2022

The STATE of BIRTH JUSTICE

Resources curated by Birth Detroit, Elephant Circle, and Mothering Justice with support from SisterSong.

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OUR PURPOSE IS TO EDUCATE, INFORM, & ENGAGE OUR COMMUNITIES STATEWIDE IN REALIZING BIRTH JUSTICE.

Birth Detroit's mission is to midwife safe, quality, loving care through pregnancy, birth and beyond.

Mothering Justice's mission is to empower mothers of color to influence policy on behalf of themselves and their families.

Inspired by elephants who give birth within a circle of support, **Elephant Circle** envisions a world where all people have a circle of support for the entire perinatal period.

SisterSong's mission is to strengthen and amplify the collective voices of indigenous women and women of color to achieve reproductive justice by eradicating reproductive oppression and securing human rights.

Facilitators

Tatiana Omolo, MPP, MSW, is the Government Affairs and Public Policy Manager at Mothering Justice. In this role, Tatiana manages the organization's government affairs and policy strategies at the local, state, and national level. Her early childhood years were spent living in Moscow, Russia, and Mombasa, Kenya, before moving to California. Growing up in a multicultural and multi-racial family fueled her interest in global racial and gender disparity. A graduate of Pomona College, where she earned her BA in Sociology, Tatiana also holds an MPP and MSW from the University of Michigan, where her research and policy focus concentrated on the intersection of racial and gender inequality within global and domestic political systems and communities. Tatiana is passionate about empowering communities to create and advocate for community-developed policies that center the lived experiences of our most vulnerable members.

Elon Geffrard BS, ICCE, CLC, CD (DONA) is a co-founder and Program Director at Birth Detroit. She has been a birth doula since 2016, she came to doula work "accidentally" after being a home visitor for a local health department. While maintaining a private and community based doula practice, Elon has served as project coordinator, statewide speaker and consultant with a number of public health projects but finds her greatest joys in serving women as they transition into motherhood and fostering shifts in attitudes, policy, and practice around pregnancy, labor and birth- at the system's level. She is a certified parent educator (Effective Black Parenting), certified childbirth educator (ICEA), trained in Lamaze childbirth education and is a certified lactation consultant (ALPP). She brings to the Birth Detroit team a passion for nurturing expectant families and enhancing the quality of women's health services.

The STATE of BIRTH JUSTICE

Facilitators

Shanayl Bennett is a birth worker and mom of three from the Eastside of Detroit. She has a background in community health work and family planning. Currently, she is the Black Maternal Health and Reproductive Justice Organizer at Mothering Justice. She is hoping to use her personal and professional experience to become a change agent in the community around access to quality care in the maternal health space.

Indra Lusero is a birth justice attorney who loves to tackle new territory, dive-in to cutting-edge issues and ideas, and navigate periods of change and uncertainty. Indra is the founder of Elephant Circle and the Birth Rights Bar Association. As a Queer, Genderqueer, Latinx parent rooted in the Rocky Mountain West, Indra is attuned to the importance of people on the margins and their role in leading us to dismantle oppressive systems and build a more equitable world. Indra practices a multidisciplinary approach, including legal advocacy, community-based lobbying and rulemaking, community organizing, arts and education. Indra regularly speaks about birth justice, informed consent, and policy approaches to substance use and pregnancy. Indra was the architect of Colorado's 2021 Birth Equity legislation.

Leseliey Welch, MPH, MBA, is a public health leader with a business mind and a visionary heart, holding love as a guiding value, a way of being, an action and a politic. She is Co-founder of Birth Detroit and Birth Center Equity, a mom and a tireless advocate for work that makes communities stronger, healthier and more free. Leseliey leads a team of birth workers, birth advocates and community leaders planning Detroit's first freestanding community birth center Birth Detroit and is proud of the launch of Birth Center Equity to grow and sustain birth centers led by Black, Indigenous and people of color across the country.

The STATE of BIRTH JUSTICE

BIRTH JUSTICE AGENDA

Birth justice is the human right to a safe and respectful birth experience. This includes our rights to bodily autonomy, the power to make choices, and access to midwifery care. Birth Detroit believes that all people deserve access to all safe birth options. Our mission is to midwife safe, quality, loving care through pregnancy birth and beyond. We envision a world where birth is safe, sacred, loving and celebrated for everyone. Our values are Safety, Love, Trust and Justice.

1. **Grow the number of Black midwives training and working in Detroit.**
   - Partner to make Detroit a model city for community birth education.
   - Contribute to Metro Detroit Midwives of Color scholarship fund for Black midwives.

2. **Support Birth Detroit families to ACTT*:**
   - **A**sk questions until we have enough clarity
   - **C**laim our space
   - **T**rust our bodies
   - **T**ell our stories

3. **Sustain Birth Detroit as a community born, led and committed health resource vital to Detroit's future.**
   - Lead a community birth education and story sharing campaign, highlighting the legacy and power of midwives and birth workers of color.

4. **Promote racially just and gender affirming policies to realize our human rights to bodily autonomy, to have or not have children, and to raise our children in safe, and sustainable environments.**

Research shows that midwifery model care improves maternal and infant health outcomes, and supports birth centers as part of integrated health systems. Birth Detroit is a leader in growing access to midwifery model care in Michigan.

POLICY AGENDA

REIMBURSEMENT
Establish Michigan Medicaid reimbursement and private health insurance coverage for Certified Professional Midwives (CPMs) and Certified Nurse Midwives (CNMs) providing perinatal and birth care in community birth settings.

LICENSURE
Gain state licensure for freestanding birth centers to facilitate reimbursement & sustainability and improve safety & standards of care.

INTEGRATION
Lead scaling of Black-led neighborhood midwifery clinics and freestanding accredited birth centers as part of integrated health systems, including warm and formal relationship building for care coordination and safe birth across birth settings.

EXTEND COVERAGE
Extend Medicaid coverage for postpartum people to one-year after birth.

**Black Coalition for Safe Motherhood*

BIRTH DETROIT

What is Birth Justice?
Compiled by Farah Diaz- Tello & Carmen Mojica

· Birth Justice is a movement that is designed to respect the rights of all individuals who aspire to become birthing individuals and have a child in a supportive environment: one in which the birthing individual has autonomy over their body and the ability to choose the ways in which their birthing process flows, from the prenatal to the postpartum process. It means having access to evidence-based maternity care, accurate information about pregnancy, the risks and benefits of medical procedures, and the agency to choose whether or not to undergo those medical procedures. Birth Justice has also defined it as having the power to make those choices and give birth free from fear of intimidation or interference from the state due to "noncompliance" with medical advice, or because of poverty, race or ethnicity, or immigrant status. It is also having access to competent and culturally respectful labor support.

· Long before the term "birth justice" was coined, the ancestral black foremothers used their knowledge of childbearing, resistance to enslavement, oral tradition, human rights organizing and policy work to end inequities in maternal, infant, and child health. It has been emerging in the last two decades, with deep roots in black granny midwifery and the spirit of Black resistance in the United States.

· The birth justice movement is being led Black women and women of color, so the focus is on dismantling inequalities around race, class, citizenship, sexual orientation, and all of the intersecting oppressions that lead to negative birth outcomes, particularly for women of color, trans/gender non-conforming folks, low-income communities, and immigrant women. It works towards reclaiming the midwifery tradition, securing access to these alternative birthing practices, raising awareness and building grassroots power, as well as not only addressing the high maternal and infant mortality rates for women of color but also other issues that cause pain and trauma.

What *isn't* Birth Justice

· Though reasons reach back to the enslavement, two particular movements in the United States have propelled the contemporary birth justice movement into existence: the natural birth movement and reproductive justice.

  o The natural (or alternative) birth movement began in the 1950's and 1960's when mostly college educated white women came across writing from Europe that inspired a desire in claiming their right to joyful and empowered birthing experiences. They challenged the medicalization of childbirth, the hegemony of male physicians and the medical technology while building alternative grassroots birthing communities across the country. While this movement has been successful in the incorporation of family members in the delivery room, reducing routine medical interventions, and the creation of birth centers, it has presented false narrative of white midwives and birth advocates following in the footsteps of vanishing black granny midwives.

o The political advances made by natural birth movement in legalizing midwifery, as well as the development of doulas, lactation consultants, childbirth education classes and other improvements for childbearing individuals, do not challenge the entrenched inequalities rooted in the commercialization of health care and the rise of the medical industrial complex. This movement was able to appeal to legislators by aligning itself with motherhood and consumerism rather than advocating for safe, empowering perinatal care as a human right for all regardless of pay. It mobilized popular ideologies about the rights of the consumer, shedding their more radical origins in favor of a focus on consumer rights to gain support of otherwise reluctant legislators.

§ Reducing birth justice to the right shop has negative consequences, particularly for poor women, women of color, women with disabilities, and trans/gender non-conforming people. These groups of people are currently more recipients and dependents rather than consumer-citizens the way white middle class women often are. It also ignores other vulnerable pregnant people, including but not limited to: incarcerated women, women in immigration detention centers, young women in juvenile halls who are subjected to practices that endanger their pregnancies including shackling, denial of prenatal care and inadequate nutrition, and stigmatizing birthing individuals, such as people living with mental or physical disability or drug addiction, who battle for the right to carry their pregnancies and to receive the support they need to raise their infants.

- Natural birth advocates portray medicalized birth as a patriarchal invention by male doctors. This ignores the racial origins of the field of obstetrics in the United States, and the fact that the advances made in the field of obstetrics and gynecology were made primarily by white male physicians to only benefit middle class and affluent white women. The natural birth movement lacks this knowledge that the privileges they have gained and those they have fought for have always come at the expense of Black people.

o The term “reproductive justice” was coined by a group of black women in 1994. From this group, a framework and Sister Song, a collective led by indigenous women and women of color, emerged. Reproductive justice organizations have been slow to confront the medical violence and coercion that women experience during pregnancy, labor and childbirth. National Advocates for Pregnant Women (NAPW)in 2001 made visible the inconsistence that arise when the human right to a safe, respectful birth experience is not seen as a central part of the reproductive justice agenda. While respecting the important work and strides of the reproductive justice movement, NAPW made the point that the movement seldom defended the right of birthing women to out of the hospital birth, vaginal birth after cesarean (VBAC) or midwifery care. It has said little about the epidemic rates of cesarean section and seldom comments on the media’s

depiction of homebirth and refusal of cesarean section as irresponsible. In addition, the notion that midwifery and doula care as a luxury remained unchallenged despite the fact that these services can make change to the experience of Black and marginalized individuals' birthing experiences. At the SisterSong conference in 2011, 30 birth activists in the United States came to discuss the need for birth oppression to be seen a s a central concern and called for national movement led by women of color to challenge coercion and medical violence, reclaim midwifery traditions on communities of color, and raise awareness about strategies to overcome birth inequities.

Sources:

Birth Justice: Black Women, Pregnancy, and Childbirth edited by Julia Chinyere Oparah and Alicia D. Bonaparte

NAPW Working Paper: Birth Justice as Reproductive Justice by Farah Diaz-Tello and Lynn M

What is "Community-Based"?

The term "community-based" is used dozens of times in the Momnibus legislation and is an important concept in improving maternal health. It is a term that is used in many disciplines, from social work to public health, healthcare, the arts, design, technology, research and more. Frameworks like "reproductive-justice" and "intersectionality" are also informative and relevant to the use of "community-based" in this context.[1]

While there isn't one shared definition, research has demonstrated that "people largely agree about what community is" and that an element of community-based success is making sure people are "empowered to function in ways that are meaningful to their community base."[2] Doulas and midwives, especially midwives who attend people in community-birth settings, are often considered "the key" to addressing the U.S. maternal health crisis.[3]

This session's Birth Equity Bill Package is a community-based response to our maternal health crisis.

Community-based solutions are different – that's why they work. This bill package was not developed by a health system's policy staff or professional association's lobbyist. It was developed by people rooted in community and people who don't gain from maintaining the status quo, or aren't financially invested in the status quo.

It is inspired by and driven by direct-experience with community-birth, midwives and doulas. It is the kind of work that the Momnibus seeks to support in both form and content. **As a result the process and priorities of the bill package may be different** than the status quo**. This is may be disorienting or uncomfortable for people who are part of or invested in the status quo.**

But when the status-quo has demonstrated that it is ineffective[4] looking beyond the status quo is essential. [5] That is what these bills do.

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[1] *See* L. Ross et. al. Eds., Radical Reproductive Justice, (Feminist Press 2017).
[2] KM MacQueen et al. "What is community? An evidence-based definition for participatory public health." Am J Public Health. 2001;91(12):1929-1938. doi:10.2105/ajph.91.12.1929
[3] *See* Nora Ellmann, "Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis," Center for American Progress, April 14, 2020. Available at: https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/
[4] *See* Alison Young, "Hospitals know how to protect mothers. They just aren't doing it." USA Today, December 15, 2019. Available at: https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/
[5] *See* our other fact sheet available at https://www.elephantcircle.net/s/Opportunity-for-a-paradigm-shift-in-maternity-care.pdf

How a Bill becomes a Law — Michigan Legislature

This is a general and very brief description of the major steps of the legislative process a bill must go through before it is enacted into law.

Introduction

Bills may be introduced in either house of the Legislature. Senate bills are filed with the Secretary of the Senate and House bills with the Clerk of the House. Upon introduction, bills are assigned a number. At the beginning of each biennial session, House bills are numbered consecutively starting with House Bill No. 4001 and Senate bills are numbered starting with Senate Bill No. 1. In both houses, joint resolutions are assigned a letter.

Title Reading

Under the State Constitution, every bill must be read three times before it may be passed. The courts have held, however, that this requirement can be satisfied by reading the bill's title. Upon introduction, the bill's title is read a first and second time in the Senate and is read once in the House. The bill is then ordered to be printed. A bill cannot be passed or become law until it has been printed or reproduced and in the possession of each house for at least five days.

Referral to Committee

Upon introduction, a bill is also referred to a standing committee in the Senate by the Majority Leader and in the House of Representatives by the Speaker of the House. All bills involving an appropriation must be referred either directly to the appropriations committee or to an appropriate standing committee and then to the appropriations committee.

Committee Review

Committee members consider a bill by discussing and debating the bill. The committee may also hold public hearings on the bill.

Committee Action

A standing committee may act on a bill in various ways. The committee may:

a. Report the bill with favorable recommendation.
b. Report the bill with amendments with favorable recommendation.
c. Report the bill with the recommendation that a substitute be adopted.
d. Report the bill without recommendation.
e. Report the bill with amendments but without recommendation.
f. Report the bill with the recommendation that the bill be referred to another committee.
g. Take no action on a bill.
h. Vote to not report a bill out of committee.

In the cases of d and e, the bill, upon being reported from committee, is tabled on the floor (temporarily removed from consideration). A majority vote of the members present and voting in the house where the bill is tabled is required to remove the bill from the table before it may be given further consideration.

In both houses, a majority vote of the members serving on a committee is necessary to report a bill. If a committee fails to report a bill, a motion to discharge the committee from consideration of the bill may be offered in the house having possession of the bill. If this motion is approved by a vote of a majority of the members elected and serving, the bill is then placed in position on the calendar for floor action. In the House, at least a one-day prior notice of the motion to discharge must be given to the Clerk of the House.

Committee Reports

If a bill is reported from committee favorably with or without amendment or in the form of a substitute bill, the committee report is printed in the journal under the order of business entitled "Reports of Standing Committees" in the House. On being reported favorably from committee, the bill and recommended committee amendments (if any) are placed on the order of "General Orders" in the Senate. In the House, the bill and amendments are referred to the order of "Second Reading."

General Orders or Second Reading

For the purpose of considering the standing committee recommendations on a bill, the Senate resolves itself into the Committee of the Whole and the House assumes the order of Second Reading. Amendments to the bill maybe offered by any member when the bill is being considered at this stage of the legislative process. In the Senate, a simple majority of members present and voting may recommend adoption of amendments to the bill and recommend a bill be advanced to Third Reading. In the House, amendments may be adopted by a majority serving, and a majority voting may advance the bill to Third Reading. In the House, a bill may be placed on Third Reading for a specified date.

Third Reading

While there are provisions in the House Rules and the Senate Rules for reading bills unless exception is made, in practice, bills are not read in full in either chamber. In both houses, amendments must be approved by a majority vote of the members serving and the previous question maybe moved and debate cut off by a vote of a majority of the members present and voting. At the conclusion of Third Reading, the bill is either passed or defeated by a roll call vote of the majority of the members elected and serving (pursuant to the State Constitution, approval of certain measures requires a "super majority" of a two-thirds or three-fourths vote) or one of the following four options is exercised to delay final action on the bill: (a) the bill is returned to committee for further consideration; (b) consideration of the bill is postponed indefinitely; (c) consideration is postponed until a certain date; or (d) the bill is tabled.

Following either passage or defeat of a bill, a legislator may move for reconsideration of the vote by which the bill was passed or defeated. (A motion to reconsider can be made for any question.) In the Senate, the motion for reconsideration must be made within the following two session days; in the House, the motion must be made within the next succeeding session day.

Five-Day Rule

No bill can become law at any regular session of the Legislature until it has been printed and reproduced and in the possession of each house for at least five days. (Constitution, Art. IV, Sec. 26.)

Immediate Effect

No act shall take effect until the expiration of 90 days from the end of the session at which the measure was enacted. The Legislature may give immediate effect to an act by a two-thirds vote of the members elected and serving in each house. (Constitution, Art. IV, Sec. 27.)

Enactment by the Legislature

If a bill passes, it is sent to the other house of the Legislature where the bill follows the procedure outlined above, resulting in defeat or passage.

If a bill is passed by both houses in identical form, the bill is ordered enrolled by the house in which the bill originated. Following enrollment and printing, the bill is sent to the Governor.

If a bill is passed in a different form by the second house, the bill must be returned to the house of origin and one of the following occurs:

a. If the amendment(s) or substitute bill of the second house is accepted in the house of origin, the bill is enrolled, printed, and sent to the Governor. It should also be noted that either house may amend an amendment made by the other to a bill or joint resolution. At any time while in possession of the bill, either house may recede from its position in whole or in part and the bill may be returned to the other house for this purpose. If this further action is agreed to by both houses, the bill is ordered enrolled.

b. If the amendment(s) or substitute proposal of the second house is rejected in the house of origin, the bill is then sent to a conference committee (a special committee composed of three legislators from each house) which attempts to compromise differences between the two versions of the bill. The conference committee can consider only issues in the bill upon which there is disagreement between the two houses. However, when the agreement arrived at by the conferees is such that it affects other parts of the bill, such as in an appropriations measure, the conferees may recommend further amendments to conform with the agreement. The conferees may also recommend corrections to any errors in the bill. The conference committee may reach a compromise approved by at least a majority of the conferees from each house, and submit a report to the house of origin. If adopted, the report and bill are transmitted to the second house. If the conference committee report is approved in the second house, the bill is then enrolled, printed, and sent to the Governor. A conference report may not be amended by either house. If the conference committee is notable to agree, or if the report is rejected by either house, a second conference committee is appointed. When a second conference has met and the two houses are still unable to agree, no further conference is in order.

Approval by Governor

Upon receipt of an enrolled bill, the Governor has fourteen days to consider the bill. The Governor may:

a. Sign the bill, which then either becomes law at the expiration of ninety days after the Legislature adjourns sine die or on a date beyond the ninetieth day specified in the bill. If the bill has been given immediate effect by a two-thirds vote of the members elected to and serving in each house, the bill will become law after the Governor signs the bill and files it with the Secretary of State or on a day specified in the bill.

b. Veto the bill and return it to the house of origin with a message stating the Governor's objections.

c. Choose not to sign or veto the bill. If the bill is neither signed nor vetoed, the bill becomes law fourteen days after having reached the Governor's desk if the Legislature is in session or in recess. If the Legislature should adjourn sine die before the end of the fourteen days, the unsigned bill does not become law. If the Legislature has adjourned by the time the bill reaches the Governor, he or she has fourteen days to consider the bill. If the Governor fails to approve the bill, it does not become law.

Legislative Veto Response

If the Governor vetoes a bill while the Legislature is in session or recess, one of the following actions may occur:

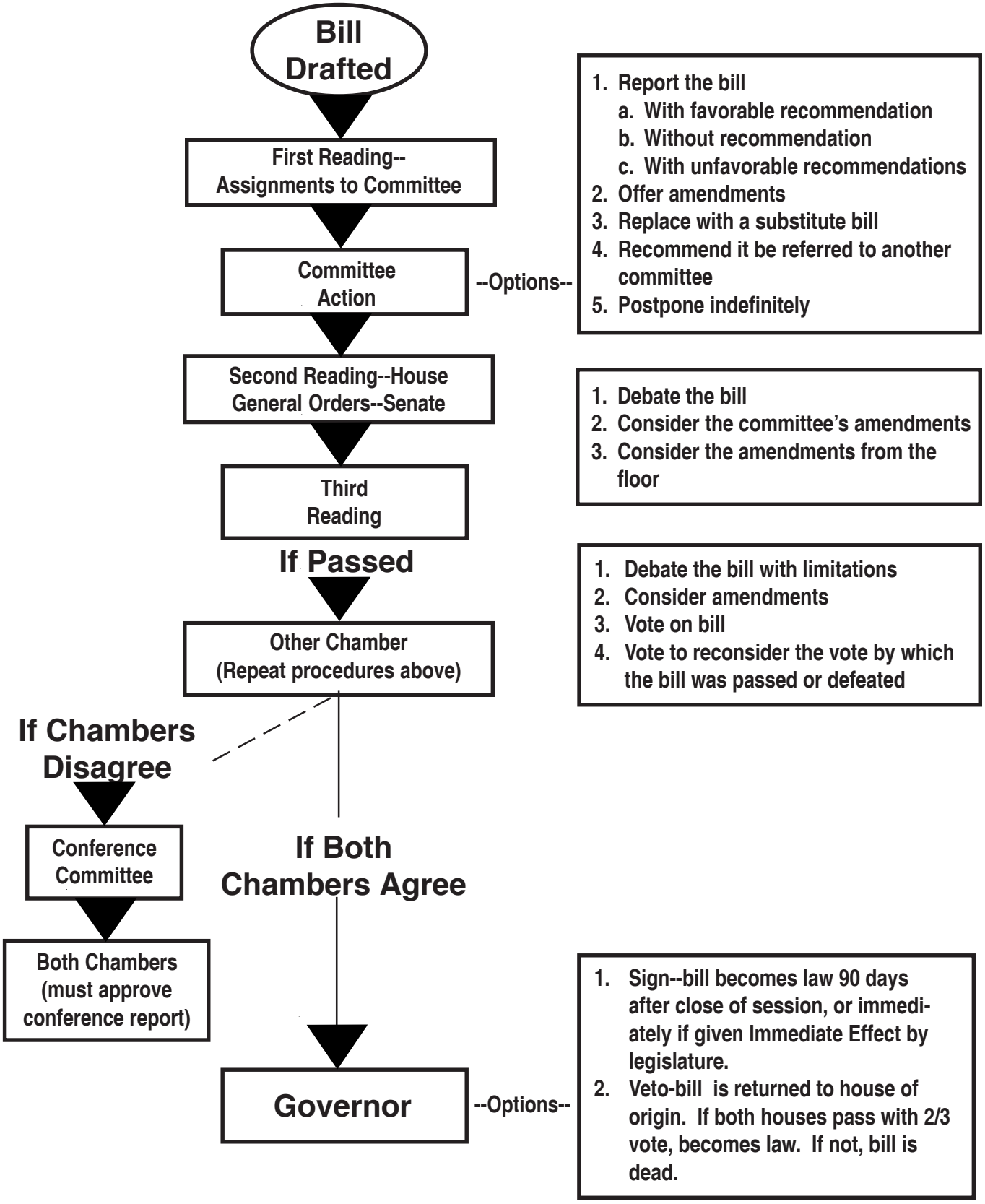
a. The Legislature may override the veto by a two-thirds vote of the members elected to and serving in each house. The bill then becomes law.

b. The bill may not receive the necessary two-thirds vote and thus the attempt to override the veto will fail.

c. The bill may be tabled.

d. The bill may be re-referred to a committee.

How A Bill Becomes A Law In Michigan



Source: "How a Bill Becomes a Law in Michigan." Michigan State University, College of Agriculture & Natural Resources, https://www.canr.msu.edu/uploads/files/How_bill_becomes_law.pdf.

Lack of Information is a Weapon of Oppression

March 02, 2021

If you are in a position to influence or block policy solutions and do not have the information you need, cede your power to someone who does. Unfortunately, this essay arises from our experience with professionals who have insisted that they cannot support a particular policy solution, or even need to block policy change, due to *a lack of information*. **This is unacceptable.** It is especially unacceptable when the policy solutions are being advanced by people who are directly impacted. There will always be someone whose life experience required them to find, understand, process and take a stand based on the available information, and those life experiences make them well-suited to policy change. Those life experiences are *information* that can and should be translated into policy solutions.

Lacking information is unacceptable since there is plenty of information freely and widely available.[i] From time to time a specific data point may be lacking. But in these situations, it is not just possible, but responsible and necessary, to make sense of missing data. Missing data *is information,* and information about which policy decisions can be made.

When it comes to maternal health[ii] policy, "lack of information" is additionally unacceptable because the information is there and the time for action is now. Whole generations of professionals encountering this "lack of information" in maternal health have dedicated their lives to both gathering information and making sense of missing data. Those dedicated researchers took the "lack of information" claim as an earnest assessment, and not "delay and denial" on the part of policymakers willfully blocking needed change to the status quo. But it is worth examining "lack of information" as both earnest, and as a pattern of delay or denial that has dire maternal health consequences.

"When researchers have analyzed maternal deaths and near-deaths to understand what went wrong, one element they have noted time and again is what some experts have

dubbed “delay and denial” — the failure of doctors and nurses to recognize a woman’s distress signals and other worrisome symptoms, both during childbirth and the often risky period that follows."[iii] Though more removed from the clinical setting, delay and denial happens in policymaking too, and the consequences are just as dire. Lacking information is part of a dangerous pattern in perinatal health care.

Providers fail to listen to their patients, people who have critical information, and this leads to poor care. This was put starkly by Susan Goodhue when she told USA Today, “The staff, by not knowing, and not listening and not taking precautions, almost killed us.”[iv] Indeed, not listening guarantees a lack of information. It is worse for Black, Indigenous and other women of color, as Pat Loftman aptly described to ProPublica, “If you are a poor black woman, you don’t have access to quality OBGYN care, and if you are a wealthy black wom[a]n, like Serena Williams, you get providers who don’t listen to you when you say you can’t breathe,”[v] referring to Serena Williams’ high profile experience with providers who initially ignored her when she told them she was having a pulmonary embolism after giving birth.

As midwife Demetra Seriki points out in this 9News Interview, "Being heard is a life-saving conversation that every Black person needs to have with their provider. And if they’re not getting it with this provider they need to get it somewhere else."[vi] The same is true when it comes to policymaking, we can no longer countenance providers who fail to listen and then stand in the way of necessary change. The stakes are too high.

Whether it be the voice of patients, or experts, researchers, and advocates too much critical information is being dismissed by people in a position to save lives. “Failure to listen to Black women” is such a common problem across industries that it is Googleable, and it is unconscionable every time. Lacking information about maternal health, in this day and age, means you have either failed to make gathering information a priority, or you have dismissed certain information as illegitimate. The egregious inequities in perinatal outcomes by race alone should give you pause and make you look closely at how and to what extent you are contributing to those inequities; how and to what extent you are missing distress signals, how and to what extent your lack of information is part of the problem.

Lack of information has been a persistent excuse for obstetric racism both at the individual and structural levels from the beginning; it was designed that way. Individual distress signals are delegitimized among providers, and expert, researcher, and advocate distress signals are delegitimized among policymakers. Many, many people had information about obstetric racism before the information was prioritized or legitimized. [vii] This antipathy to information in maternal health has costs and must be urgently addressed.

The antidote is simple: make it a priority to gather information and listen more. Interrogate whether your lack of information is actually a failure to receive the available information; listening can be impeded by bias. It is part of the structure of white supremacy and other systems to categorize the voices of people of color, women, the queer, disabled, incarcerated etc, as illegitimate or *not information.* There is a long history of denying the information that Black and Indigenous people have (and need), denying the information that communities of color have (and need), denying the information that all kinds of marginalized people have (and need). "Lack of information" from people in power, when there is a cacophony of information being delegitimized, is a weapon of oppression.

Of course, it's possible that when people say they lack information what they actually mean is that processing the information requires them to take a stand; perhaps a stand against white supremacy or some other powerful system. This too should give us pause. At whose expense and for whose benefit can you afford *not to take a stand?* At whose expense and for whose benefit can you afford *not to listen*? This is a good question in general and particularly acute when it comes to maternal health.

It is irresponsible to be in a policymaking position without the capacity to process information and the courage to take a stand. People who have been marginalized figure out how to process information and take the associated risks because they must as a matter of survival. Cede your power to them. Whether it is a lack of prioritization, a lack of legitimization, or a lack of willingness to take a stand, there is no excuse for showing up to influence policy *without information*. Come to the table ready or cede your power to those who are.

[i] Though there are other places to start, consider the 1925 White House Conference on Child Health and Protection that determined "untrained midwives approach, and trained midwives surpass, the record of physicians in normal deliveries." *See* Judith Pence Rooks, Midwifery and Childbirth in America (Temple University Press 1997).

[ii] Using the term "maternal health" here, though the people who need health care for pregnancy and birth are not just moms, because there is a field of inquiry referred to in this way where there is a bounty of information.

[iii] Katherine Ellison and Nina Martin, "Severe Complications for Women During Childbirth Are Skyrocketing — and Could Often Be Prevented," ProPublica, December 22, 2017.

[iv] Alison Young and Alison Young, "Hospitals know how to protect mothers. They just aren't doing it." USA Today, Jul. 26, 2018. See also this video:
https://twitter.com/USATODAY/status/1022535120237080581

[v] Annie Waldman, "New York City Launches Initiative to Eliminate Racial Disparities in Maternal Death," ProPublica, July 30, 2018. Available at:
https://www.propublica.org/article/new-york-city-launches-initiative-to-eliminate-racial-disparities-in-maternal-death And speaking of not breathing, *see also* Rachel Hardeman, et. al., "Stolen Breaths," N. Engl. J. Med. July 16, 2020. Available at:
https://www.nejm.org/doi/full/10.1056/NEJMp2021072

[vi] 9News.com, February 25, 2021. Available at: https://9news.com/embeds/video/73-33122767-fea2-44b7-a0aa-2ae9b40fd925/iframe?jwsource=cl

[vii] Not just in recent history, but for decades and decades and even hundreds of years. Every person whose reproduction has been politicized, through slavery or colonization just to name two broad examples, has information about inequities in health outcomes. The problem is not a lack of information but a characterization of some information as *not information*. There are so many citations for this, but to reinforce the point check out this Executive Summary from 2015.

MI MOMNIBUS: Momnibus for Michigan?Why Now?

What is Momnibus?
Momnibus is a piece of legislation (an act) that includes several bills to improve maternal and infant health by addressing systemic racism and other social determinants of health. The Black Maternal Health Momnibus Act of 2021 was introduced at the federal level in 2020 by Congresswoman Alma Adams, Congresswoman Lauren Underwood, Senator Kamala Harris, and Black Maternal Health Caucus members. It contains nine bills to "comprehensively address every dimension of the maternal health crisis in America." It has not yet been passed.

Do states have Momnibus?
In the last year, birth justice advocates in Colorado and California passed local Momnibus bill packages to address access, inequities, and mistreatment in their state maternal health systems. These state Momnibus Acts are a model for other states seeking to transform maternity care.

The Colorado Momnibus, called the Birth Equity Bill Package, is a package of three bills crafted with the support of Elephant Circle. This bill helps lead the way to broader conversations at the state level. It is an example of addressing the wide range of issues facing pregnant people in one comprehensive policy platform. This comprehensive approach is a hallmark of the reproductive and birth justice movements.

What would Momnibus mean for Michigan?
Now is the time for Momnibus in Michigan (MI Momnibus). Birth justice advocates from around the state are working to address systemic racism in our maternal health system by increasing access to midwifery care and centering ourselves as leaders in our own care. Legislative barriers are limiting the reach of this crucial work. Licensing birth centers and reimbursing midwifery care across birth settings is paramount to improving maternal health in Michigan. A comprehensive statewide bill, centering community needs and desires, reducing barriers to midwifery care, and respecting the human rights and dignity of all birthing people would help improve maternal health equity and the lives of Michigan families.

Who can make it happen?
Together, we can make it happen! A strong coalition of community change-makers can come together to improve access to midwifery-led maternal health care for all Michigan families. Mothering Justice, Birth Detroit, and Elephant Circle, with support from SisterSong, are convening community stakeholders from across Michigan to start the conversation.

Why now?
All people deserve access to safe birth options of their choice – and to dignity and respect in maternal health care. Disparities in maternal health care are preventable. Research shows us what works, and our communities know what we want. Our families cannot wait.

What is the Birth Detroit Birth Justice and Policy Agenda?
The Birth Detroit Birth Justice and Policy Agenda suggests actions to improve access to care and realize birth justice in our state. Birth center licensure, reimbursement for midwives and doulas, Medicaid coverage extension, comprehensive support for rural and urban families, and more Black, Indigenous, and providers of color are needed.

What is needed?
You tell us! Mothering Justice, Birth Detroit, and Elephant Circle have developed a short survey to invite input from communities across Michigan. Survey link will be available after the first State of Birth Justice Community Town Hall on February 8th.

For more information email mibirthjustice@gmail.com.

Together we can create a safer, more just place for birth in Michigan!

Additional RESOURCES

01

Every Mother Counts Advocacy Toolkit

02

21-Point Black Midwives Care Model

03

21-Point Black Midwives Care Model

04

Elephant Circle's Birth Equity Policy Platform

05

Share your ideas towards Birth Equity Here

Thank you for joining us for the State of Birth Justice Community Town Hall.

ACKNOWLEDGEMENTS

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