromised in the health-care setting.⁴⁴⁶ In the context of maternity care, the International Federation of Gynecology and Obstetrics (FIGO) calls for obstetricians to provide women “respect, dignity and informed choice” and to “incorporate a rights-based approach.”⁴⁴⁷ The right to physical integrity encompasses a pregnant woman’s refusal of medical treatment, even where refusal could potentially harm her fetus.⁴⁴⁸ Accordingly, medical interventions cannot be imposed based on the primacy of fetal interests over a woman’s right to physical integrity during childbirth.⁴⁴⁹ Moreover, a woman may accept a medical intervention to benefit her child at a higher risk to her own health after receiving informed consent; the key is the ability to choose what to do with one’s body.⁴⁵⁰ However, as the Special Rapporteur on Violence against Women has reported, women globally

⁴⁴⁰ United Nations, Beijing Declaration and Platform for Action, ¶ 97, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995); The National Human Rights Institution, *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions*, 18, U.N. Doc. HR/PUB/14/6 (2014).

⁴⁴¹ UDHR, *supra* note 390, art. 3; ICCPR, *supra* note 391, art. 9.

⁴⁴² UDHR, *supra* note 390, art. 12; ICCPR, *supra* note 391, art. 17.

⁴⁴³ UDHR, *supra* note 390, art. 5; ICCPR, *supra* note 391, art. 7.

⁴⁴⁴ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. #16, ratified Oct. 21, 1994, 1465 UNTS 85, 113 [hereinafter CAT]. Torture, as defined in the Convention against Torture (CAT) has four essential elements: (1) an act inflicting severe pain or suffering, whether physical or mental; (2) the element of intent; (3) the specific purpose; and (4) the involvement of a state official, at least by acquiescence. *Id.*

⁴⁴⁵ Hum. Rts. Council, Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment, ¶ 28, U.N. Doc. A/HRC/22/53 (2013).

⁴⁴⁶ Hum. Rts. Council, Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment, ¶ 28-29, U.N. Doc. A/HRC/22/53 (2013).

⁴⁴⁷ The framework also emphasizes that obstetricians should prevent the exclusion and maltreatment of individuals that are marginalized and socioeconomically disadvantaged. International Federation of Gynecology and Obstetrics (FIGO), *FIGO Statement: Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth* (2021), available at www.figo.org/resources/figo-statements/ethical-framework-respectful-maternity-care-during-pregnancy-and-childbirth.

⁴⁴⁸ The ICCPR does not support the proposition that the right to life, protected in Article 6(1), extends to prenatal life. The drafters of the ICCPR specifically rejected a proposal to amend this article to provide that “the right to life is inherent in the human person from the moment of conception, this right shall be protected by law.” U.N. GA OR Annex, 12th Session, Agenda Item 33, ¶ 96, 113, 119, U.N. Doc. A/C.3/L.654. Moreover, in the context of abortion, the Human Rights Committee interpreting this article has recognized that states “should remove existing barriers that deny effective access by women and girls to safe and legal abortion” and that “restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy.” Hum. Rts. Comm., General Comment No. 36: Article 6 of the International Covenant on Civil and Political Rights, on the right to life, ¶ 8, U.N. Doc. CCPR/C/CG/36 (Oct. 30, 2018); see also Special Rapporteur on Violence against Women, Its Causes and Consequences, Rep. of the Special Rapporteur on Violence against Women, Its Causes and Consequences, ¶ 66, U.N. Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999) (noting “[g]overnment failure to take positive measures to ensure access to appropriate health-care services that enable women to safely deliver their infants as well as to safely abort unwanted pregnancies may constitute a violation of a woman’s right to life...”); Duncan, *supra* note 346, at 432.

⁴⁴⁹ Duncan, *supra* note 346, at 426.

⁴⁵⁰ *Id.* At 432.

experience a lack of autonomy and decision-making in pregnancy, such as the inability to choose their preferred delivery position(s).⁴⁵¹ Violations of informed consent further increase with structural inequalities, like the power imbalance between doctors and patients, stigma, and discrimination, resulting in individuals from marginalized groups disproportionately vulnerable to having their informed consent compromised.⁴⁵²

The coercive birthing environment facilitated by the overmedicalized Florida maternal care system, which is associated with barriers in access to midwives and doulas, is a violation of the right to physical integrity. While Florida, like other states, requires physicians to disclose the material risks, benefits, and alternatives to treatment, this rarely occurs in the childbirth setting.⁴⁵³ Women are subject to unwanted medical interventions and do not receive a complete and objective explanation of the benefits, risks, and alternatives to the medicalized approach to childbirth, including the usage of midwives and doulas. They are thus prevented from making a fully informed decision about their maternal care in violation of the right to physical integrity.⁴⁵⁴ Providers need to inform women of the risks of all treatment options to avoid providing more invasive and potentially harmful maternal care.⁴⁵⁵ They should also support women's choice of community birthing options methods when evidence demonstrates such a choice to be reasonable and even beneficial, like for VBAC.⁴⁵⁶ This would also subsequently increase eligibility for midwife delivery.⁴⁵⁷ Moreover, while Florida's consent law requires harm to raise a successful informed consent claim, no physical harm is required for a breach of physical integrity under the human rights-based framework—the violation itself is sufficient for a remedy.⁴⁵⁸ Women from marginalized populations are also more likely to experience these violations, in direct violation of the right to equality, as discussed below.

2. Obstetric Violence as Cruel, Inhuman, and Degrading Treatment in Maternal Care

Florida's overmedicalized healthcare system further exposes women to obstetric violence, or abuse and coercion during childbirth,⁴⁵⁹ violating the human right to freedom from CIDT, in addition to the rights to privacy, security of person, and health. Obstetric violence during childbirth can cause significant trauma, even post-partum post-traumatic stress disorder that may require therapy.⁴⁶⁰ In 2014, WHO acknowledged many women globally experience “disrespectful, abusive, or neglectful treatment during childbirth in facilities,” and advocated for a prevention plan that was endorsed by over 90 organizations.⁴⁶¹ WHO condemned “outright physical abuse, profound humiliation and verbal abuses,

⁴⁵¹ Hum. Rts. Council, Report of the Special Rapporteur on violence against women, its causes and consequences, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. ¶ 30, U.N. Doc. A/HRC/74/137 (2019).

⁴⁵² Hum. Rts. Council, *Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment*, ¶ 28-29, U.N. Doc. A/HRC/22/53 (2013).

⁴⁵³ § 766.103, Fla. Stat. (2021); The Legal Infrastructure, *supra* note 191, at 2215; Kukura, *supra* note 28, at 779-780.

⁴⁵⁴ The Legal Infrastructure, *supra* note 191, at 2220; Duncan, *supra* note 346, at 437.

⁴⁵⁵ Duncan, *supra* note 346, at 437.

⁴⁵⁶ See Molly Enking, Public Broadcasting Service, *After a C-section, women who want a vaginal birth may struggle to find care* (2018), available at <https://www.pbs.org/newshour/health/c-section-vbac-vaginal-maternal-health>.

⁴⁵⁷ Duncan, *supra* note 346, at 437-38.

⁴⁵⁸ *Id.* At 436.

⁴⁵⁹ Kukura, *supra* note 28, at 724.

⁴⁶⁰ Diaz-Tello, *supra* note 322, at 59.

⁴⁶¹ World Health Organization (WHO), *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, 1 WHO/RHR/14.23 (2014), available at https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal or admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and the detention of women and their newborns in facilities after childbirth due to an inability to pay.”⁴⁶² While assault, harassment, and disrespect occur during labor, it also can occur prenatally, and in extreme cases, women have even experienced sexual assault by their obstetrician.⁴⁶³

Both the Committee Against Torture (CAT Committee), which monitors implementation of CAT, and the Special Rapporteur against Torture have addressed torture and CIDT in health care settings. The CAT Committee has affirmed that States have an obligation to “prohibit, prevent and redress torture and ill-treatment in all contexts . . . [including institutions] where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.”⁴⁶⁴ This applies to healthcare settings and healthcare providers, and States must exercise due diligence to prevent, investigate, prosecute and punish violations.⁴⁶⁵ The Special Rapporteur on Torture further noted that “there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in healthcare may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity.”⁴⁶⁶

Obstetric violence takes place in Florida’s maternal care system, constituting gender-based violence and amounting to CIDT. Both the WHO and CEDAW Committee recognize that obstetric violence is a form of gender-based violence that threatens women’s right to physical integrity.⁴⁶⁷ Similarly, both the Special Rapporteur on Violence Against Women and the Special Rapporteur on Torture and Other Cruel, Inhuman, and Degrading Treatment have expressed concerns about obstetric violence as a form of gender-based violence.⁴⁶⁸ The Special Rapporteur on Violence against Women remarked that “[t]he painful stories told by women through the submissions received by the Special Rapporteur revealed that mistreatment and violence against women in reproductive health-care services and childbirth in health facilities happen all around the world and affect women across all socioeconomic levels.”⁴⁶⁹ The subjugation of expecting mothers to potentially harmful interventions without proper informed consent or information on alternative treatments, even with some rationale provided, constitutes gender-based violence that may amount to CIDT.⁴⁷⁰ This is particularly the case when it comes to forced or coerced surgeries (as in *Pemberton*, described above, where a woman was subject to an involuntary C-section),

⁴⁶² *Id.*

⁴⁶³ Kimberly Allers, Washington Post, *Obstetric violence is a real problem. Evelyn Yang’s experience is just one example* (2020), available at <https://www.washingtonpost.com/lifestyle/2020/02/06/obstetric-violence-is-real-problem-evelyn-yangs-experience-is-just-one-example/>; See also Diaz-Tello, *supra* note 322, at 57-59 for recent case studies.

⁴⁶⁴ Hum. Rts. Council, *Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment*, ¶ 23, U.N. Doc. A/HRC/22/53 (2013).

⁴⁶⁵ Hum. Rts. Council, *Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment*, ¶ 24-25, U.N. Doc. A/HRC/22/53 (2013).

⁴⁶⁶ Hum. Rts. Council, *Report of the Special Rapporteur on violence against women, its causes and consequences, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, ¶ 13, U.N. Doc. A/HRC/74/137 (2019).

⁴⁶⁷ World Health Organization, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*, WHO/RHR/14.23 (2015). CEDAW COMM., General Recommendation No. 19: Violence against women, ¶ 7, U.N. Doc. A/47/38 (1992). In *A.T. v. Hungary*, the CEDAW Committee held that Hungary’s lack of specific legislation to combat domestic violence and sexual harassment violated the right to security of person. CEDAW Comm., *A.T. v. Hungary*, U.N. Doc. CEDAW/C/36/D/2/2003.

⁴⁶⁸ Hum. Rts. Council, *Report of the Special Rapporteur on violence against women, its causes and consequences, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, ¶ 1, U.N. Doc. A/HRC/74/137 (2019); Hum. Rts. Council, *Report of the Special Rapporteur on torture and other cruel, inhuman, and degrading treatment*, ¶ 46, U.N. Doc. A/HRC/22/53 (2013).

⁴⁶⁹ Hum. Rts. Council, *Report of the Special Rapporteur on violence against women, its causes and consequences, A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, ¶ 16, U.N. Doc. A/HRC/74/137 (2019).

⁴⁷⁰ See *id.*

which constitute a violent act or battery.⁴⁷¹ Furthermore, the disproportionate impact of informed consent violations and obstetric violence on women from marginalized groups makes CIDT violations more likely.⁴⁷² Additionally, obstetric violence occurs when Florida’s maternal care system threatens women with arrest or the taking of their children for not choosing hospital birth.⁴⁷³

3. Physical Integrity Violations through Inadequate Access to Family Planning

Additionally, inadequate access to reproductive care in Florida violates women’s physical integrity. The right to physical integrity includes women’s control over matters related to their sexual and reproductive health, free of coercion, discrimination, and violence.⁴⁷⁴ This includes a right to decide freely and responsibly on the number, spacing, and timing of their children, and to have access to the information, education, and means to do so.⁴⁷⁵ CEDAW Article 16 affirms equal rights within a family, as well as a woman’s right to choose whether or not to have a family.⁴⁷⁶ “[States] shall take all appropriate measures to eliminate discrimination against women [relating to] marriage and family relations and [shall] ensure, on the basis of equality of men and women...the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education, and means to enable them to exercise these rights.”⁴⁷⁷ Women’s control over their reproductive capacity is central to their lives and dignity, and the decision to embark on the journey of motherhood directly relates to a woman’s access to reproductive health services. The CEDAW Committee asserts that “access to health care, including reproductive health, is a basic right.”⁴⁷⁸ Similarly, CESCR seeks to reverse the barriers restricting “access to the full range of sexual and reproductive health facilities, services, goods and information.”⁴⁷⁹

If operating effectively, the Family Planning Waiver Program can support this right. It enables access to essential services, such as family planning, STD testing, medications, and physical exams. However, the Waiver Program currently suffers from low enrollment and service utilization.⁴⁸⁰ Moreover, it has a limited scope of services⁴⁸¹, including a lack of adequate support for abortion⁴⁸² and gaps in mental health services.⁴⁸³

⁴⁷¹ Diaz-Tello, *supra* note 322, at 57; Kukura, *supra* note 28, at 798.

⁴⁷² Diaz-Tello, *supra* note 322, at 57.

⁴⁷³ *Id.* at 57-59.

⁴⁷⁴ United Nations Human Rights Special Procedures, *Women’s Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends* (Oct. 2017), available at <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>.

⁴⁷⁵ United Nations Department of Economic and Social Affairs: Population Division, *Abortion Policies and Reproductive Health around the World* (2014), available at <https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>; See also CEDAW, *supra* note 389, Article 16.

⁴⁷⁶ CEDAW, *supra* note 389, art. 16.

⁴⁷⁷ CEDAW, *supra* note 389, art.16(1). See also Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa art. 14, adopted July 11, 2003 [hereinafter Maputo Protocol].

⁴⁷⁸ Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), ¶ 1, U.N. Doc. CEDAW/A/54/38/C/1/Rev.1 (1999)[hereinafter CEDAW Comm. General Comment No. 24].

⁴⁷⁹ CESCR General Comment No. 22, *supra* note 388, ¶ 2.

⁴⁸⁰ See AHCA, *supra* note 147.

⁴⁸¹ See Florida Agency for Health Care Administration (AHCA), *Medicaid Family Planning Waiver Program* (2023), available at https://ahca.myflorida.com/medicaid/family_planning/index.shtml.

⁴⁸² See Guttmacher Institute, *State Facts About Abortion: Florida, National Background and Context* (June 2022), available at <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-florida>.

⁴⁸³ See Florida Department of Children and Families, *Adult Mental Health (AMH)* (2023), available at <https://www.myflfamilies.com/services/substance-abuse-and-mental-health/adult-mental-health>.

A well-functioning Waiver Program can further prevent egregious violations that rise to the level of CIDT. In particular, the Waiver Program's goals of increasing child spacing intervals through contraception and reducing unintended pregnancies provide important ways to protect women from dehumanizing treatment, such as unsafe abortions.⁴⁸⁴ By providing access to adequate healthcare services, the Waiver Program reduces the likelihood that women will be forced to turn to dangerous medical practices and inhuman treatment.

E. Right to Equality and Nondiscrimination

The maternal and infant health crisis disproportionately harms marginalized groups by violating the right to non-discrimination and equality, a core human rights principle. Article 1 of the UDHR proclaims that all human beings are born “free and equal in dignity and rights,”⁴⁸⁵ while Article 7 declares that everyone is “equal before the law and [is] entitled without any discrimination to equal protection of the law.”⁴⁸⁶ This statement is further echoed in the ICCPR, which declares all persons to be “equal before the law” and “entitled without any discrimination to the equal protection of the law,” including on “any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”⁴⁸⁷ Moreover, under international human rights law, equality requires addressing not just intentional discrimination, but disparate impacts.⁴⁸⁸ As the

Human Rights Committee explained, the term “discrimination” refers to “any distinction, exclusion, restriction, or preference . . . which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights.”⁴⁸⁹ Furthermore, enjoyment of rights “on an equal footing” does not call for identical treatment.⁴⁹⁰ Rather, “the principle of equality” may even require different treatment, such as in the case of pregnant women, or “affirmative action in order to diminish or eliminate conditions which cause or help to perpetuate discrimination.”⁴⁹¹

Additionally, both the ICCPR and ICESCR prohibit discrimination with regards to their provisions.⁴⁹² In fact, non-discrimination is an essential element of the accessibility component of the right to health, and CESCR sets out that

⁴⁸⁴ The Waiver Program seeks to (1) increase access to family planning services, (2) reduce the number of unintended pregnancies, (3) increase child spacing intervals through contraception, and (4) reduce costs by reducing unintended pregnancies by women who would be eligible for Medicaid pregnancy related services. See AHCA, *supra* note 162.

⁴⁸⁵ UDHR, *supra* note 390, art. 1.

⁴⁸⁶ UDHR, *supra* note 390, art. 7.

⁴⁸⁷ ICCPR, *supra* note 391, art. 26.

⁴⁸⁸ Hum. Rts. Comm., General Comment 18: Non-Discrimination, ¶¶ 6, 8, 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (Nov. 10, 1989); Committee on the Elimination of Racial Discrimination, General Recommendation 14, Definition of Racial Discrimination (Forty-second session, 1993), U.N. Doc. A/48/18 at 114 (1994).

⁴⁸⁹ Hum. Rts. Comm., General Comment 18: Non-Discrimination, ¶¶ 6, 8, 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (Nov. 10, 1989); Committee on the Elimination of Racial Discrimination, General Recommendation 14, Definition of Racial Discrimination (Forty-second session, 1993), U.N. Doc. A/48/18 at 114 (1994).

⁴⁹⁰ Hum. Rts. Comm., General Comment 18: Non-Discrimination, ¶¶ 6, 8, 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (Nov. 10, 1989); Committee on the Elimination of Racial Discrimination, General Recommendation 14, Definition of Racial Discrimination (Forty-second session, 1993), U.N. Doc. A/48/18 at 114 (1994).

⁴⁹¹ Hum. Rts. Comm., General Comment 18: Non-Discrimination, ¶¶ 6, 8, 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (Nov. 10, 1989); Committee on the Elimination of Racial Discrimination, General Recommendation 14, Definition of Racial Discrimination (Forty-second session, 1993), U.N. Doc. A/48/18 at 114 (1994).

⁴⁹² ICCPR, *supra* note 391, art. 2(1) (“Each State Party . . . undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized . . . without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status”); ICCPR, *supra* note 391, art. 3 (“The State Parties . . . undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights . . .”); ICESCR, *supra* note 385, art. 3 (“The State Parties . . . undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights . . .”).

“health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population...without discrimination...”⁴⁹³ Moreover, states must “abstain[] from enforcing...[and] imposing discriminatory practices relating to women’s health status and needs.”⁴⁹⁴

Specific international human rights treaties further focus on ensuring equality and non-discrimination on the basis of gender and race. CEDAW addresses “discrimination against women” with regards to their “human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”⁴⁹⁵ In its Preamble, CEDAW both recognizes “the social significance of maternity” and that “the role of women in procreation should not be a basis for discrimination.”⁴⁹⁶ The failure to dedicate adequate resources and effectively implement policies that protect maternal health in the U.S. violates women’s rights to non-discrimination and equality. “Preventable maternal mortality can result from or reflect violations of a variety of human rights, including...the right to freedom from discrimination...”⁴⁹⁷ Most maternal deaths in the U.S. are preventable, but they continue to increase due to vast differences in and an overall shortage of maternity care providers relative to the number of births.⁴⁹⁸ This “undersupply” of maternity providers includes midwives, a lack of

access to comprehensive postpartum support, and inadequate insurance coverage.⁴⁹⁹ A state’s healthcare system must provide health care services that are “available, accessible, and of good quality...[as well as] accountable, free from discrimination, and ensur[ing] the active participation of women in the decision-making.”⁵⁰⁰

Moreover, human rights law recognizes the importance of addressing intersecting discrimination. As the CEDAW Committee explained, “discrimination against women [is] inextricably linked to other factors affecting their lives... including... ethnicity/race, indigenous or minority status, colour, socioeconomic status . . .”⁵⁰¹ Women thus “experience varying and intersecting forms of discrimination, which have an aggravating negative impact,” and violations “may affect some women to different degrees, or in different ways.”⁵⁰² ICERD specifically requires states to “condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating [discrimination] in all its forms.”⁵⁰³ ICERD further emphasizes freedom from racial discrimination as a cross-cutting right, including with regards to “the right to public health, medical care, social security and social services.”⁵⁰⁴ In the U.S., women of color disproportionately suffer from poor maternal

⁴⁹³ CESCR General Comment No. 14, *supra* note 386, ¶ 12(b).

⁴⁹⁴ *Id.*

⁴⁹⁵ CEDAW, *supra* note 389, art. 1.

⁴⁹⁶ *Id.*

⁴⁹⁷ Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA* (2011), available at <https://www.amnestyusa.org/files/deadlydeliveryoneyear.pdf>.

⁴⁹⁸ Roosa Tikkanen, et al., The Commonwealth Fund, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Nov. 18, 2020), available at <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#:~:text=Policy%20Implications,postpartum%20supports%20are%20contributing%20factors.>

⁴⁹⁹ *Id.*

⁵⁰⁰ Amnesty International, *supra* note 500.

⁵⁰¹ Comm. on the Elimination of Discrimination Against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, ¶ 19, U.N. Doc. CEDAW/C/GC/35 (07, 2017) [hereinafter CEDAW Comm. General Comment No. 35].

⁵⁰² *Id.* at ¶12.

⁵⁰³ ICERD, *supra* note 427, art. 2.

⁵⁰⁴ See ICERD, *supra* note 427, art. 5 (e)(iv).

health outcomes compared to their white counterparts, in part to discrimination in the deliverance of healthcare.⁵⁰⁵ On average, women of color experience pregnancy-related mortality rates at three times the rate of white women by three times.⁵⁰⁶ Moreover, socioeconomic, geographic, cultural, and language factors further

exacerbate disparities.⁵⁰⁷ Medicaid expansion, improving the Waiver Program, and expanded access to midwifery and doula services would help address many of these disparities by increasing access to vital health services for marginalized groups.

F. Special Protections for Motherhood and Childhood

Special protection for the health of mothers and children is imperative to addressing the maternal and infant health crisis, as well as significant reproductive health challenges. The UDHR recognizes, “Motherhood and childhood are entitled to special care and assistance.”⁵⁰⁸ This protection lays the foundation for a focus on the health of both mothers and children, including the stages leading up to and after birth.

At least eleven international declarations, resolutions and conventions specifically support parents, mothers, and children.⁵⁰⁹ Article 10 of ICESCR recognizes the family as the “natural and fundamental group unit of society,” and requires that parties provide the “widest possible protection and assistance” as necessary.⁵¹⁰ Moreover, Article 10 accords special protection to mothers during a “reasonable period of time before and after birth.”⁵¹¹ Similarly, Article 24(2)(d) of the CRC enumerates protection with appropriate prenatal and post-natal healthcare for mothers.⁵¹² CESCR General Comment 14 emphasizes that “[p]ublic health infrastructures should provide sexual and reproductive health services, including safe motherhood...”⁵¹³ CEDAW expands upon these special protections by requiring family education to include “proper understanding of maternity as a social function and the recognition of the common responsibility of men and women.”⁵¹⁴ CEDAW further calls on states to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary,” as well as affirming women’s right to reproductive choice.⁵¹⁵ Moreover, the Special Rapporteur on Violence against Women call on States to “ensure that family education includes a proper understanding of maternity as a social function.”⁵¹⁶

These treaty provisions seek to support the immense responsibility that falls upon motherhood. Moreover, these special measures for maternity protection are recommended for all States and “shall not

⁵⁰⁵ Duncan, *supra* note 346, at 440.

⁵⁰⁶ Latoya Hill, et al., Kaiser Family Foundation (KFF), Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them (Nov. 2022), available at <https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/>.

⁵⁰⁷ Duncan, *supra* note 346, at 440-41.

⁵⁰⁸ UDHR, *supra* note 390, art. 25(2).

⁵⁰⁹ These international instruments include, but are not limited to, the UDHR, ICCPR, ICESCR, CEDAW, Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, International Labor Organization Maternity Protection Convention, Millennium Development Goals 2000, UNICEF Innocent Declaration 1990: On the Protection, Promotion and Support of Breastfeeding, International Code of Marketing of Breast-Milk Substitutes, <https://libertyandhumanity.com/themes/maternal-and-infant-health/human-rights-instruments-supporting-motherhood/>.

⁵¹⁰ ICESCR, *supra* note 385, art. 10.

⁵¹¹ *Id.*

⁵¹² CRC, *supra* note 387, art. 24(2)(d).

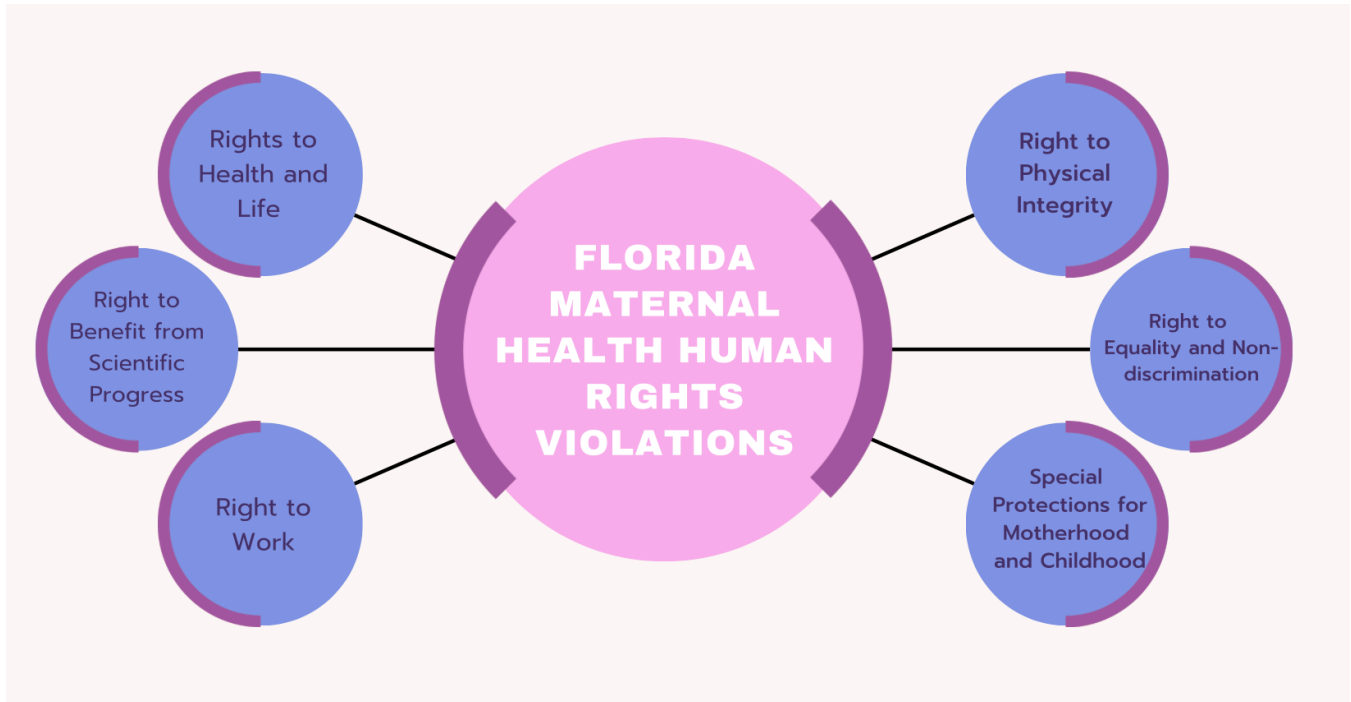
⁵¹³ CESCR General Comment No. 14, *supra* note 386, ¶ 36.

⁵¹⁴ CEDAW, *supra* note 389, art. 5.

⁵¹⁵ CEDAW, *supra* note 389, art. 12(2).

⁵¹⁶ See Hum. Rts. Council, Report of the Special Rapporteur on violence against women, its causes, and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence ¶ 39, U.N. Doc. A/HRC/74/50 (2019).

be considered discriminatory.”⁵¹⁷ In fact, numerous instruments outline the State’s obligation to put women-and-child-focused legislation at the forefront of policy-making to ensure that these categories of people are not exploited, violated, or abused.⁵¹⁸ States should utilize a gender-based approach to healthcare services and policies.⁵¹⁹ To better protect mothers and children and address the current maternal and infant health crisis, Florida should expand Medicaid, strengthen the Waiver Program, and provide access to midwives and doulas.



⁵¹⁷ CEDAW, *supra* note 389, art. 4.

⁵¹⁸ See generally ICCPR, *supra* note 391, art. 24(1) (emphasizing the rights of the child); United Nations Declaration on the Rights of Indigenous Peoples art. 21(2), G.A. Res. 61/295, U.N. Doc. A/RES/61/295 (Sept. 13, 2007), adopted Sept. 13, 2007 [hereinafter UNDRIP] (emphasizing the rights of indigenous women and children); UN General Assembly, *Convention on the Rights of Persons with Disabilities* art. 16 A/RES/61/106, adopted 24 January 2007 (emphasizing the rights of disabled persons).

⁵¹⁹ CESCR General Comment No. 14, *supra* note 386, ¶ 20.

IV. RECOMMENDATIONS

International human rights law requires States to “respect, protect, and fulfill the human rights of their residents.”⁵²⁰ All levels of government within the U.S. should recognize the right to the highest attainable standard of physical and mental health, requiring the provision of healthcare that is available, accessible, acceptable and of high quality.⁵²¹ This section outlines human rights-based recommendations for Florida Medicaid expansion, improvement of Florida’s family planning waiver program, and expanding access to midwives and doulas for expecting mothers. To effectively address the maternal and infant health crisis and help realize the rights of its residents, Florida should take the following steps:

A. Expanding Medicaid Recommendations

Florida can effectively address the maternal and infant health crisis by opting to expand Medicaid. More than half of pregnancy-related deaths in the state would be preventable through Medicaid expansion.⁵²² By providing healthcare access, and reducing the coverage gap, women and children in Florida will be able to minimize their risks of pregnancy-related and early infancy complications, which will in turn reduce the maternal and infant mortality rate.

Take Advantage of the One Year Postpartum Extension:

- New mothers are now eligible for all Medicaid services from **60 days to 12 months**.
 - This includes not just postpartum visits but also primary care, specialty care, mental health care, prescription drug benefits, transportation services, and more for one year after the end of pregnancy.
- Primary Care Physicians and Healthcare Providers can **Save Lives** through this new extension by:
 - Preventing up to one-third of maternal deaths that occur 1 week to 1 year after childbirth
 - Preventing complications from pregnancy-related behavioral and mental health conditions
 - Preventing complications from chronic conditions such as hypertension, diabetes, and obesity
 - Helping moms and birthing people plan and prepare for their next pregnancy
- Mothers experiencing **pregnancy loss are covered for one year**
 - Mothers who have experienced a miscarriage or fetal or infant death are also covered for the full year postpartum extension
 - Primary Care Physicians and Healthcare Providers should ensure that these mothers are connected to the physical and mental health care they need, including grief support and counseling

During the third trimester, physicians and healthcare providers should talk to their patients about the importance of connecting to a primary care physician and appropriate specialists

⁵²⁰ United Nations, Human Rights Office of the High Commissioner, *International Human Rights Law* (2023), available at <https://www.ohchr.org/en/professionalinterest/pages/internationallaw.aspx>.

⁵²¹ The Committee on Economic, Social, and Cultural Rights (CESCR) provides the fundamental elements for the right to health in all forms to include availability, accessibility, acceptability, and quality in General Comment No. 14. CESCR General Comment No. 14, *supra* note 386, ¶12 (a)-(d).

⁵²² Bravender, *supra* note 44.

B. Florida’s Family Planning Waiver Program Recommendations

To adequately protect human rights within the Family Planning Waiver Program, Florida should address the following:

- ***Increase participation in the Waiver Program through increased advertisement, communication, and innovation.*** The Waiver Program should publicize its services and statistics that support them throughout Florida through advertisements, social media, maternal health campaigns, partnerships, and other nuanced practices of increasing involvement. Representatives of the Waiver Program should advocate for participation in the Waiver Program by publicly speaking to local communities.
- ***Improve service accessibility⁵²³ through remote options and increased telecommunication availability.*** The Waiver Program should offer on-going telehealth services. If remote service and telecommunication are not feasible options for families, Florida should provide free, safe, and accessible transportations.
- ***Clarify any ambiguous terms or language related to family planning.*** For example, “counseling services” and “laboratory tests” should be defined to clarify the various opportunities available to beneficiaries. Moreover, the term “family planning” should be defined.
- ***In direct contrast to the recently passed six-week abortion, protect the right to safely obtain abortions by providing affordable access to abortion facilities, adequate education regarding the process and, if necessary, alternative services, increasing the number of clinics in “abortion desert” counties.⁵²⁴*** Moreover, Florida’s state medical schools should include abortion within the obstetric training. An efficient way to do this would be to include access to safe abortions as a service under the Waiver Program.
- ***Expand services offered by the Waiver Program to mental health services.*** As “family planning” is not officially defined by federal law,⁵²⁵ the Waiver Program need not be restricted to current services. Moreover, information should be provided on the full range of birthing options, including midwife and doula services. The Waiver should also cover psychological counseling services.
- ***Provide comprehensive health education in schools, including medically accurate sexual health education.*** The Waiver Program could increase comprehensive health education through advocacy, partnerships with schools, and seminars. This educational initiative should include information on the importance of consent, sexually transmitted diseases such as HIV/AIDs, and options for abstinence or safe sex practices.⁵²⁶ Rather than current expansion of parental rights, Florida should commit to best public health practices, which includes comprehensive, medically accurate, and age-appropriate sex education.

⁵²³ Florida Department of Health, *supra* note 122.

⁵²⁴ See generally Guttmacher Institute, *supra* note 485.

⁵²⁵ See Walls, *supra* note 177.

⁵²⁶ The Sexual Information and Education Council of the United States, *Florida State Profile: Florida’s Sex Education Snapshot* (May 21, 2021), available at https://siecus.org/state_profile/florida-state-profile/.

The duty to **respect** entails a responsibility to prevent undue restriction and encourage participation. As such, Florida must ensure that eligible participants understand the extent of the Waiver Program's services, promote the services, and seek to increase utilization of the services. Florida could also take measures, such as through publicization, surveys and studies, to ensure that the Waiver Program adequately addresses the user-specific needs of the community. This would both promote the Waiver Program, educate the community about the available services, and increase participation.

The duty to **fulfill** requires that states take positive action to facilitate the enjoyment of the relevant human rights. This can be accomplished through increased education about and participation in the Waiver Program. Utilization of the program has shown a decrease in unintended births, as well as an increase in maternal health and program savings.⁵²⁷ Generally, effective family planning is known to result in fewer strains on community resources, such as social services and healthcare systems.⁵²⁸ Moreover, family planning increases the involvement of partners in deciding when to have children, decreases unintended pregnancy, and helps families experience less physical, emotional, and financial stress, while allowing them to dedicate more time and energy to individual and family development.⁵²⁹ As a whole, improved family planning increases the availability of economic opportunities.⁵³⁰

C. Expanding Access to Midwives and Doulas Recommendations

Expanding access to high quality and culturally sensitive midwives and doulas for *low-risk* pregnancies is imperative to addressing the national and state maternal health crisis and the striking disparities in healthcare outcomes for our most vulnerable populations. The challenge is to transform maternity care from an industry, largely driven by economic interests, to a system that prioritizes not just infant but also maternal well-being.⁵³¹ Generally, Florida can improve maternity care by increasing access to high-quality, culturally- and linguistically-congruent, evidence-based care; reforming healthcare reimbursement methods; enhancing maternal care performance measurement, consumer engagement, and health professionals' education; diversifying workforce composition and distribution; and by

⁵²⁷ Center for Disease Control and Prevention, *Evidence Summary: Prevent Unintended Pregnancy*, 3-4 (2015), available at <https://www.cdc.gov/sixteen/docs/6-18-evidence-summary-pregnancy.pdf#:~:text=Without%20public%20funding%20for%20family%20planning%20services%2C%20the,maternity%20and%20infant%20care%20by%20preventing%20unplanned%20births.5%2C6>.

⁵²⁸ Butler A. Stith and Clayton E. Wright, Institute of Medicine (U.S.) Committee on a Comprehensive Review of the HHS Office of Family Planning Title X Program, *A Review of HHS Family Planning Program: Mission, Management, and Measure of Results* (2009), available at <https://www.ncbi.nlm.nih.gov/books/NBK215219/>.

⁵²⁹ See id.

⁵³⁰ See id.

⁵³¹ Brown, *supra* note 2, at 27.

responding to the physical, emotional, and socioeconomic challenges patients face.⁵³² Being a complex issue with numerous facets, the fastest way to achieve the changes needed would be through comprehensive legislation that address the numerous barriers that prevent an optimal maternal healthcare system inclusive of midwives and doulas.⁵³³

This section outlines recommendations for Florida to address the overmedicalization of childbirth and increase use of the physiological model. The recommendations seek to realign economic incentives, reform the maternal medicolegal framework, and fill gaps in education. To fully achieve the goal of actively respecting, protecting, and fulfilling women's and infants' human rights, Florida law and policy makers should take the following steps to expand access to midwives and doulas:

- ***Realign economic incentives and the politico-economic structure surrounding childbirth.***
 - Establish metrics, tied to incentives and/or consequences, around quality care.
 - Provide for fair, adequate, and equitable reimbursement for midwives and doulas based on services provided.
 - Florida's Department of Health together with the Florida Perinatal Quality Collaborative, should stand up an independent panel consisting of obstetricians and perinatologists, nurses, midwives, doulas, lactation specialists, and public health professionals to determine best, evidence-based, holistic practices for integrated maternal care.⁵³⁴
 - Florida's Department of Health and the Perinatal Quality Collaborative should work collaboratively with Florida's Maternal Mortality Review Committee to expand collection of individual and aggregate level data on⁵³⁵: obstetric violence; the utilization of overused and underused maternal care services; the utilization of midwifery and doula services; pregnancy-related maternal complications, including severe maternal morbidity; pregnancy-related infant complications and mortality; women's satisfaction with prenatal care and labor care; and breastfeeding initiation and other significant indicators of both prenatal and postnatal maternal health. Moreover, it should make this data readily available to the general public.
 - The Florida legislature, together with the Florida Department of Health should incentivize entry into maternity healthcare professions among women of color.⁵³⁶
 - Like Louisiana's Alliance for Innovation of Maternal Health, Florida Department of Health should collaborate with hospitals to implement a patient safety bundle on obstetric care inclusive of midwifery and doula services to improve maternal health through education, care coordination, and patient safety protocols.⁵³⁷
- ***Utilize available federal funding to build capacity for and support for community birthing options and build key community partnerships in under-served communities of color.***

⁵³² NPWF, *supra* note 4, at 13, 15.

⁵³³ Brown, *supra* note 2, at 27.

⁵³⁴ Kukura, *supra* note 28, at 796.

⁵³⁵ NASHP, *supra* note 7 at 1. MMRCs are multidisciplinary committees in states and cities that perform comprehensive reviews of pregnancy-related deaths occurring within a year of the end of a pregnancy. *Id.*

⁵³⁶ NASHP, *supra* note 7, at 10.

⁵³⁷ NASHP, *supra* note 7, at 5.

- Florida should use its Title V Maternal and Child Health (MCH) Block Grant program funding to build capacity for community-based doula and midwife programs, including birthing centers and community-based perinatal health worker organizations.⁵³⁸
- Florida should also apply for funding provided by the State Maternal Health Innovation program administered by the U.S. Health Resources and Services Administration. These funds support states by fostering partnerships with maternal health experts and optimizing their resources to support programs, such as midwifery and doula services, that help prevent maternal mortality and severe maternal morbidity and reduce disparities in maternal health outcomes.⁵³⁹
- Florida should combine multiple funding streams to fund initiatives related to expanding access to midwifery and doula services, including Medicaid, Section 1115 Medicaid Waiver Programs, CHIP, the Title V MCH Block Grant and the State Maternal Health Innovation Program. Florida should incentivize and encourage community development endeavors, pursuant to the Community Reinvestment Act, to fund programs that expand access to midwifery and doula services.⁵⁴⁰
- ***Reform the restrictive regulations of community birthing options.***
 - Florida should expand licensure to include Certified Midwives, and allow them to practice to the full scope of their abilities. Midwives’ right to work includes the right to practice at the top of their license.⁵⁴¹
 - Additionally, Florida should eliminate the requirement that practicing midwives have physician supervision or written collaborative agreements.⁵⁴²
 - Florida should re-evaluate each restrictive regulation to reassess its justification and value, and to determine its impact on access to holistic maternal health services, and maternal health outcomes. For example, consistent with ACOG guidelines and their policy with home birth, Florida should allow vaginal birth after VBAC in birthing centers.
 - Florida’s Office of Court Education should ensure its judges receive training in birth justice, specifically, human rights-based education on the deprivation of rights of pregnant and birthing people.
- ***Create an official certification process for doulas, in collaboration with national and state doula training programs, and doulas and midwives of color.***⁵⁴³ The institution of a national or state-wide credential process would also provide uniformity of educational, training, and professional standards of conduct and accordingly, bolster doulas’ credibility within the medical system.⁵⁴⁴ It would further help doulas receive federal healthcare reimbursement. Doula training

⁵³⁸ NASHP, *supra* note 7, at 4-5. One example of a state that utilized the Title V MCH Block Grant funds is Indiana via its Safety Pin Program and The Speak Life Program.

⁵³⁹ The United States Commission on Civil Rights, *Racial Disparities in Maternal Health: U.S. Commission on Civil Rights 2021 Statutory Enforcement Report*.

⁵⁴⁰ Karen Kali and Samantha Autar, National Community Reinvestment Coalition, *The Community Reinvestment Act and Its Connections to Health Outcomes* (April 2022), available at <https://ncrc.org/the-community-reinvestment-act-and-its-connections-to-health-outcomes/>.

⁵⁴¹ Studies have found that states with a regulatory framework that allows autonomous midwifery practice have more midwives and a higher proportion of midwife-attended births as compared to states with more restrictive regulations. Yang et. al., *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*, 26 *Women’s Health Issues* 262, 265 (2016). States promoting autonomous midwifery practice had double the number of midwife providers. Brittany Ranchoff and Eugene Declercq, *The Scope of Midwifery Practice Regulations and the Availability of the Certified Nurse-Midwife and Certified Midwifery Workforce, 2012-2016*, *J. of Midwifery and Women’s Health* 65, 119, 123 (2020).

⁵⁴² 464.012(3), Fla. Stat. (2021); Florida Board of Nursing, *Updated Standards for Protocols: Physicians and ARNPs*. <https://floridasnursing.gov/standards-for-protocols-physicians-and-arnps/>.

⁵⁴³ NHLP, *supra* note 184, at 6. The licensing of doulas is controversial. Given there has been no associations of doulas with any harms, a better strategy may be to not impose any licensing credentials and to provide them the ability to practice via medical practitioner safe harbor practitioner exemption acts, which would allow them to practice without official licensure, however, the barriers to reimbursement may still exist if such a strategy is chosen. Moreover, safe harbor practitioner exemption acts affect more than just doulas, which could be seen as both a pro and a con.

⁵⁴⁴ NHLP, *supra* note 184, at 6.

should include training on addressing social determinants of health (SDOH) and implicit bias and providing culturally congruent care. This credentialing process must be made affordable and easily accessible to aspiring doulas to ensure adequate representation from marginalized groups.

- ***Assess the role of tort law and malpractice insurers in minimizing access to midwives, and raising C-section rates.*** Florida should aim to support the rights of birthing people and their families in the case of malpractice resulting in harm, while simultaneously ensuring that providers, particularly midwives, are not unduly burdened by rising costs of malpractice insurance.
- ***Allow women freedom to be more autonomous in choosing their method of childbirth by eliminating criminal liability via fetal homicide laws.*** Given the complexity of any maternal care options and the lack of medical expertise of expecting mothers, Florida should add an exception to fetal homicide laws for expecting mothers.
- ***Expand medical insurance coverage and reimbursement for midwives and doulas.***
 - For all private insurance beneficiaries, Florida should ensure midwives and birthing centers are covered in its benchmark plans for low-risk pregnancies.⁵⁴⁵
 - To remedy the issue of insurance companies' and Medicaid MCOs' failure to provide sufficient network adequacy for midwifery services, Florida's Agency for Healthcare Administration should strengthen its enforcement of its network adequacy standards, ensuring midwives and birthing centers are accessible.⁵⁴⁶
 - Florida should mandate coverage for extended model doula support. There are numerous ways to accomplish this for both Medicaid and private insurers:
 - To ensure coverage for *all* Medicaid beneficiaries, and not just some MMCO beneficiaries, Florida should mandate coverage for doulas by designating doula services as a “preventative service” via a State Amendment plan.⁵⁴⁷ MMCOs may also utilize funds provided by Medicaid's community coordinated care provisions potentially to reimburse doula services.⁵⁴⁸
 - To ensure coverage for all private insurance beneficiaries, Florida should cover extended-model doula services in its state benchmark plans for all pregnancies.⁵⁴⁹

⁵⁴⁵ Ellmann, *supra* note 411, at 1-3.

⁵⁴⁶ See NASHP, *supra* note 7, at 42.

⁵⁴⁷ NASHP, *supra* note 7, at 5. Unlike Florida, Minnesota and Oregon both pay for doula services as a Medicaid service by having doulas be certified and registered to receive Medicaid reimbursement. NHLP, *supra* note 184, at 9. Minnesota chose to cover doula services as an extended service for pregnant women while Oregon chose to cover the services as a preventive service. NASHP at 4. Oregon's choice to cover doula services as a preventive service gave the state more billing policy flexibility than Minnesota. NASHP, *supra* note 7, at 5. Preventive services provided by a traditional health worker who meets state-established qualifications are an exception to the licensure requirements for matching federal Medicaid funding. NASHP, *supra* note 7, at 4-5. Thus, states can cover recommended adult preventive services by licensed providers if it offers it to the whole population, receiving a 1% increase in federal matching funds. 29 C.F.R. § 2590.715.2713; NHLP, *supra* note 184, at 13. While states who have taken up this option could cover doula services with cost sharing for pregnant women, Florida has not taken this option. NHLP, *supra* note 184, at 13. CMS regulations allow state to cover prevent services provided by a licensed provider. 42 C.F.R. § 440.130(c); Social Security Act § 1905(a)(13), 42 U.S.C. 1396(d); NHLP, *supra* note 184, at 13. For services not provided by a licensed provider, a state may submit a State Amendment Plan to include these preventive interventions as long as they are recommended by a physician or other licensed practitioner within the scope of their practice. 42 C.F.R. § 440.130(c); Social Security Act § 1905(a)(13), 42 U.S.C. 1396(d); NHLP, *supra* note 184, 13. Both Minnesota and Oregon utilized this method initially for Medicaid payments for doula services. NHLP, *supra* note 184, at 13.

⁵⁴⁸ Under the Coordination and Continuity of Care provision of Medicaid managed care regulations, MCOs must identify and coordinate community-based, non-medical services that meets patient's health needs. 42 C.F.R. § 438.208. An example of such a service is the coordination of the transportation to a clinic for a patient who lacks a car. This provision enables MCOs to use capitation payments to cover such community coordination services and requires that coordination services be considered for MCO capitation rate-setting purposes. 42 C.F.R. § 438.208(b)(2)(iv); 42 C.F.R. § 438.4(b)(3). The payment of the service may also be considered in the numerator of the medical loss ratio for the MCO as a standard contract requirement for all MCOs and an activity that improves health care quality. 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (referring to direct claims paid to providers for services covered under the contract); 42 C.F.R. § 438.8(e)(1), (e)(3)(i), (referring to activities that improve health care quality); 45 C.F.R. § 158.150(b)(2)(i)(A)(1) (listing care coordination as an activity that improves health care quality).

⁵⁴⁹ Ellmann, *supra* note 411, at 1-3.

- **Remedy gaps in healthcare providers' and the general public's education on community birthing options and maternal care.**
 - The state legislature should appropriate funding to support midwives' and doulas' trainings and certifications, particularly for doulas of color and those serving under-served communities.⁵⁵⁰
 - Florida should ensure maternal care providers are educated on: the safety of (and evidence base supporting) integrated maternity care with consultation, shared care, and seamless transfer from community birth settings as needed⁵⁵¹; the phenomenon of obstetric violence; and the coercive nature of court-mandated orders, termination of care, and the threat of child removal. Florida should establish medical education requirements for medical and nursing students around the role, benefits, and scope of midwifery and doula care.⁵⁵²
 - Florida Department of Health should encourage insurers to educate members about the benefits of community birth settings, midwifery care, and doula care.

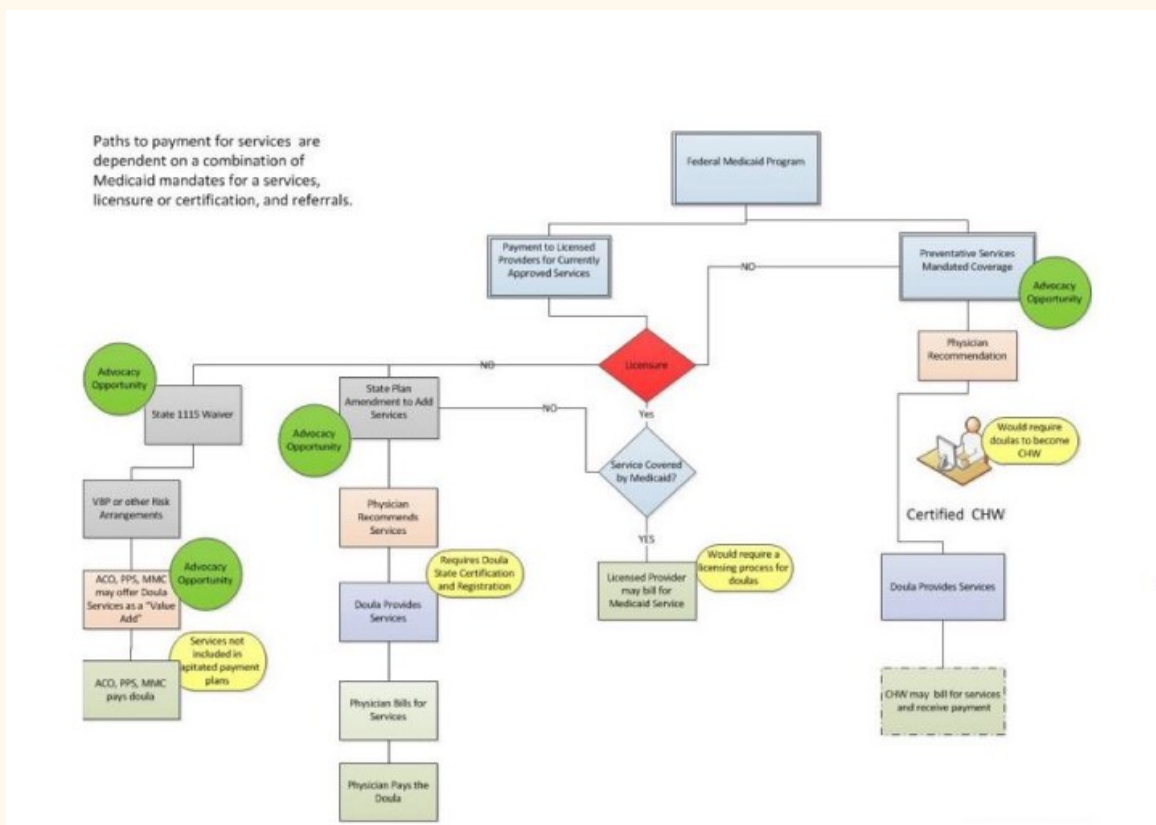


Photo from NHLP, *supra* note 184, at 22.

⁵⁵⁰ NPWF, *supra* note 4, at 29.

⁵⁵¹ NASHP, *supra* note 7, at 42. Florida can encourage or create guidance about adopting the “Best Practice Guidelines: Transfer from Planned Home Birth to Hospital” and accompanying Model Transfer Forms.

⁵⁵² NHLP, *supra* note 184, at 3.