Mayor's Office to
End Domestic and
Gender-Based Violence

REMARKS OF

DEPUTY COMMISSIONER TESA AROZQUETA
MAYOR'S OFFICE TO END DOMESTIC AND GENDER-BASED VIOLENCE

BEFORE THE NEW YORK CITY COUNCIL
COMMITTEE ON WOMEN AND GENDER EQUITY

on

"int 1094-2024: Culturally Competent Training on Recognizing the Signs of FGM/C"

June 3, 2025

Good morning, Chair Louis and Members of the Committee on Women and Gender Equity. I am Tesa Arozqueta, Deputy Commissioner of External Affairs and Community Initiatives of the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV). I am joined by Arrizu Sirjani, ENDGBV's Senior Policy Advisor. ENDGBV operates the City's five Family Justice Centers and directly manages a contract portfolio of prevention and intervention programming. Our office builds capacity for agency staff and community members to identify and respond to domestic and gender-based violence (DV/GBV) through outreach and training. We also develop policies and best practices to strengthen the City's approach to these issues. We collaborate with City agencies, over 100 nonprofit providers, community stakeholders, and people with lived experience to reduce barriers and ensure access to inclusive, culturally responsive services for all survivors, including those impacted by FGM/C.

Thank you for the opportunity to speak with you about Intro. 1094-2024.

FGM/C has long been recognized as a form of gender-based violence with profound physical, psychological, and emotional consequences. For this reason, it is already integrated across ENDGBV's existing work. We approach FGM/C as part of a broader spectrum of gender-based harms—those that disproportionately

impact women and girls—and which demand a trauma-informed, survivor-centered response.

At our Family Justice Centers, FGM/C often surfaces indirectly. Clients may seek help for intimate partner violence or other abuse, and in the process of building trust, disclose prior experiences with FGM/C. Our staff are trained to recognize and respond to these disclosures with cultural humility and sensitivity—even when they are not the presenting concern. In fact, FGM/C has been consistently included in ENDGBV's gender-based violence training, because we understand it as a core part of our mission.

In 2022, pursuant to Local Law 109, ENDGBV convened a multidisciplinary Advisory Committee on FGM/C. This group included survivors, advocates, healthcare professionals, service providers, and City agency partners. Together, we assessed the current landscape in New York City and developed practical, community-informed recommendations to strengthen prevention and response efforts.

Among the Committee's key findings was the need for training that is tailored, culturally competent, and role specific. A single model will not meet the needs of the diverse professionals who may encounter FGM/C. The content and

delivery must reflect each sector's unique responsibilities, whether in healthcare, education, child protection, or law enforcement.

The Committee also emphasized that training and advocacy must be led by community-based advocates—especially those with lived experience. These leaders have deep cultural insight and trusted relationships that position them to guide meaningful outreach, build trust, and shape effective strategies that reflect the realities of impacted communities.

Importantly, beyond training, the Advisory Committee advanced several additional recommendations to support a truly comprehensive response. These include culturally responsive public outreach co-developed with survivors and grassroots organizations to ensure materials are accurate, accessible, and resonate with impacted communities; ethical, survivor-informed data practices, including exploring anonymous and voluntary data collection tools that protect privacy and avoid re-traumatization; and ongoing community engagement, with survivors and credible messengers continuously involved in shaping policies and programs.

ENDGBV remains fully committed to advancing this work in collaboration with sister agencies and community partners. As the office tasked with citywide

coordination on FGM/C, we continue to lead cross-sector conversations, support implementation, and provide technical assistance and training as needed.

We believe this work must remain flexible, survivor-centered, and rooted in cultural humility, built in close partnership with those most directly impacted. ENDGBV's ongoing efforts already reflect this commitment. While we appreciate the intent of Int. 1094-2024, we respectfully note that its goals align closely with work that is well underway. We do not believe new legislation is necessary to advance this mission—we are already doing this work, and we will continue to do so with urgency and care.

We look forward to continued collaboration with the Council, our sister City agencies, and community-based partners to advance a coordinated, survivor-centered response to FGM/C. Thank you for the opportunity to testify today. I welcome any questions you may have.

Testimony

of

Gretchen Van Wye, MA, PhD

Assistant Commissioner for Vital Statistics and Vital Records and Chief Epidemiologist

New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Women and Gender Equity

on

Intro 1258-2025

June 3rd, 2025
City Hall
New York, NY

Good morning, Chair Louis, and members of the Committee. I am Dr. Gretchen Van Wye, Assistant Commissioner for Vital Statistics and Chief Epidemiologist at the New York City Department of Health and Mental Hygiene (the NYC Health Department). On behalf of Acting Commissioner Morse, thank you for having me here today to discuss Int. 1258-2025, which requires the NYC Health Department to issue death certificates with sex designations that are consistent with the gender identity and establish a procedure to request correction of the sex designation on a death certificate.

The NYC Health Department has a long-standing commitment to representing the gender identities of individuals in accordance with their preferences, starting in 2015 with birth certificates. In 2020 the NYC Health Department made it easier for transgender and non-binary people to have death records that accurately reflect their gender identity. On January 2, 2020 option X for decedent sex became effective and the current options for completing the sex field are male, female, undetermined, and X. If there is a need to change a sex designation on the death certificate a surviving spouse, domestic partner, child, parent, sibling, or other party referenced in the NYC Health Code—may submit a request within the first year to the facility where the death occurred, or if more than a year from when the death occurred, submit an application directly to the NYC Health Department.

Most of these changes are submitted to the NYC Health Department by the facility where the person passed within the first year after death, as they are the party that works directly with the family, and they are required to report the death. Since the NYC Health Department instituted option X, there have been very few decedents whose surviving families have chosen to apply to the NYC Health Department for a gender marker change on a death certificate. We have received fewer than five requests to change a gender marker on a death certificate after 1 year.

While it is important to honor people's gender identity in a respectful manner, there are reasons why individuals may choose not to make this correction, such as entitlement to benefits, ongoing estate issues, and others. For example, we heard from individuals from the community that if they had transitioned after many of their working years had ended, they were concerned that their loved ones might have difficulty accessing Social Security, life insurance, and other benefits.

Now I'll turn my attention to Intro 1258-2025. The NYC Health Department is grateful for Council's desire to be respectful to individuals' lived experience and gender identity, including in death. The Department has a long-standing commitment to representing the gender identities of individuals in accordance with their preference and uses the word "sex" rather than "gender" on the death certificate for a variety of reasons -- including that the distinction between sex and gender has long been conflated, the distinction is not uniformly followed, so that we do not "out" people who have made a gender identity change as compared to those who did not. As I previously discussed, we already have this process in place and have no plans to remove this option to correct the sex marker on a death certificate.

We look forward to working with Council to ensure this legislation fits within our current mandate for providing vital records to New Yorkers and having a robust discussion of our processes.

Thank you for having me here today to discuss Int. 1258-2025. I am happy to take your questions.

Testimony

of

Zahirah Mc Natt, MHSA, DrPH

Deputy Commissioner for the Center for Health Equity and Community Wellness and Chief Equity Officer

New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Women and Gender Equity

on

Intro 1285-2025

June 3, 2025
City Hall
New York, NY

Good morning, Chair Louis, and members of the Committee. I am Dr. Zahirah McNatt, Deputy Commissioner for the Center for Health Equity and Community Wellness and Chief Equity Officer at the New York City Department of Health and Mental Hygiene (the Health Department). Thank you for the opportunity to provide testimony today on Int. 1285-2025, which requires the NYC Health Department to establish a program to train individuals to become doulas and provide doula services. First, I want to provide an overview of our Citywide Doula Initiative and how it fits into the broader NYC Health Department goal of HealthyNYC.

HealthyNYC is the City's vision for how to improve life expectancy and create a healthier city for all. The NYC Health Department is working with partners across the city to ensure that New Yorkers are able to realize their full health potential, regardless of who they are, where they are from and where they live. Supporting the health of birthing people is a critical aspect of this work. Extreme racial inequities persist in maternal mortality. Black women and birthing people are four times more likely than their white counterparts to die from pregnancy-associated causes. Our goal is to address this inequity by reducing maternal death rates among Black women and birthing people by 10% by 2030. This guides our strategies for promoting the health of all New York families.

The NYC Health Department is focused on ensuring that every child, birthing person, and family recognize their power and have the opportunity to reach their full health and development potential. This requires access to comprehensive, respectful care and accurate health information to empower families to make healthy choices.

One crucial component of this effort is our Citywide Doula Initiative, or CDI. Launched in 2022, the CDI is made up of three complementary components: direct services, workforce development, and systems change to promote doula-friendly hospitals. As part of the Health Department's New Family Home Visits Initiative, the CDI provides high-quality, no-cost doula care in marginalized neighborhoods throughout New York City, as well as for residents of shelters and foster homes and teenagers who are income-eligible for Medicaid.

The CDI also develops the city's doula workforce with free training for community residents, an apprenticeship program for new doulas, professional development for all doulas working in the program, and a fair wage for time spent in program trainings and meetings. The CDI's trained

doulas support families in planning for childbirth, navigating labor and delivery, and welcoming their newborn. They also educate clients and their family members about early warning signs of perinatal complications, including those that could lead to maternal morbidity or mortality. And they provide screening, education, and referrals on topics like mental health, food insecurity, intimate partner violence, infant feeding, safe sleep, bonding, child development, and social services—a well-rounded array of support for families at one of the most vulnerable times of their lives.

The third pillar of the CDI focuses on systems change. The team works with community-based doula programs and maternity hospitals to implement a hospital doula-friendliness model that builds collaborative relationships between clinical providers and doulas. Although the NYC Health Department does not regulate hospitals, we collaborate with and work alongside them to help them change their organizational culture and create and implement doula-friendly policies and practices to reduce racial health inequities in birth outcomes for Black and Latino people. Six hospitals have completed our doula-friendliness intervention, and their average doula-friendliness assessment score improved by 33% from baseline to endline. Hospitals showed the largest improvement in the key capacity areas of patient awareness of doula support, and implementation of general doula-friendly hospital policies and practices. We are currently working with three hospitals in a second cohort, and the team is working to add additional hospitals as staff capacity allows. The Health Department also co-leads the New York Coalition for Doula Access (NYCDA), which centers doulas in defining professional standards and advocating for increased access to doula care. Current priorities are equitable Medicaid reimbursement for doulas and establishing a doula-friendly hospital designation.

We are pleased to report that since 2022, the CDI doulas have served more than 3,000 clients and attended more than 2,200 births. The program has also trained 148 community members as doulas. We are also pleased that no pregnancy-associated deaths have been reported for CDI clients, indicating that doula support may help reduce maternal mortality. A recent Comptroller's audit also found that "among both Black and Hispanic women, CDI clients experienced better birth outcomes than those in the general population, including for C-sections, low birth weights, and pre-term births."

There is still more to do. Data from our Office of Vital Statistics shows that in 2024, only 5.5% of NYC births were supported by doulas, and in our Taskforce on Racial Inclusion and Equity (TRIE)

neighborhoods, the percentage was even lower at 4.4%. However, this inequity would likely have been far greater without the Citywide Doula Initiative. CDI doulas supported 884 births in 2024, which was **almost half** of the doula-attended births in TRIE neighborhoods that year. However, those 884 births represent only 2% of the more than 41,000 births in TRIE neighborhoods in 2024. This means that most birthing people in disinvested neighborhoods do not have access to doulas, but the opportunity exists to expand these resources and eliminate maternal health inequities in NYC.

Our hope is that the CDI becomes a replicable model for cities and states seeking to reduce inequities in perinatal health outcomes.

That brings us to the legislation before us today, Int. 1285-2025. The NYC Health Department supports this legislation, provided that sufficient resources continue to be available for the program. We are grateful for Council's interest in promoting doula-supported births and centering the health of birthing people all across the City.

Thank you for the opportunity to testify today on this critical program.





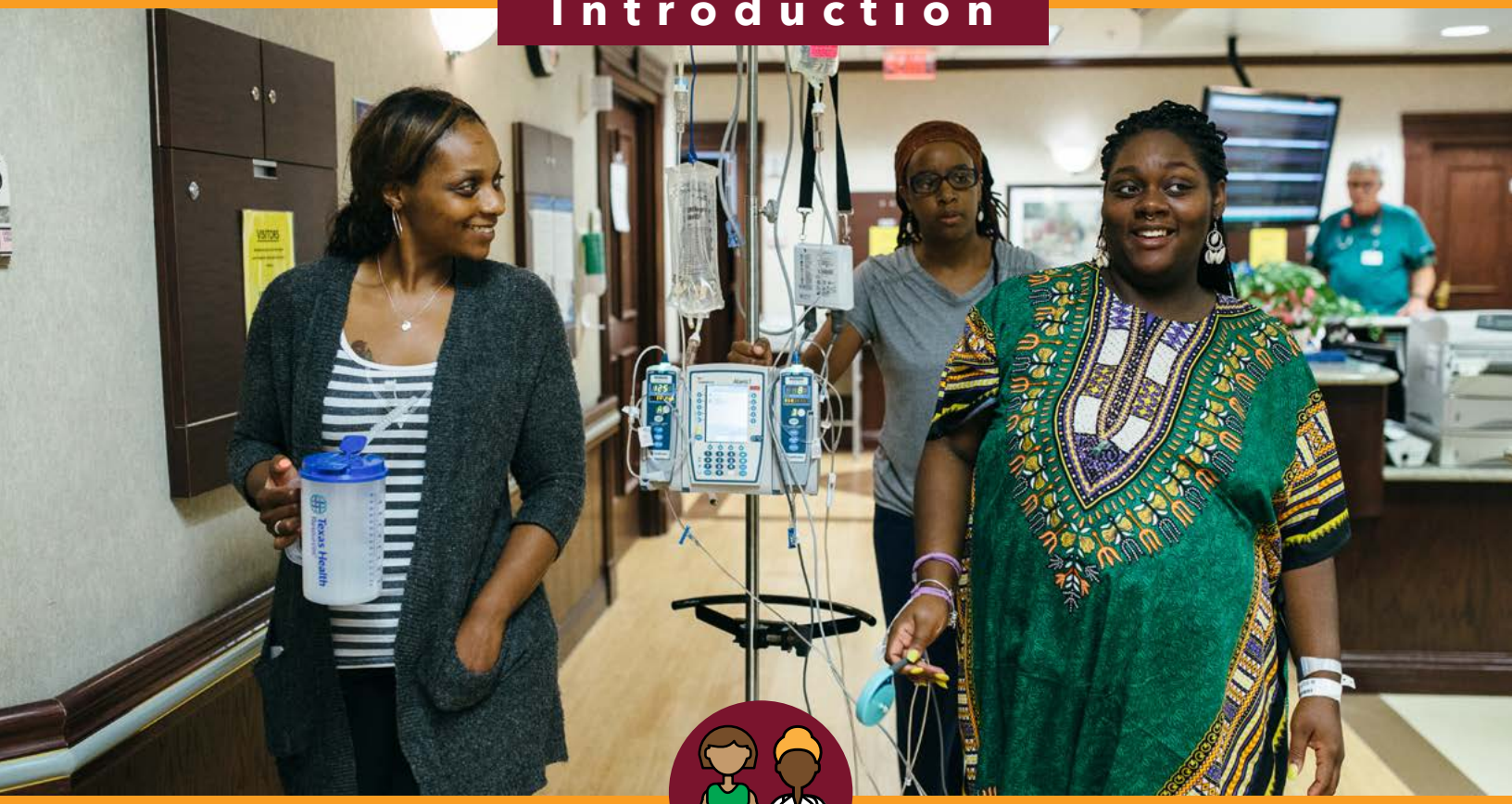


Hospital Doula-Friendliness Guidebook

NYC Health

Contents

Introduction



A doula is a trained birth specialist who offers various culturally sensitive services to clients (pregnant, birthing and postpartum people and their families) before, during and after childbirth. These may include ongoing physical, emotional, spiritual and informational support. Doulas help their clients prepare for birth, advocate for their wishes, encourage them to take an active role in their pregnancy journey and assist them with their transition into parenthood. Doulas frequently work closely with midwives to support physiological birth; both midwife and doula support are associated with improved maternal health outcomes and lower rates of medical intervention in birth. Studies have shown that doula support during and after birth can lead to improved perinatal outcomes, such as lower rates of cesarean birth (also known as C-section) and postpartum depression, and higher rates and increased duration of breastfeeding.[1] Early evidence from community-based doula programs that provide three or more prenatal home visits suggests that clients in such programs are less likely to have a preterm or low-birth-weight baby.[2]

Such support is critical given the current crisis of infant and maternal mortality in the U.S. and in NYC. In 2019 in NYC, approximately 57 people died from pregnancy-associated causes and 28 from pregnancy-related† causes.[3] Between 2008 to 2014, 2,300 to 3,100

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* Pregnancy-associated death: The death of a person from any cause during pregnancy or within one year from the end of pregnancy.

† Pregnancy-related death: The death of a person from a pregnancy complication, a chain of events initiated by pregnancy or the aggravation of an unrelated condition by the physiological effects of pregnancy.

New Yorkers suffered a life-threatening complication in childbirth.[4] Such negative outcomes disproportionately affect Black people, who were eight times more likely than white people to die from a pregnancy-related cause between 2011 and 2015.[5] Many intersectional factors lead to this inequity, and no single intervention can address all of them. However, evidence shows that doula support has the potential to reduce racial health inequities in birth outcomes for Black and Latino people and increase respectful care during birth.[6-11] Supporting organizational culture change to build anti-racist health care systems can increase access to doula support.

This guidebook provides hospitals with guidance on implementing policies and practices that improve collaboration between hospital staff and doulas. It details the ways doulas' expertise complements health care providers' expertise, explains the concept of doula-friendliness and discusses what doula-friendly policies might look like. It then lists specific procedures for assessing and improving the capacity of hospitals to implement these policies. Throughout the guidebook, narratives titled "A Tale of Two Hospitals" show examples of how doula-friendly and doula-unfriendly policies might affect the experiences of patients and caregivers.

These materials were developed as part of the Maternity Hospital Quality Improvement Network (MHQIN) initiative of the NYC Department of Health and Mental Hygiene (the NYC Health Department). This guidebook contains best practices, tips and lessons learned from MHQIN for optimizing the processes outlined. It concludes with four appendices containing practical resources: a literature review of doula-effectiveness studies, a list of doula organizations in NYC and New York State, a sample doula-friendly policy and a letter modeling doula-friendly communication.

"One of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula."

– American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine, March 2014[12]

What Doulas Do

- **Birth doulas** provide support for birthing people during labor and delivery. They typically meet with clients one or more times during pregnancy, as well as one or more times postpartum. Birth doulas are present during labor and birth for guidance and to help with comfort measures, which can include breathing, relaxation, movement and positioning techniques, as well as comforting touch. They also facilitate collaborative decision-making by encouraging respectful communication between clients, their families and the medical team. Immediately after birth, they support skin-to-skin contact and breastfeeding.
- **Postpartum doulas** work with families in the weeks and months after birth, providing nonmedical support to assist with the transitions of the postpartum period and caring for a newborn. They help the new family unit by providing evidence-based information, including on postpartum warning signs; supporting breastfeeding or other feeding, recovery,

skin-to-skin contact, and parent-infant bonding; encouraging continuous engagement with providers in the postpartum period; and providing practical help with cooking and other household duties. A postpartum doula helps new parents understand what to expect from their baby and teaches infant-soothing and coping skills.

- **Community-based doula programs** increase access to low- or no-cost doula care (birth and postpartum) in communities at risk of poor outcomes. Most community-based doulas are members of the community they serve, and they all provide culturally appropriate support and connect families to resources that help them thrive. They can provide more home visits and a wider array of services and referrals than private doulas. Community-based doulas are also trained on how racial, institutional and interpersonal bias and social determinants of health affect communities of color. They often provide full-spectrum support, including preconception, birth, postpartum, abortion and bereavement.

In a hospital setting, doulas can facilitate positive and respectful communication between the birthing person and hospital staff. They can also provide guidance on comfort measures during labor, such as breathing techniques, position changes, soothing touch, visualization, hydrotherapy, aromatherapy and the use of a birth ball or peanut ball. Doulas can help connect clients with additional resources, assist them in navigating hospital protocols, provide resource referral and follow-up, and assist with prenatal and postpartum visits.

A key strength of community doula support is continuity of care. Due to typical patterns of maternal care service delivery for Medicaid patients, the community doula may be the one provider that the birthing person can see consistently from pregnancy through the early postpartum period. This establishes trust and a sense of security, which are especially important when the client or birthing person is meeting the clinical team for the first time at the birth.

> **"My doula kept me safe and comfortable, staying in positions that suited my needs, solely focusing on me. It really helped to have someone who supports you and reacts in split seconds for your needs during stressful contractions. Doctors and nurses are there, but none of them sit and hold your hand and help you stay focused and calm. In that sense, a doula is an irreplaceable support every woman needs. I recommend getting a doula to all expecting women that I know based on my one experience. It would be awesome if they were accepted and respected by medical society for their huge positive impact on birth process."**
>
> – Doula client

What Doulas Do Not Do

Doulas do not diagnose medical conditions or perform clinical tasks. They also do not make decisions for the client or impose their own values or goals on the client.

Most doulas receive formal training. Some may also seek certification, but **unlike medical roles, certification is not required for practice**. Evidence on the benefits of doula care is not based on certification or training of doulas but on the provision of continuous labor support.[13]

What Is Doula-Friendliness?

In a hospital setting, **doula-friendly** describes institutions that "consistently demonstrate support of the doula's role in its full scope and integrate doulas into the birthing team. Doula-friendliness is grounded in policies and practices that reflect an understanding of the benefits of doula care and actively create a space where patients, doulas and clinicians collaborate to ensure the best birth outcomes and experience for the patient."[14]

Hallmarks of a Doula-Friendly Hospital

A doula-friendly hospital is one that includes:

1. Staff knowledge of doula support

The hospital actively trains staff (including but not limited to registration, triage, ambulatory, labor and delivery, and security) and ensures they are knowledgeable about the doula's role in promoting positive maternal and neonatal outcomes, including a positive birth experience.

2. Doulas as part of the birthing team

The hospital encourages its clinical team to regularly share updates with doulas regarding labor progress and potential use of interventions, both verbally and on the whiteboard, and utilizes insights from doulas' understanding of their clients and their expertise in birth support, with patients' verbal or written consent. It also provides physical accommodations as needed, such as access to a chair or break area if the client needs time alone.

3. Increasing awareness of doulas among patients

The hospital actively and consistently educates patients about the benefits of doula support using all available communication channels (such as staff-patient encounters, social media, posters, and brochures and videos played in the waiting area) and uses an established referral system to connect interested patients with community doula organizations.

4. Doula policy

The hospital develops, communicates, shares and implements a clear doula policy that provides guidelines for doulas' access to the hospital and participation in care, the laboring techniques supported by the hospital, and a bidirectional reporting system including a formal doula liaison to help address any emerging issues. The hospital facilitates the provision of continuous, calming doula support by allowing doula presence from triage to recovery unless there is a compelling medical reason otherwise (for a full description of what to include in a doula policy, see Hospital Doula Policy on Page 21).

Becoming a doula-friendly hospital is a cultural shift implemented through policy and practice, as well as through individual decisions and actions taken by dozens of staff members every day. To create these changes, hospitals should collaborate with the local doula community to develop clearly written policies that are shared with all staff and with doulas, updated routinely, and followed consistently. It is imperative that obstetric, midwifery and nursing staff receive periodic training on the most current policies, with clear instructions on safe implementation.

A Tale of Two Hospitals

Jessica realizes she is in labor, and after a quick call with her doula, Ashley, she decides to head to the hospital. Jessica arrives first and heads up to the labor and delivery floor. Ashley is not far behind.

Tale 1

Jessica introduces herself to the security guard, who welcomes her and gives her directions to the labor and delivery floor. When Ashley arrives at the nurses station, she is greeted warmly and asked to sign in. The nurses tell her that Jessica is in triage, and one of them walks Ashley to her client's bedside. Jessica has been frightened and tense – it is her first time giving birth – but Ashley's arrival puts her at ease. The resident on duty comes over to say hello and explains that all the patient rooms are full right now but that Ashley is welcome to stay with Jessica while she is in triage. The only exception will be a few questions that have to be asked of Jessica in private, but that should only take a few minutes. Jessica says, "Oh, no, I'd rather she stay with me the whole time." The nurse agrees, and Ashley settles in to rub Jessica's hands and help her breathe through her contractions as they wait for a room to open up.

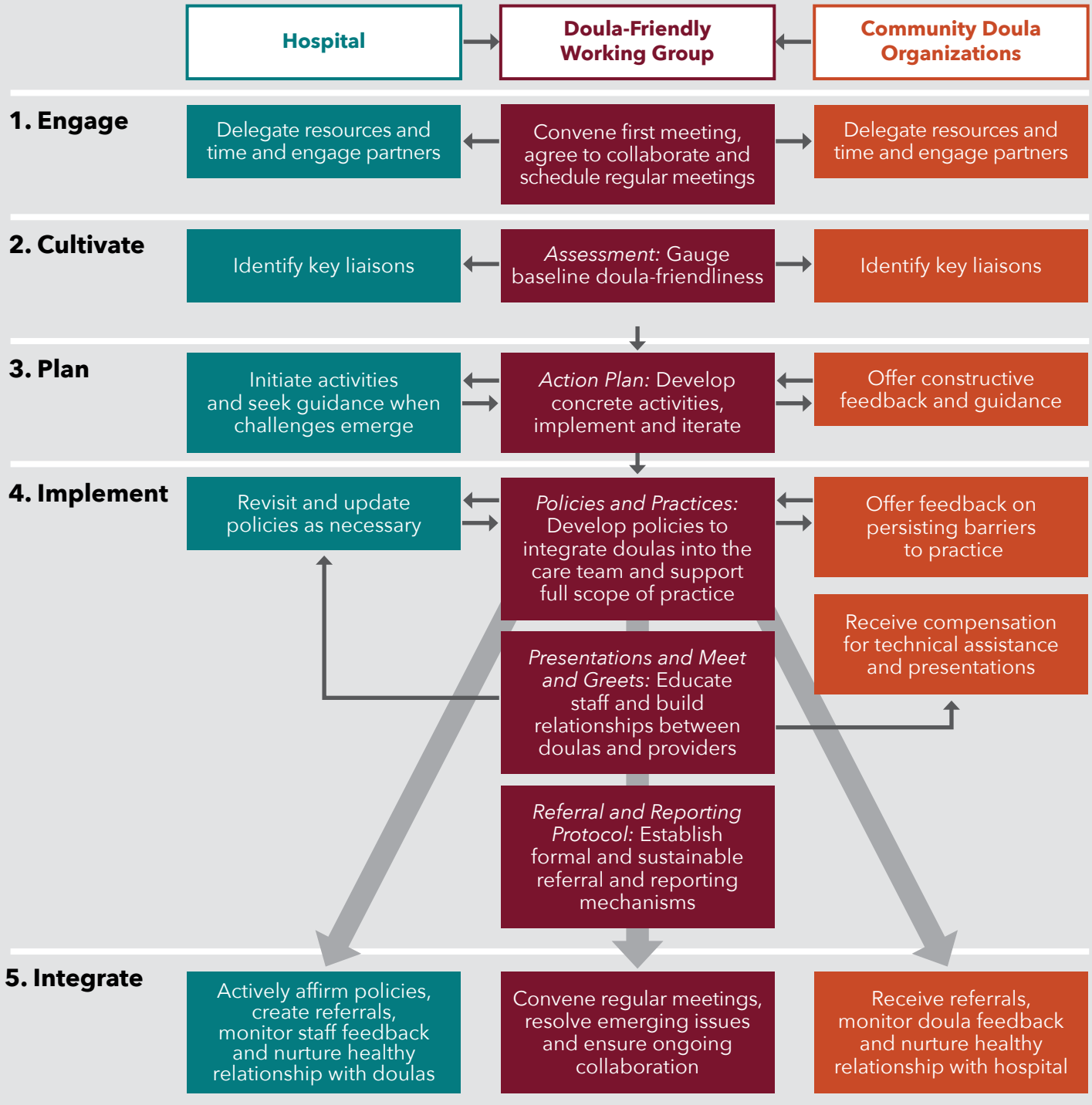
Tale 2

Jessica introduces herself to the security guard, who says, "A doula, huh?" and asks to see proof that she is certified. Ashley explains that she does not have her certificate with her, but that certification is not required to practice as a doula. The guard says, "Well, you cannot go up without it." Ashley texts Jessica to let her know what is going on. Jessica replies, "I hope you can come soon; the contractions really hurt, and I'm scared." Jessica calls her husband at home, tells him where her doula certificate is, and asks him to scan it and text it to her. She shows it to the guard, who lets her go up to the labor and delivery floor. When she walks in, one of the nurses says, "Where do you think you're going?" Ashley explains that she has come to meet her client. The nurse says that because Jessica is still in triage, Ashley will have to wait in the waiting room. Ashley texts Jessica to give her an update. An hour goes by. Jessica texts that she is thinking of getting an epidural because the pain is so intense. Ashley asks again if she can join her client but is told no, she cannot join Jessica until she gets to a room.

Hospital Doula-Friendliness Process Map

This process map serves as a guide for involvement in this process. In complement to the suggested process steps starting on Page 9, it shows how to collaborate and steps to take to integrate doulas into the care team, build out referral pathways and ultimately increase hospital doula-friendliness. Given capacity and expertise, a local health department or maternal health organization might guide this process through engagement, planning, implementation and closeout.

Figure 1: Hospital Doula-Friendliness Process Map



Source: Maternity Hospital Quality Improvement Network

How To Optimize the Process

Here is some guidance on how to ensure that the process of increasing doula-friendliness goes as smoothly as possible. As the procedure involves diverse perspectives and high stakes, it is necessary to encourage thoughtful communication and mutual respect throughout the process. As a case study, read this section to learn more about MHQIN and the lessons learned from it.

Here is an outline of suggested steps:

1. **Reach out to doula programs that support the neighborhoods your hospital serves.** To find community-based doula programs in your hospital's area, search for local doulas using the directory at the end of this guidebook, which lists organizations throughout NYC and New York State. Speak with doulas who already attend births at your hospital for further recommendations.
2. **Schedule a first meeting together.** This is a chance for groups to get to know each other, learn about services and complete the Doula-Friendliness Assessment (see Page 11).
    - From the hospital, invite a mixture of leadership, residents, midwives, nurses and physicians from the labor and delivery unit (who will understand labor and birth policies and practices), the postpartum unit (who will understand postpartum, breastfeeding and neonatal intensive care policies and practices), and prenatal clinics (who will be able to refer patients to community-based doulas).
    - From community-based doula programs, invite people in leadership roles, doulas who already provide support at the hospital or would like to, and administrative staff.
    - From the doula-friendly working group, invite hospital staff, community-based doula program staff and any other maternal health partners that can support facilitation of this process.
3. **Identify a doula-friendly hospital champion.** This will be a point person at the hospital who can coordinate with community-based doula programs and other partners to ensure that regular meetings are held, the action plan is implemented and there is coordination with hospital leadership. This role can be filled by anyone on the labor and delivery care team, such as a resident, nurse, midwife or medical student. Nursing leaders are often optimal candidates for the role of doula champion because of the critical influence they have on provider-doula interaction.
4. **Schedule an action-planning session.** In this meeting, review the scored assessment together and develop a step-by-step action plan for moving to a more robust level of doula-friendliness in each key capacity area.
5. **Schedule doula support presentations for hospital staff.** These presentations can include information on a doula's role, evidence supporting the benefits of doula care, what doula support looks like in the hospital, doula-friendly policies and how to integrate doulas into the care team.
    - Grand rounds events are a natural fit for these presentations, but the training should extend beyond clinical staff. As front desk and security staff are the first to interact with doulas upon entry to the hospital, it is vital to ensure that the presentations reach all staff.

- Include prenatal clinic staff in educational sessions, as they may make and receive referrals in collaboration with the doula program.

6. **Schedule doula meet and greet events for hospital staff.** These events are an opportunity to build relationships between hospital staff and doulas. Staff can also use these events to ask questions about what to expect as doula support becomes more common on their floor.
   - To reach the greatest number of hospital staff members, it can be helpful to schedule these events during shift changes.
7. **Schedule a referral meeting with prenatal clinic staff and the doula program.** At this meeting, develop a formal referral process and identify who will make and receive referrals.
   - Hospitals are encouraged to apply for funding to pay doula-program staff for administrative tasks such as outreach, referrals and matching patients with doulas.

Funding

For funding source ideas, see Implementing Change Despite a Lack of Resources on Page 32.

Contracts With Doula Organizations

If possible, the hospital should allocate funds to pay doula organizations for their support during this process. A contract with a doula organization should include funding for attending meetings and providing trainings (including meetings related to capacity assessment, action planning, policy development and referrals, as well as doula presentations and meet and greets). Hospitals may wish to advocate for funding doula-support services with public or private payers.

Equipment

Hospitals should have equipment available so doulas can provide their full scope of practice, which prioritizes comfort, freedom and mobility. Equipment includes birthing balls, peanut balls, birthing bars and beds, handheld fetal doppler machines, and wireless maternal-fetal monitors. If possible, hospitals or collaborating organizations should allocate funding for this equipment.

Collaboration

Community-based doula programs and maternal health programs are also encouraged to initiate collaboration with hospitals, as capacity allows. If outside programs initiate this process, hospitals will need to understand the value of improving hospital doula-friendliness and be receptive to collaboration.

It can also be helpful to work with the local health department, if it has staff capacity, experience in community engagement and positive relationships with community-based organizations. To identify the appropriate contact person, search for staff who work in maternal and child health or in a department with a similar focus.

Doula-Friendliness Assessment: Instructions

Goal: To measure the level of doula-friendliness of the hospital.

This assessment should be completed as a baseline measurement when the hospital begins efforts to become more doula-friendly and again at the end of a defined timeline to measure progress. The findings from the assessment will be scored and used to inform action planning, which includes identifying strategies hospitals can use to improve doula-friendliness. Review of the assessment can ensure all collaborators are equally informed throughout this process.

> **"It takes work to understand how providers think and feel about doulas. That deep work connecting with providers is necessary to make transformational change. Our work is not 'one size fits all.'"**
>
> – Doula

How To Complete the Assessment

Who Should Facilitate

The facilitator role is integral to the success of this program and should be fulfilled by someone who is comfortable with relationship-building, mediating and addressing power dynamics when necessary. The facilitator could be your hospital's doula-friendly champion or could come from a local health department, doula program or maternal health partner program. Administering and scoring the assessment and following through on next steps is a complex and time-consuming process, so this person should be able to sustain capacity for the initiative over the course of at least two years.

Who Should Attend

From the hospital, invite a mixture of leadership, residents, midwives, nurses, nurse practitioners, social workers, community health advocates, physicians

assistants, and physicians from the labor and delivery unit, the postpartum unit, and prenatal clinics, as well as staff from the anesthesia department. This can include staff from the working group but also expand beyond that. From community-based doula programs, invite program staff and doulas, especially those who have supported clients at the hospital before.

Implementing the Assessment

The facilitator should ask questions of the participants. To gather all relevant information, ask participants to be specific and comprehensive in their responses, and ask follow-up questions. At least one person should take thorough notes, which will inform how the assessment is scored. Questions are posed to the group of hospital staff and doulas. This process typically takes about 90 minutes.

All participants should be invited to contribute to every section with their perspective. Seek input from a variety of staff, as people in different positions may have useful views or experiences to contribute. Encourage open sharing and allow multiple opinions to be expressed.

A grading rubric with all assessment questions is provided on Page 13 for reference. Suggestions for possible responses to several questions are included after the rubric.

Scoring the Assessment

The assessment includes six key capacity areas for doula support. Each capacity area is graded on one of three levels – basic, moderate or robust – which are defined at the top of each section. Review participants' responses and use these definitions to determine which score each capacity area receives.

Next, for each key capacity area, award points according to the following scale:

- **Basic:** 1 point
- **Moderate:** 2 points
- **Robust:** 3 points

Once each key capacity area has been scored, add up all points to score the overall assessment as follows:

- 6 to 9 points: **Basic**
- 10 to 15 points: **Moderate**
- 16 to 18 points: **Robust**

Doula-Friendliness Assessment: Rubric

Figure 2: Doula-Friendliness Assessment Rubric

Key Capacity Area	Basic	Moderate	Robust
Staff Knowledge of Doula Support	**Most or all staff have limited or no understanding of a doula's scope of services and the benefits of doula support**	**Variability in staff understanding of a doula's scope of services and the benefits of doula support**	**Most or all staff have a clear understanding of a doula's scope of services and the benefits of doula support**
What is your current understanding of a doula's role? How would you describe their work?	Participant can only vaguely describe one or two characteristics of doula care	Participant clearly articulates at least three concrete characteristics of doula care	Participant exhibits a strong understanding of doula care and clearly articulates five or more concrete characteristics of doula care
Are you aware of the evidence-based benefits of doula care? If so, what evidence are you familiar with?	Participant can only vaguely describe one or two evidence-based benefits of doula care	Participant clearly identifies at least three concrete, evidence-based benefits of doula care	Participant clearly identifies four or more concrete, evidence-based benefits of doula care
What proportion of your staff are familiar with the role of doulas, as well as the benefits of doula support?	Participant reports that there is high variability in staff understanding, with less than 50% of staff sharing an understanding of a doula's scope and benefits	Participant reports that there is some variability in staff understanding, with between 50% and 75% of staff sharing an understanding of a doula's scope and benefits	Participant reports near universal understanding, with 75% or more of staff sharing an understanding of a doula's scope and benefits
Doulas as Part of the Birthing Team	**Cannot identify tangible benefits of doulas to the care team and does not prioritize doula integration**	**Recognizes the added value of doulas to the care team, but there is not wide agreement among staff on prioritizing doula integration**	**Clearly identifies tangible benefits of doulas to the care team and describes reciprocal support between doulas and care team; wide agreement among staff on prioritizing doula integration**
How do doulas support the care team? What is their added value to the team? How does the care team support doulas?	Participant cannot describe more than one way that doulas support, add value to or are supported by the care team	Participant describes at least two ways that doulas support, add value to or are supported by the care team	Participant clearly describes four or more ways that doulas support, add value to or are supported by the care team

Rubric continues on next page

What does respect for a doula look like to you?	Participant can only vaguely identify attitudes or actions that demonstrate respect for doulas	Participant identifies at least two concrete attitudes or actions that demonstrate respect for doulas	Participant clearly identifies three or more concrete attitudes or actions that demonstrate respect for doulas
Is there consensus among your staff on the way doulas should be integrated into the team?	Staff have highly variable ideas about how to integrate doulas into the team, with less than 50% of staff sharing a unified approach	Staff have largely consistent ideas about how to integrate doulas into the team, with 50% to 75% of staff sharing a unified approach	Staff have a strong consensus about how to integrate doulas into the team, with more than 75% of staff sharing a unified approach
Increasing Awareness of Doula Support Among Patients	**Information about doulas is not routinely shared with patients; no activities to increase awareness**	**Information about doulas is shared with patients but not routinely; few or no activities to increase awareness; referrals to doula resources occur infrequently**	**Information about doulas is shared with patients as part of routine care and creates opportunities for patients to learn about doula care; staff have established referral pathways to doula resources**
Do you routinely share information about doulas with your patients? If so, how?	Staff share information about doulas with identified priority patient populations less than 50% of the time; staff do not refer patients to doulas	Staff share information about doulas with identified priority patient populations between 50% and 75% of the time; staff share information about doulas through a single method; staff occasionally and informally refer patients to doulas without an established system	Staff share information about doulas with identified priority patient populations more than 75% of the time; staff share information about doulas through multiple methods; staff consistently refer patients to community doula organizations through a sustainable system that includes a designated point person, communication method with community doula organizations and an intake form or referral platform
Have you engaged in any activities to increase doula awareness among patients?	Participant has not engaged in any activities this year	Participant engages in activities once or twice per year	Participant engages in multiple activities per year

Rubric continues on next page

Policies and Practices – General	No policies or practices are in place regarding doulas	Current policies exist but are not written or shared routinely with staff	Clear, written policies have been developed with input from doula community and shared with staff and doulas; policies are updated routinely or as necessary and are followed consistently
Do you currently have any policies or practices in place regarding doulas? If so, what are they?			
If policies exist, how often are they updated or reviewed?			
How are doula policies shared with staff? With doulas?			
Polices and Practices – Laboring	**Allows no laboring techniques**	**Allows one or two laboring techniques**	**Allows most or all laboring techniques**
Do you allow varied labor positions? Do you allow patients to get out of their beds, to walk around, squat and so on?			
Do you allow wireless or intermittent monitoring for low-risk patients?			
Do you allow patients to change conditions in their rooms, such as to adjust lighting or use amplified sound or music of their choice?			
Do you allow use of birthing assistive equipment, such as birthing balls or squatting bars? Do you provide any of these?			
Do you provide access to tubs and showers during labor whenever possible?			

Rubric continues on next page

Policies and Practices – Doula Presence	Counts doulas toward allotted number of support people; strict policies prohibit doulas from being with their client at certain times or from providing postpartum support	Maintains one or two policies or practices that restrict doulas' presence with their clients	Allows doulas to accompany their clients at all times (unless there is a compelling medical reason otherwise) and facilitates provision of continuous postpartum support; doulas are not counted toward allotted number of support people
Except for the limited time necessary to maintain privacy or for medical reasons, are doulas permitted to accompany their client at all times during labor and delivery? Does this include during triage and during cesarean births or other procedures?			
Are doulas counted toward the patient's allotted number of support people in the labor and delivery room?			
While at the hospital, are doulas allowed to support the patient with postpartum breastfeeding support and additional comfort measures?			

Source: Maternity Hospital Quality Improvement Network

Potential Answers to Select Questions

What is your current understanding of a doula's role? How would you describe their work?

- Continuous calming support
- Emotional support
- Informational support
- Physical support
- Comfort techniques
- Supports partner or family
- Advocacy and informed consent
- Facilitates patient-provider communication
- Helps navigate hospital protocols
- Prenatal support
- Postpartum support
- Connects to community resources
- Supports breastfeeding
- Continuous support from pregnancy to postpartum
- Participant not familiar

Are you aware of the evidence-based benefits of doula care? If so, what evidence are you familiar with?

- Better patient experience
- Less pain medication use
- Fewer preterm births
- Fewer low-birth-weight babies
- Higher Apgar scores
- Fewer cesarean births
- Less epidural usage
- Less need for Pitocin
- Fewer instrumental deliveries
- Reduced racial inequities
- Higher breastfeeding rates
- Shorter labors
- Less postpartum depression
- Better mother-baby bonding
- Participant not familiar

How do doulas support the care team? What is their added value to the team? How does the care team support doulas?

- Continuous calming support
- Help patients navigate hospital
- Encourage patients to ask questions
- Educate patients about the birthing process and possible procedures
- Help patients prepare for procedures
- Provide language support
- Help manage other visitors
- Help patients into and out of various positions

- Notify care team of needs or issues
- Screen patients for social needs
- Refer patients to outside resources
- Allow care team members to focus on clinical care
- Participant not familiar

What does respect for a doula look like to you?

- Recognizing doulas are chosen by the patient
- Understanding benefits of doulas
- Introducing doulas to the team
- Addressing doulas by name
- Treating doula as a member of the team per Code of Conduct
- Engaging doula in decision-making
- Allowing doula to provide full scope of practices
- Participant not familiar

Do you currently have any policies or practices in place that support patients receiving the full scope of doula support and services? If so, what are they?

- Fetal monitoring
- Placental release
- Delayed cord clamping
- Immediate skin-to-skin
- Eating and drinking in labor
- Add doula to patient board
- Do not require certification
- Reporting protocol
- Tablets for virtual support
- Provider or doula "listening sessions"
- Inclusion in huddle or rounding
- Acknowledgment of birth plan and preferences

Additional Questions

These additional questions will not be scored but may help the assessment create a fuller picture of the way hospitals interact with doulas.

- What percent of your patients would you estimate currently use doulas during birth?
- How are doula policies shared with staff? With doulas? If policies exist, how often are they updated or reviewed?
- Do you have an example of a time when labor and delivery staff and doulas collaborated for a positive birth experience? What do you think led to this positive collaboration?
- Do you have an example of a time when collaboration between labor and delivery staff and doulas did not go well? What happened? What do you think could have been done better?
- What happens when a doula and hospital staff disagree about something during the birthing process?
- Have any strategies been developed to foster more collaborative relationships?
- What do you think can strengthen the relationship between labor and delivery staff and doulas?
- Have you designated a doula-friendly hospital champion to continue educating providers about doula care and address ongoing issues? If not, who is the appropriate person for this role?
- Have you created a mechanism for reporting any issues that providers or doulas have?
- Have you designated a point person to manage educating patients about doula care and coordinate referrals to local doula organizations? If not, who is the appropriate person for this role?
- Have you scheduled recurring meetings with local doula organizations to review successes and challenges?

How To Develop an Action Plan

Completing the doula-friendliness assessment gives hospitals an overview of their readiness to integrate doula support into their patients' birthing experiences. The next step is to create an action plan. This plan will identify challenges that remain, set goals to overcome those challenges and plan concrete actions to achieve those goals. The action plan should be developed collaboratively during a meeting with all involved stakeholders.

The Action Plan Meeting: Who Should Attend

From the hospital, invite a mixture of leadership, residents, midwives, nurses, nurse practitioners, social workers, community health advocates, physicians assistants, and physicians from the labor and delivery unit, the postpartum unit, and prenatal clinics, as well as staff from the anesthesia department. This can include staff from the working group but also expand beyond that. From doula programs, invite program staff and doulas, especially those who have provided support at the hospital before. It is helpful to include those who were at the initial assessment meeting.

During the meeting:

1. Using easel-pad sheets, a blackboard or whiteboard, or virtual whiteboard software, the facilitator creates a collaborative brainstorming space for each key capacity area from the assessment.
2. All participants review and discuss the findings from the scored assessment.
3. The facilitator invites all participants to contribute ideas for action steps that can help move the hospital toward a more robust level of doula-friendliness. These can be written down on sticky notes, dictated to the facilitator or submitted through the virtual whiteboard.
   - See the action plan template on Page 20 for examples.
4. All participants discuss and prioritize achievable steps. Group similar steps together to streamline processes and ensure that action items can be completed within an overall timeline. Focus first on areas where the hospital scored "basic" and then on those where it scored "moderate."
5. Leads and timelines are assigned for each action item.
6. The facilitator or doula champion arranges to follow up with the lead for each action item at agreed-upon intervals to monitor progress on the plan.

Action Plan Template

Goal: To improve hospital collaboration with doulas by improving capacity in key areas of doula-friendliness.

Improvement Timeline: By [date], doula-friendliness scores at [health care facility] will improve by [number of points] compared with the baseline assessment.

Figure 3: Doula-Friendliness Action Plan Template

Key Capacity Area	Tasks or Action Steps What will be done?	Responsibilities Who will do it?	Timeline By when?
Staff Knowledge of Doula Support	Example: Provide doula presentation to all staff during grand rounds. 1. 2. 3.		
Doulas as Part of the Birthing Team	Example: Nurses will orient doulas to labor and delivery floor and include the doula's name on the whiteboard. 1. 2. 3.		
Increasing Awareness of Doula Support Among Patients	Example: Information on doula support to be provided in childbirth education classes. 1. 2. 3.		
Policies and Practices – General	Example: Develop and implement formal doula policy along with a one-page handout to share with doulas. 1. 2. 3.		
Policies and Practices – Laboring	Example: Purchase birthing balls, peanut balls and birthing bars, ensuring adequate availability and staff training. 1. 2. 3.		
Policies and Practices – Doula Presence	Example: Collaboratively develop policy with the anesthesia department to allow doula presence during epidurals. 1. 2. 3.		

Source: Maternity Hospital Quality Improvement Network

Hospital Doula Policy

The primary aim of establishing doula policies in hospitals is to create a nurturing and inclusive environment that acknowledges the **vital** role doulas play in offering **continuous** physical, emotional and informational support to people during childbirth. These policies can integrate doulas as valued members of the birthing team and foster effective collaboration between patients, doulas and health care providers. This allows hospitals to enhance the overall birthing experience, improve maternal and neonatal outcomes, and cultivate a positive and empowering atmosphere for expectant people and their families. These policies should reflect the practical needs of both doulas and expectant patients. Developing these policies requires interdisciplinary cooperation among various health care disciplines, including obstetrics, nursing, midwifery and doula care.

When developing their policies, hospitals should focus on the Principles of Doula Support in the Hospital. To read the principles, visit **nyc.gov/health/doula** and search for the report titled **The State of Doula Care in NYC 2023**.[‡] The principles show on Page 37 of the report and formed the basis of this guidebook's Hallmarks of a Doula-Friendly Hospital (see Page 6) to support the integration of doulas into the birthing team. Doula-friendly policies show an understanding of the benefits of doula care and foster a collaborative space where patients, doulas and clinicians work together to ensure the best possible birth outcomes. Additionally, a sample hospital doula policy is included on Page 49.

Establishing clear and comprehensive doula-friendly policies is an essential step toward creating an atmosphere and culture where doulas can provide effective care for

[‡] **https://www.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2023.pdf**

their clients. If staff throughout the hospital are not aware that those policies exist or do not follow them routinely, doulas may still face a significant challenge. Communication of doula-friendly policy changes will therefore need to be emphasized.

A comprehensive doula policy should include:

The Definition of the Doula Role – Dos and Don'ts

Including dos and don'ts within doula policies is essential to establish clear guidelines and expectations regarding the role of doulas in the hospital setting. Hospitals can ensure a shared understanding of doulas' responsibilities and boundaries by outlining the specific activities and behaviors that doulas do and do not engage in. This promotes a standardized approach to doula care and fosters effective communication and collaboration among doulas, patients and health care providers, ultimately contributing to a positive and empowering birthing experience for expectant people. Having these guidelines in place can foster a harmonious environment within the birthing unit and prevent misunderstandings or conflicts that might arise due to varying interpretations of the doula's role.

The following elements should be included in this section of the policy:

- What doulas do
- What doulas do not do
- How staff should facilitate continuous doula labor support

Procedures for Hospital Access for Doulas

It is crucial to include procedures for hospital access to ensure clarity regarding protocols for the presence of doulas during the birthing process. By clearly defining the specific areas within the hospital where doulas are allowed to provide support, hospitals can create an environment that accommodates the needs and preferences of pregnant people. This clarity helps prevent any potential misunderstandings or conflicts that might arise, ultimately fostering a collaborative and inclusive atmosphere for all stakeholders involved. Outlining the access procedures for doulas emphasizes their integral role within the birthing team. This recognition promotes effective communication and care coordination that contributes to improved maternal and neonatal outcomes and positive birthing experiences.

The following elements should be included in this section of the policy:

- Doulas should be allowed in triage, birth, delivery and recovery as requested by the patient, absent a compelling medical reason otherwise
- Doulas should not be counted toward the allotted number of visitors
- Doulas should be allowed in triage, birth, delivery and recovery regardless of certification status

Laboring Techniques Supported by the Hospital

By outlining the specific supportive laboring techniques that the hospital endorses, hospitals foster a collaborative environment that prioritizes the physical and emotional well-being of the expectant parent during labor. Having clear guidelines establishes a consistent birthing experience and enables health care providers and doulas to easily collaborate. Encouraging nonmedical comfort techniques and continuous support contributes to reducing stress and anxiety for patients and promotes a more comfortable and empowering birthing experience.

The following elements should be included in this section of the policy:

- Nonmedical comfort techniques supported during labor
- Staff support and facilitate continuous calming support by doulas during procedures such as epidurals
- Support persons (doula, partner or other support person) allowed to remain with the birthing person during cesarean births unless there is a compelling medical reason otherwise

Reporting Protocol

Establishing reporting protocols in the hospital doula policy promotes effective communication and addressing of any issues or concerns that may arise during the birthing process. A clear protocol for reporting ensures that any challenges involving doula support are promptly addressed and resolved, fostering a proactive and supportive approach to perinatal care. The ideal reporting protocol facilitates a streamlined process for both doulas and hospital staff to report any issues and enables timely intervention and appropriate follow-up actions. Hospitals should develop and implement a well-defined reporting mechanism that underscores the hospital's commitment to patient safety and satisfaction by emphasizing the importance of maintaining open communication and transparency. By encouraging feedback and communication, hospitals can enhance the overall quality of care provided to expectant patients and contribute to a positive and empowering birthing experience. A reporting protocol is included in the sample doula policy on Page 49. A more detailed protocol should be included in the policy one-pager including specific contact information.

For more information about implementing a report protocol, see Page 29.

Doula-Friendly Labor and Delivery Policies

The following are labor and delivery hospital policies that support birth as a physiological process and can benefit all birthing people. These policies reflect the Hallmarks of a Doula-Friendly Hospital (Page 6). All hospital staff who interact with doulas and their clients should know about, understand and follow all policies that are adopted. Hospitals should ensure that patients also can access and understand all labor and delivery policies. This helps facilitate informed decision-making and promotes a culture of respect for patients' agency and personhood.

Wireless Fetal Monitoring

A fetal monitoring policy describes the laboring person's options for monitoring and explains when such monitoring may be necessary. These policies should support intermittent or continuous as well as internal or external fetal monitoring. Evidence shows that birthing people often appreciate the comfort, freedom and mobility offered by wireless monitoring. Doulas' work to help their clients assume various positions or use the shower may be challenging or impossible to do while using wired monitors. If possible and if infrastructure allows, hospitals or collaborating organizations should allocate funding for wireless monitors.

Ambulation During Labor

A labor ambulation policy outlines the ways patients can move around or change positions, including what is supported when they do or do not have an epidural. It promotes mutual understanding of when a laboring person may or may not safely ambulate. Evidence shows that, barring specific medical conditions or anesthesia, doulas should be allowed to help their laboring clients out of bed to ambulate if desired. Evidence also supports allowing laboring people to use the toilet or the shower as a laboring station, absent a compelling medical reason otherwise. A clear policy can greatly reduce unnecessary conflict between doulas and staff during labor.

A Tale of Two Hospitals

Kristine has arrived at the hospital with her partner and doula. She is in active labor and is considered a low-risk patient. As her contractions intensify, her doula, Sabine, reminds her to welcome these surges, as they mean that labor is progressing. Sabine also reminds her that walking and other forms of movement, such as hip swaying (on or off a birthing ball) and slow dancing can help her cope with labor.

Tale 1

Kristine tells her nurse, Nurse Joi, that she would like to walk up and down the hallway outside her room. Her nurse responds, "Sure! From what I can see from the tracing, your baby has been doing great, and your vitals also look wonderful. You're a great candidate for intermittent monitoring. I'll let Dr. Lee know that you want to walk around, and if he's OK with this, we should be able to get you off the monitor for 30 minutes at a time so you can walk freely." After walking the hallway while off the monitor for a half hour, it is time for Kristine's contractions and her baby's heart tones to be monitored again. Nurse Joi informs Kristine that she has the option of using the hospital's wireless monitors. This will let her move more freely without interruption. The wireless monitors are also waterproof, so she can even use the shower if she wants. Kristine emphatically agrees, and once hooked up to the wireless monitors, she announces that she is ready for some hydrotherapy!

Tale 2

Kristine tells her nurse, Nurse Fox, that she would like to walk up and down the hallway outside her room. Her nurse responds, "Oh, we don't allow that here. Once you're in active labor, it's best that you remain in bed. It allows us to monitor the baby more accurately." Feeling disappointed and growing hopeless, Kristine begins to cry, saying, "I just don't think I can bear this any longer if I have to be stuck in bed. I really didn't want to get an epidural, but it's so painful. I just need to move around more." Nurse Fox responds, "We can't let you get out of bed, but we can help with an epidural."

"My initial birth plan was all natural. In this situation, my doula would always keep me calm, encouraging me and saying things like 'You got this!' which is what I needed to hear. My birth plan did not go as planned. However, my doula made it easier. Her calm and soothing spirit, encouraging words and especially her massages made me enjoy my birth. The main goal was to leave the hospital with my baby boy healthy!"

– Doula client

Eating and Drinking During Labor

This policy clarifies what patients may eat and drink during labor. Many professional and public health organizations including the World Health Organization (WHO), American College of Nurse-Midwives (ACNM), National Institute for Health and Care Excellence (NICE) and Society of Obstetricians and Gynecologists of Canada recommend that low-risk birthing people eat or drink as desired during labor.[15] While the American College of Gynecologists (ACOG) advises against eating during labor, it also notes that "these restrictions have recently been questioned. ... This [newer research] may inform ongoing review of recommendations regarding oral intake during labor."[16]

Acknowledgment and Respect of Birth Plan, Preferences and Goals

Doulas often work with their clients to create a birth plan and a list of preferences and goals. Policies may encourage or require members of the birthing team to review this plan before birth. Discussing patients' birth goals with them from the beginning of their birth experience is part of consensual care and demonstrates an awareness of and respect for the patient's wishes. It can also lead to greater collaboration and cooperation between doulas and staff, allowing clearer communications. This foundation of mutual respect also creates a state of patient empowerment. If deviations from the birth plan are required, this policy helps respect the agency of the patient in decision-making.

Placenta Release

A patient may want to keep the placenta for a cultural ritual, encapsulation or other purpose. A formal policy on whether a birthing person can take the placenta home after being discharged can help eliminate confusion and discrepancies in expectations among birthing people, doulas and hospital staff. In turn, doulas can better support their clients' birth preferences.

Delayed Cord Clamping

Many people include delayed cord clamping as one of their birthing goals. The umbilical cord is rich in red blood cells that can keep a baby's iron levels high in the first few weeks after birth. Consistent with other professional organizations, ACOG recommends delaying umbilical cord clamping in vigorous term and preterm infants for at least 30 to 60 seconds after birth.[17] To help doulas support their clients, a written policy on whether the hospital supports this practice should be available for reference. The policy should specifically describe the length of time that constitutes a delay and the procedure by which this is done for vaginal and cesarean births.

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§ Some parents who feed their babies from their chest prefer this term, including some transgender and nonbinary parents. Always respect the language a patient prefers in describing their own body.

** **https://www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/ten-steps-to-successful-breastfeeding**

Immediate Skin-to-Skin Contact After Birth

In order to support new parents who aim to breastfeed or chestfeed,[§] hospitals should develop policies that detail how providers can facilitate skin-to-skin contact for birthing patients. Uninterrupted skin-to-skin contact between a newborn and the birth parents or caregivers, including after a cesarean, is one of the **10 Steps to Successful Breastfeeding** outlined in the WHO's Baby-Friendly Hospital Initiative.** The hospital's policy should detail circumstances under which immediate skin-to-skin contact is safe and when it could interfere with a medically urgent procedure.

For additional model policies, see pages 152 to 177 of the California Maternal Quality Care Collaborative's Toolkit To Support Vaginal Birth and Reduce Primary Cesareans at **bit.ly/cmqcc-birth-toolkit**.

A Tale of Two Hospitals

After many hours of labor, Noelle begins to feel constant rectal pressure and alerts her doula, Diana.

Tale 1

Seconds later, Dr. Ruiz enters her room and asks, "Are you ready to meet your baby, Noelle? Can I check your cervix?" Noelle consents, and Dr. Ruiz soon announces, "Baby is crowning! Have you been feeling the urge to push?" Noelle says, "Yes, with each contraction."

Tale 2

Seconds later, Dr. Lake enters her room, puts on gloves, takes a seat at the edge of her bed and says, "I'm going to check you now. I need you to open and relax your legs." He then performs a cervical check, as Noelle winces in pain. "It's time to push," Dr. Lake says flatly.

Realizing her baby will be born soon, she reminds Diana that she wants immediate and uninterrupted skin-to-skin contact, and she wants to hold her baby while any routine assessments are done. In between contractions, Diana calmly reminds the medical team of Noelle's wishes.

Dr. Ruiz assures Noelle that her desires will be met. Several minutes later, Noelle's precious son is born, and she is overcome with profound joy. Dr. Ruiz places him on Noelle's chest right away. The first hour of his life is spent entirely in her arms, and he latches with ease, marking a smooth start to breastfeeding. The nurse performs all routine newborn assessments while he is in his mother's arms.

"We can't promise that," says Dr. Lake. "The nurse needs to do a thorough exam to make sure everything is all right with your baby." Once Noelle's son is born, he is placed on her chest, and she is overcome with profound joy. However, moments later, as her son is attempting to latch on to her breast for his first feed, a nurse tells Noelle that she has to take the baby over to the warmer to get him cleaned up and make sure there are no issues. Diana says, "She asked that all assessments be performed while the baby is in her arms. She also said she prefers to delay wiping her baby down." The nurse is visibly annoyed and says she will not be able to assess the baby while Noelle is holding him. Feeling defeated and not wanting to cause a stir, Noelle gives her baby to the nurse.

Best Practices for Implementing Doula-Friendliness

Build Relationships With Community-Based Doula Programs

Successful implementation of doula-friendly policies is often shaped by relationships with doulas and doula programs. Meet regularly (preferably monthly) with these programs to:

- Strengthen relationships between hospital staff and doulas
- Collaboratively develop policies and practices
- Solicit feedback on barriers and facilitators to doula access
- Develop a formal referral process, as well as a protocol for reporting any issues that may arise
- Collaboratively develop an action plan for integrating doulas into your setting
- Identify a hospital doula-friendliness champion

"It was really about maintaining relationships. I think that was the essence of it. Yes, [it's] important to implement doula-friendliness. But if a relationship isn't established, a relationship [in that there can be] consistent communication, then really, the technical assistance and implementing doula-friendliness wouldn't work."

– Doula

Increase Staff Awareness of Doula Support

Staff should familiarize themselves with what doulas do, the evidence-based benefits of doula-friendliness and what doula support looks like in a hospital setting. Education about doula support should be ongoing. This ensures staff awareness and engagement and also accounts for staff turnover.

Here are some examples of strategies that increase staff awareness of doula support:

- Host social and educational events to bring together labor and delivery staff, prenatal staff, and doulas.
- Display educational materials about doula support (posters, brochures) in prenatal clinics and on labor and delivery floors.
- Outline the doula's responsibilities and the staff's responsibilities to support doulas in a formal doula policy that is distributed to all staff.

Increase Patient Awareness of Doula Support

An important component of becoming a doula-friendly hospital involves increasing awareness of doula support among the hospital's patient population.

Examples of how to do this:

- Incorporate information about doula support into childbirth education, prenatal and parenting classes.
- Share information about the benefits of doula support and relevant doula programs with patients during prenatal visits.
  - Develop relationships with these programs in order to make referrals directly to them.
- Distribute educational materials about doula support to patients.
  - NYC hospitals may order NYC Health Department materials by calling **311** or find more information by visiting **nyc.gov/health/doula**.
- Support doula presentations for patients. Doulas may give presentations in prenatal clinics; waiting rooms; women, infants and children (WIC) offices; group prenatal care; childbirth classes; and other settings.

Establish a Reporting Protocol for Doula-Related Issues

Hospitals should work with doula programs to establish a protocol for two-way reporting of any issues that may arise while a doula supports a client. Both hospitals and doula programs should make the process of elevating issues clear and consistent, including by providing the hierarchy and staff titles in their organization. This protocol should allow reporting to hospital staff and doula organization staff. The hospital and the doula program should both commit to investigate and address all reports.

Suggested point persons for reporting protocol:

- Hospital: Nurse manager, administrative nurse manager or charge nurse
- Doula program: Administrator or coordinator

"We found that developing explicit guidelines and policies regarding doulas offered the benefit of educating staff about the importance and critical contributions doulas can make to our common patients' birth experience."

– Health care provider

Maternity Hospital Quality Improvement Network: An Overview

Many practices in this guidebook were developed through the NYC Health Department's MHQIN. In early 2019, the NYC Health Department received support to partner with 14 maternity hospitals to reduce maternal mortality and severe maternal morbidity. Collectively, these hospitals host approximately one-third of all NYC births, including nearly half of all births to Black and Latino New Yorkers and 40% of births paid for by Medicaid. MHQIN is guided by three main strategies:

Figure 4: Maternity Hospital Quality Improvement Network

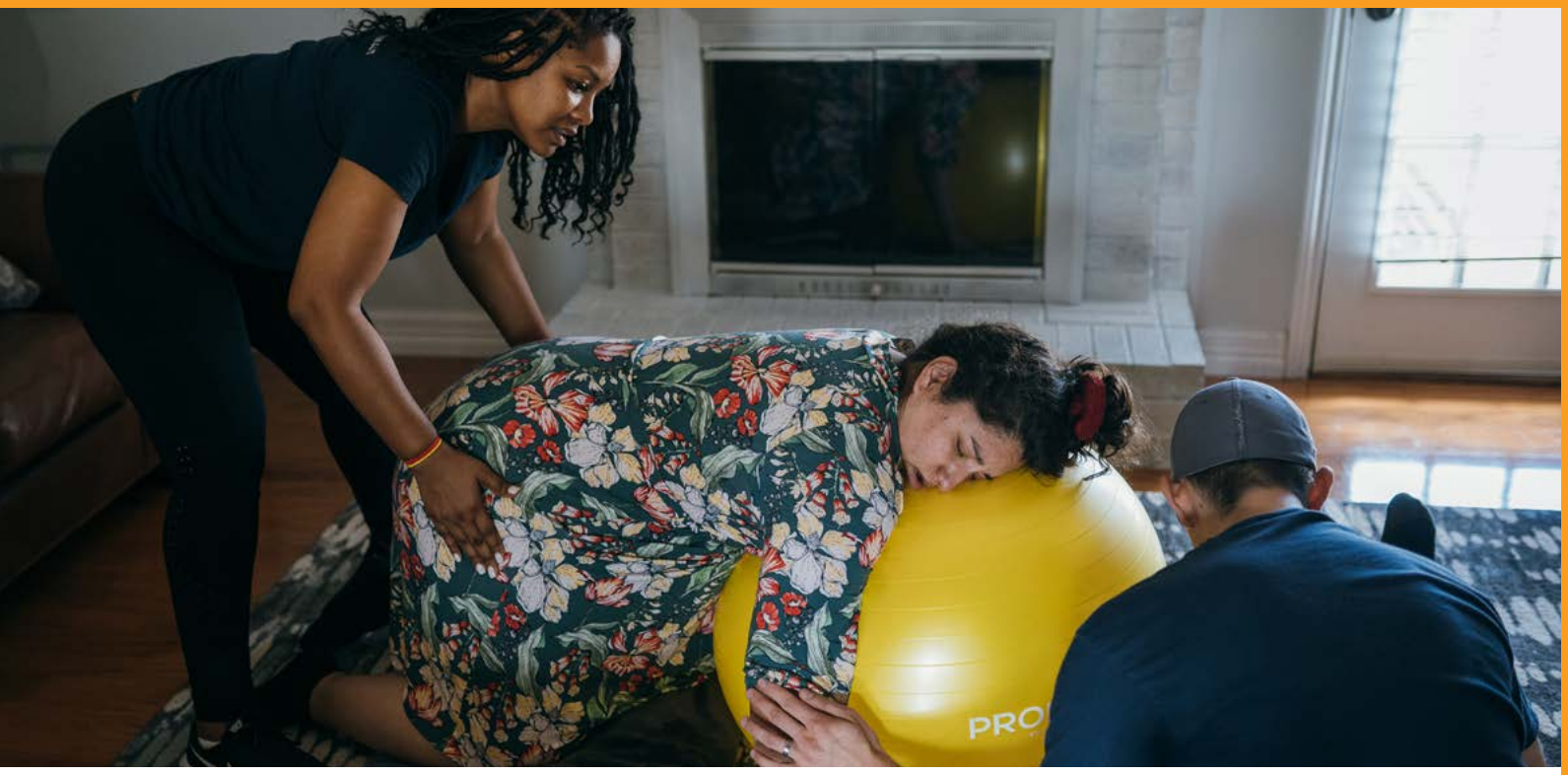
Source: Maternity Hospital Quality Improvement Network

Improving hospital doula-friendliness is part of MHQIN's strategy to support anti-racist hospital systems. The doula-friendly hospital model is built on the work of community-based doula programs, the New York Coalition for Doula Access (NYCDA) and doula advocates.

Initially, MHQIN partnered with four community-based doula programs – the By My Side Birth Support Program, the Caribbean Women's Health Association, Brooklyn Perinatal Network and Ancient Song – to foster positive working relationships between doulas and three maternity-care hospitals in NYC: Kings County and Metropolitan hospitals (both operated by NYC Health + Hospitals) and Montefiore Medical Center. MHQIN later added four additional hospitals to this cohort: Lincoln, Jacobi and Elmhurst (all operated by NYC Health + Hospitals) and Jamaica Hospital Center.

MHQIN staff developed tools to assess and score doula-friendliness in collaboration with By My Side staff and with reference to NYCDA's Principles of Doula Support in the Hospital.[18] Hospitals participated in a comprehensive process that included these steps:

- Assess hospital capacity at the beginning and end of the process to understand how the hospital works with doulas and to measure progress.
- Facilitate action planning to develop and implement achievable steps toward a more robust level of doula-friendliness, informed by the baseline assessment.
- In settings such as grand rounds, present information to hospital staff on the evidence base for doula support and integrating doulas into the care team, as well as on how to refer patients to community-based doulas.
- Host doula meet and greet events to build relationships between hospital staff and doulas.
- Develop and implement formal doula-friendly policies and practices.
- Establish formal referral pathways to community-based doula programs.



Lessons Learned From MHQIN

MHQIN intended to develop, implement, test and assess practices for improving doula-friendliness as a component of a racial-equity-focused strategy to improve birth outcomes. The protocols and practices described in this guidebook have been adapted from its experience.

Specific challenges that the MHQIN team identified and overcame while implementing the first version of these practices can be illustrative. They can serve as case studies of potential problems in the process of advocating for doula-friendliness and offer potential solutions for similar challenges that may occur during implementation.

"I did not feel supported by the hospital staff, because when my client went in for an induction, they did not let her get out of bed despite not being on any medication or epidural at first. I spoke with a resident, and we were on the same page about helping my client get ambulated, but when I did begin to guide her in moving around, all the staff from the labor and delivery floor came into her room, basically pushed me away and told me I shouldn't be doing anything to my client."

– Doula

Shifting Organizational Culture

Challenge: Existing hospital policies may prevent doulas from providing their full scope of services while supporting clients through labor. Fully changing the practices of staff who have been entrenched in the previous culture and policy could take years.

Solutions:

- Enlist the support and guidance of a qualified research and evaluation team to administer a labor culture survey to all staff or support hospital leadership in providing the doula-friendliness assessment to all their staff. Information

from the survey can be used to assess a hospital's readiness to incorporate doula-friendly practices such as reducing interventions and promoting vaginal birth. This exercise can also be educational and generate dialogue regarding a hospital's labor culture.

- Prioritize continued communication to staff on doula-friendly policies and practices. Some staff may have misconceptions about doula care or need education on how doulas can improve their patients' outcomes.
- Doula-friendly policies should be developed in conjunction with training on implicit bias as part of the hospital's overall commitment to promoting a culture of reproductive justice and patient-centered care. The reporting protocol will be a tool to address any issues with doulas as needed.

Creating Opportunities for Constructive Dialogue Between Staff and Doulas

Challenge: Staff and doulas may not have regular face-to-face dialogue outside the birth setting. This limits opportunities to address and reconcile differences in approach.

Solutions:

- Create opportunities for constructive exchanges of thought and relationship building between doulas and staff.
- Facilitate dialogue during trainings and technical assistance meetings so that hospital providers can openly share any concerns or hesitations they might have and these can be addressed.
- After each doula-attended birth, hospital staff and doulas can complete a feedback survey using a QR code that assesses how to improve collaboration.

"I like the fact that when my doctors were explaining things to me, they would also explain them to my doula Jessica, ensuring that I understood. This made me very comfortable."

– Doula client

- Coordinate regular or standing meetings between providers and doulas, and make space to address issues and highlight positive feedback. Allowing doulas to attend team huddles or grand rounds are good ways for them to share with staff what their support could look like. Doulas can also provide progress updates on their organization's partnership with the hospital. Established relationships allow for conflict resolution and collaborative delivery of trainings and patient education.

Implementing Change Despite a Lack of Resources

Challenge: Lack of resources, funding and appropriate infrastructure to participate in this process and provide doulas with the tools they need is a challenge for most hospitals. Some hospitals are understaffed or unable to purchase wireless monitors – which can support a client or patient who wants to ambulate during labor – or other equipment like birthing bars or birthing balls. In addition, older buildings may present a barrier to installing wireless monitors.

Solutions:

- While funding may be limited, hospitals can consider low- or no-cost options to increase doula-friendliness. Examples include policies that support a physiologic birth, such as allowing patients to dim the lights in their room, eat and drink during labor, try varied labor positions, play music or use aromatherapy.

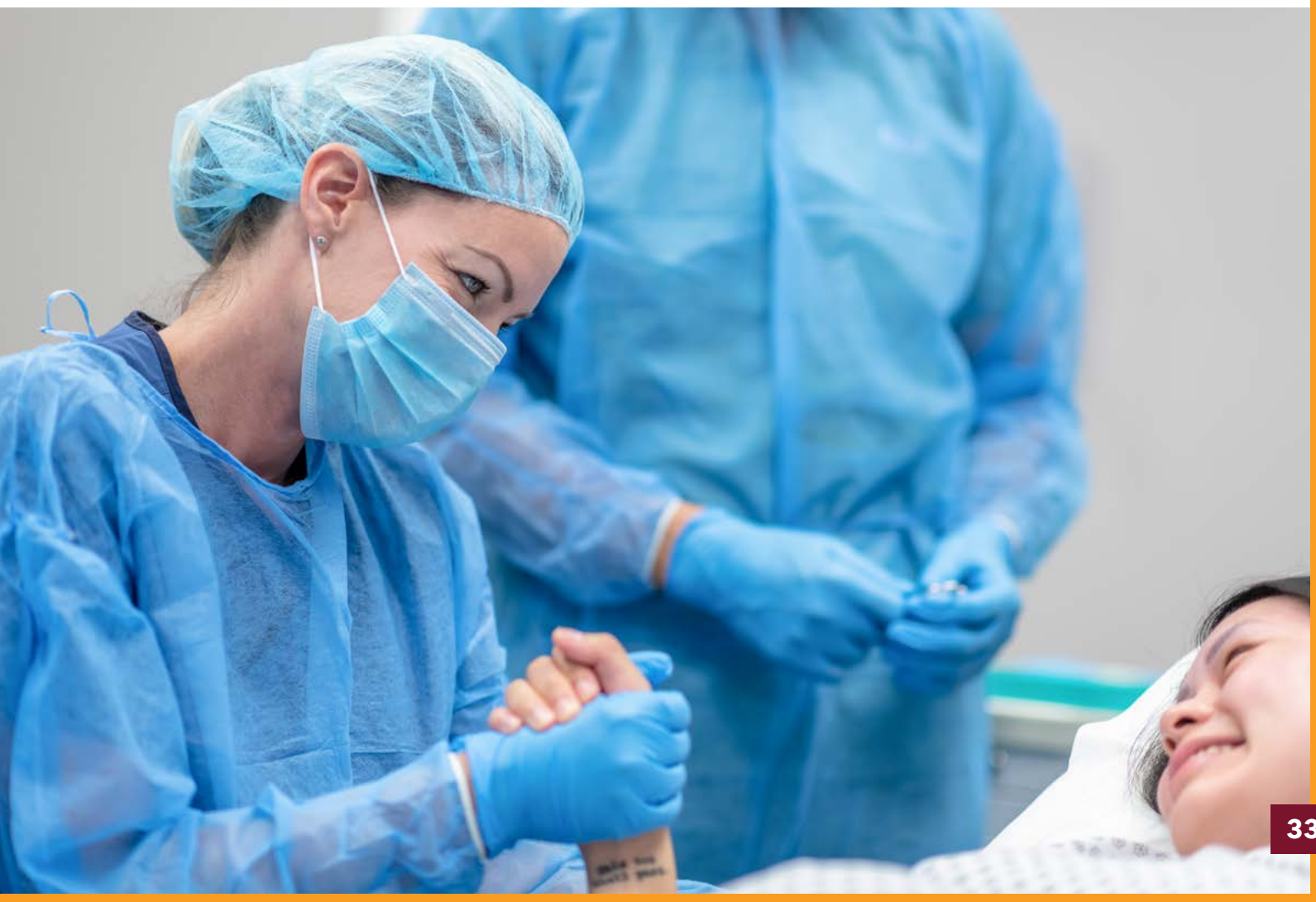
- Hospitals that have successfully obtained philanthropic or grant funding (for a list of funding opportunities, visit **aamchealthjustice.org/career-development/funding**) may be able to:
  - Hire a part-time midwife or quality improvement specialist to act as a liaison for the doula-friendly hospital work and support integration of doulas into the care team
  - Compensate a local community-based doula organization to provide doula support to the labor and delivery floor in shifts
  - Train new doulas and provide education sessions for providers
- Hospitals can also consider soliciting donations of some items, such as birthing bars, birthing balls and peanut balls.
- Hospitals can support doulas in other ways, such as by not counting them in the patient's allotted number of visitors and advocating for reimbursement of doula services by health care payers.

Implementation With Varied Levels of Leadership Commitment

Challenge: Attitudes, habits and capacity of hospital leadership can all affect how policies are implemented. Motivated leaders can help push forward a formal doula-friendly policy swiftly. However, if leaders do not prioritize doula integration, they may be slow to complete the necessary steps.

Solutions:

- It is essential to have a doula-friendly hospital champion who can take the lead



on moving this work forward. This role can be filled by anyone on the labor and delivery team, such as a resident, nurse or midwife. Support from nursing leaders is particularly important due to the influence they have on provider-doula interaction.

  - If it is difficult to obtain buy-in from leadership in one area of care or administration, hospitals can seek it from another, such as prenatal care leadership, hospital administration or patient safety staff. Having the hospital CEO or another highly placed staff member on board can help bring the work to the forefront of the hospital's priorities.

- Community-based doulas and program staff who have experience providing support at the hospital can also be a valuable resource, since they often know which staff are more amenable to doula support.

Working With Limited Doula Capacity

Challenge: While community-based doula programs have knowledge of and experience with the populations they serve, they may not have enough doulas to meet the needs of the population served by certain hospitals. As awareness of and demand for doula support increases, the need for doulas may be higher than the number of doulas available to provide services in some neighborhoods.

Solutions:

- All participants can build capacity by reengaging previously trained doulas and training new local doulas.
- To ensure enough doulas for their patients, hospitals can fund additional trainings by community-based doula programs and, when possible, pay doulas to provide services at their facilities.
- Hospitals can also advocate for doula reimbursement from insurers, including Medicaid. As an example, with federal approval, New York State Medicaid began providing coverage of doula services provided in accordance with 42 CFR section 440.130(c) effective March 1, 2024.

Improving Hospital Policies That Restrict Doula Presence

Challenge: Doulas continue to face restrictions on when and where they can be present during a client's labor and delivery. These barriers increased during the COVID-19 pandemic due to restrictive visitor policies.

Beginning in 2020, New York State Executive Order 202.25 and subsequent advisories declared that patients giving birth should be allowed to be accompanied by both a support person and a doula for the duration of their stay. However, some doulas were still unable to support their clients due to hospital interpretations of the policy or hospital policies that required doulas to provide proof of certification and training.

As policies frequently changed, staff were not always aware of the most current visitor or doula policies. In addition, some hospitals only have space for one support person in the operating room.

Solutions:

- The NYC Health Department issued a letter to providers (see Appendix 4, Page 51) with recommendations on how to ensure all staff were aware of the New York State Department of Health and state executive policies, and emphasizing the importance of decreasing barriers to

doula support during COVID-19, which may serve as a model for communicating recommendations to hospitals.

Developing Asynchronous Trainings

Challenge: With staff turnover and limited time to participate in this process, staff may become less familiar with or educated on doula support over the years. This can lead to a decrease in doula-friendliness over time.

Solutions:

- Develop educational videos for providers about the scope and evidence-based benefits of doula care.
- Develop additional videos that focus on integrating doulas into the care team, including examples of comfort measures.
- Require completion of the video module for all new staff.

Building Bidirectional Referral Pathways

Challenge: Referral pathways can be time-intensive, not conducive to patient access or not responsive to provider realities. Referral mechanisms need to be simple, streamlined and easy to implement.

Solutions:

- Develop referral pathways that include a single platform, minimal data entry and a closed-loop system that notifies the referring provider at pathway milestones.
- Ensure uniform patient education on doula support.
- Establish the referral pathway early in the process to have time to troubleshoot any issues.

Additional Recommendations

- After implementation of this process, a labor culture survey can ensure that hospitals are able to measure changes in staff attitudes and beliefs toward doula support.
- Increased access to doula support can improve patient satisfaction. Doula support can be added to existing patient satisfaction surveys, or specific surveys can be created for patients who receive doula support.
- Key informant interviews with participants in this process can also help measure progress and guide best practices.
- Complementary to the process outlined in this guidebook, hospitals associated with a university should implement mandatory education on doula support for both medical students and residents, in collaboration with community-based doulas.
- As of May 2024, NYCDA is supporting the development of a formal designation system for doula-friendly hospitals, which will be a resource to sustain this work.
- Another strategy that was not employed by MHQIN due to limited staff capacity: methods to track referrals from each partnering doula program to each participating hospital.

"There is literacy for everything – understanding doula care is hard, it is always evolving; even if you are a physician for a long time, it's hard to keep up. It's always important to provide education."

– MHQIN grand rounds participant

Conclusion

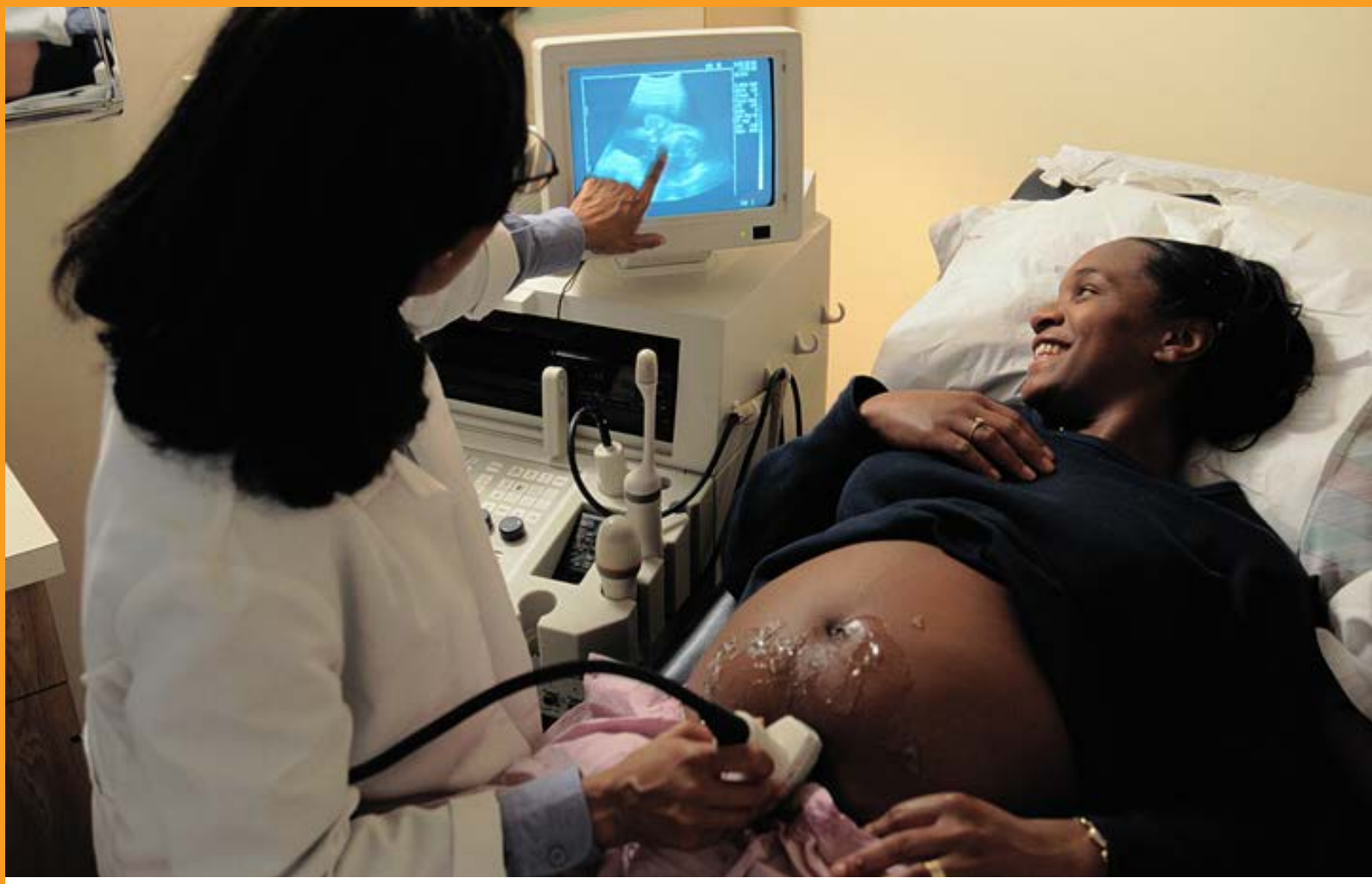
We hope this guidebook has given you clear procedures, guidance and advice on how to make your hospital more doula-friendly. These changes can create an empowering environment that honors patient autonomy, fosters collaboration and most importantly improves health outcomes. While shifts to hospital policy and culture take time and effort, health care institutions can accomplish those changes step-by-step using the following framework, as described in this guidebook (see the Doula-Friendliness Assessment instructions and rubric starting on Page 11).

Framework for Action on Doula-Friendliness

- **Assess the hospital's baseline level of doula-friendliness.**
  - Consider the key capacity areas included in the Doula-Friendliness Assessment Rubric.
- **Use the baseline assessment to develop achievable steps to improve doula-friendliness.**
  - Identify opportunities for improvement in each key capacity area.
  - Create a plan that can guide the doula-friendliness initiative and support timely progress.
- **Provide trainings and presentations to educate hospital staff.**
  - Find and create events for community doula organizations to share knowledge, such as grand rounds presentations.
- **Build relationships between hospital staff and doulas.**
  - Create opportunities for hospital staff and doulas to meet each other, ask questions, and become familiar with each other and others they may see at the hospital.
- **Develop and implement doula-friendly policies and practices.**
  - Codify policies that outline a doula's role and allow doulas to provide their full scope of care.
  - Ensure that these policies are known to all staff and implemented sustainably.
- **Establish a formal referral pathway between hospitals and community doula organizations.**
  - Ensure that this includes a two-way reporting protocol to address incidents as they arise.

Assessing and increasing doula-friendliness is a collaborative project between hospital staff and individual doulas or doula programs. The policies, attitudes and culture of a hospital surrounding doula support should first be assessed. An action plan should be created and directed toward key areas identified during the assessment. Hospital policies may need to be adjusted to create a more doula-friendly environment. Consistent and specific protocols will help clarify communication and encourage mutual respect among doulas, patients and providers. Information and perspectives should be freely shared, as a collaborative project will result in an empowering environment that can greatly benefit patients and their health care and hospital experiences.

Institutional change is never easy or without costs. The potential benefits of doula-friendliness, especially in ameliorating racial health inequities, vastly outweigh these costs. Doula support during labor and delivery leads to many improved outcomes for pregnant people and people who are giving birth. Increased use of doulas is therefore part of a strategy to reduce perinatal morbidity and mortality and to help decrease racial health inequities.



Appendices: Resources

The following appendices list resources that may be of use throughout the process of increasing doula-friendliness.

The first appendix is an extensive review of outcomes taken from empirical literature studying doula support. It can be deployed as part of educational events, informal conversations or written statements.

The second appendix is a directory of doula organizations in the NYC metropolitan area and throughout New York State, listing the areas they serve and contact information. Hospitals that wish to benefit from doula-friendly policies can use this appendix to find partner organizations.

The third appendix is an example of an extensive doula-friendly policy that follows the best practices outlined in this guidebook. It can be used as a reference when developing policies for your hospital.

The fourth and final appendix is a letter from the NYC Health Department describing the need for doula-friendliness. It is included as an example of the kind of clear communication that generates environments ready to benefit from increased doula support.

For additional supplemental materials, including the Principles of Doula Support in the Hospital and a fetal monitoring policy and procedure manual adapted from NYC Health + Hospitals, visit **nyc.gov/health/doula**.

Appendix 1: Literature Review on Doula Support

Fewer Cesarean Deliveries

- A meta-analysis of 24 trials showed that women with continuous, one-to-one support were 25% less likely to have a cesarean delivery than those without support (RR 0.75, 95% CI 0.64 to 0.88).[19]
- A randomized study of 412 nulliparous, laboring women found that 8% of those supported by a doula delivered by cesarean, compared with 13% of those observed and 18% of those who received routine care ($p = 0.06$).[20]
- A randomized controlled trial of 420 nulliparous women laboring with the support of their male partner found that 13.4% of those who also had a doula delivered by cesarean, compared with 25.0% of those without a doula ($p = 0.002$). Among those whose labor was induced, 12.5% who also had a doula delivered by cesarean, compared with 58.8% of those without a doula ($p = 0.007$).[21]
- A randomized controlled trial of 531 primigravid women found that 3.1% of those with doula support had a cesarean delivery, compared with 16.8% of those in an epidural group, 11.6% of those in a narcotic pain relief group and 26.1% of those in a chart review group, who received routine hospital care ($p < 0.001$).[22]
- A randomized study in Mexico of 100 nulliparous women in active labor who had received no childbirth preparation found that of those assigned to a childbirth educator trained as a doula, 2% delivered by cesarean, compared with 24% of those receiving standard care ($p = 0.003$).[23]
- An analysis of 1,079 Medicaid recipients in a Minnesota doula program that included pre- and postpartum home visits found that these recipients had 41% lower odds of cesarean delivery as compared against all Medicaid-funded births nationally (AOR 0.59, $p < 0.001$).[24]
- A randomized controlled trial of 555 nulliparous women found that among those who required labor induction, 20% of women who had the support of a doula delivered by cesarean, compared with 63.6% of those without ($p = 0.04$).[25]
- A randomized controlled trial of 127 primigravid women found that women with the continuous support of a doula were less likely to deliver by cesarean, at 19%, compared with 27% of the control group ($p < 0.001$).[26]
- A randomized controlled trial of 150 women in Iran found that 6% of those with doula support delivered by cesarean, compared with 8% of those in an acupressure group and 40% of those who received routine hospital care ($p < 0.001$).[27]
- A retrospective cohort study of 1,238 women in a community birth program in Canada, which included doula support before and during labor, found that program participants were 24% less likely to deliver by cesarean than those who received routine care (RR 0.76, 95% CI 0.68 to 0.84).[28]
- A retrospective analysis of 2,400 women who gave birth in the U.S. between 2011 and 2012 found that those with doula support had a 59% reduction in odds of cesarean delivery overall (AOR 0.41, 95% CI 0.18 to 0.96) and an 83% reduction in odds of nonindicated cesarean delivery (AOR 0.17, 95% CI 0.07 to 0.36), compared with women without doula support.[29]
- A randomized controlled trial of 220 participants (125 in experimental group with doula services and 95 in no-doula comparison group) in Northern Taiwan

found decreased rates of cesarean delivery (13.0% compared with 43.2%) and increased rates of normal spontaneous delivery (87.0% compared with 56.8%) in the doula group relative to the control group.[30]

- A retrospective cohort study of 298 pairs of women matched on age, race and ethnicity, state, socioeconomic status, and hospital type (teaching or nonteaching) using Medicaid medical claims from California, Florida and a Northeastern U.S. state from January 1, 2014, and December 31, 2020, found that women who received doula care had 52.9% lower odds of cesarean delivery (OR 0.471, 95% CI 0.29 to 0.79).[31]
- A retrospective cohort study of 8,989 individuals who enrolled in a comprehensive digital health platform found that the completion of at least two virtual appointments with a doula was associated with a 20% reduction in odds of cesarean delivery among all users (AOR 0.80, 95% CI 0.65 to 0.99) and a 65% reduction among Black users (AOR 0.32, 95% CI 0.17 to 0.72), compared with individuals who did not meet with a doula.[32]

Fewer Preterm Births or Low-Birth-Weight Infants in Programs That Include Prenatal Home Visits

- A data analysis of 1,079 Medicaid recipients in a Minnesota doula program found a preterm birth rate of 6.1%, compared with a national rate for Medicaid-funded births of 7.3% ($p < 0.001$).[33]
- A retrospective analysis of 1,935 Medicaid recipients in a Minnesota community-based doula program found that these recipients had 22% lower odds of preterm birth compared with all Medicaid-funded births in the West North Central and East North Central U.S. (AOR 0.77, 95% CI 0.61 to 0.96).[34]
- A retrospective analysis of 489 women in an NYC doula program found a preterm birth rate of 6.5%, compared with an 11.1% overall preterm birth rate in the project area ($p = 0.001$).[35]
- A matched cohort study of 603 women in an NYC doula program compared participants with three controls each and found that participants had lower odds of having a preterm birth (5.6% compared with 11.9%, $p < 0.0001$) or a low-birth-weight baby (5.8% compared with 9.7%, $p = 0.0031$).[36]

Greater Likelihood, Earlier Initiation and Increased Duration of Breastfeeding

- A retrospective cohort study of 1,238 women in a community birth program in Canada, which included doula support before and during labor, found that program participants were two times more likely to be breastfeeding exclusively at discharge compared with those who received routine care (RR 2.10, 95% CI 1.85 to 2.39).[37]
- A randomized controlled trial of 189 nulliparous women found that those who received doula support were more likely to be breastfeeding exclusively at six weeks postpartum (51% compared with 29%, $p = 0.01$).[38]
- A randomized controlled trial of 724 nulliparous women in Mexico found that women with doula support were 64% more likely to be breastfeeding exclusively than women without support (RR 1.64, 95% CI 1.01 to 2.64).[39]
- A prospective cohort study of 141 low-income primiparous women found that 58.3% of those with doula support (including birth and postpartum support) initiated breastfeeding within 72 hours, compared with 45.2% of those without (AOR 2.69, 95% CI 1.07 to 6.78). At six weeks postpartum, 67.6% of those in the

doula group were still breastfeeding, compared with 53.8% of those in the control group. Among women with a prenatal stressor such as high blood pressure or clinical depression, 88.9% of the doula group were still breastfeeding at six weeks, compared with 40.0% of the control group (AOR 23.76, 95% CI 3.49 to 161.73).[40]

- A retrospective evaluation of 11,471 urban women of diverse cultures found that 46% of those with doula support (by way of a hospital-based doula program) initiated breastfeeding within one hour of delivery, compared with 23% of those without doula support (ARR 1.12, 95% CI 1.08 to 1.16). Over the seven years studied, as the program became established at the hospital, rates rose from 11% to 40% for women with a doula and from 5% to 19% for those without a doula.[41]
- A retrospective analysis of 1,069 Medicaid recipients in a Minnesota doula program that included pre- and postpartum home visits found that 97.9% initiated breastfeeding, compared with 80.8% of Medicaid recipients overall in that state.[42]
- A randomized controlled trial of 586 nulliparous women found that 51% of those with doula support initiated breastfeeding within the first hour after delivery, compared with 35% of those without support ($p < 0.05$).[43]

- A retrospective analysis of 120 doula-supported births in Jefferson County, Alabama, found that doulas were associated with a tenfold increase in breastfeeding initiation (OR 10.5, 95% CI 5.4 to 23.2).[44]

Reduced Rates of Postpartum Depression

- A randomized controlled trial of 189 women found that six weeks after delivery, those with continuous support had a mean score on the Pitt depression inventory that was less than half that of women without support (10.4 compared with 23.27, $p = 0.0001$).[45]
- A randomized controlled trial of 63 nulliparous women found that at three months postpartum, those with doula support had significantly less depression on the Pitt depression inventory than those in the control group (13.63 compared with 18.29).[46]
- A retrospective cohort study of 298 pairs of women matched on age, race and ethnicity, state, socioeconomic status, and hospital type (teaching or nonteaching) using Medicaid medical claims from California, Florida and a Northeastern U.S. state from January 1, 2014, and December 31, 2020, found that women who received doula care had 57.5% lower odds of postpartum depression or anxiety (OR 0.425, 95% CI 0.22 to 0.82).[47]

Better Mother-Baby Bonding and Improved Infant Care

- A randomized controlled trial of 40 primigravid, intervention-free, vaginal births found that women with the continuous support of an untrained woman stroked ($p < 0.001$), talked to ($p < 0.002$) and smiled at ($p < 0.009$) their babies more than those who gave birth alone.[48]
- A randomized controlled trial of 104 primigravid mothers with uncomplicated deliveries found that those with doula support scored significantly higher in mother-infant interaction two months postpartum than those without support ($p < 0.05$).[49]
- A comparison study of 33 first-time mothers found that those who had doula support during childbirth became less rejecting ($t = 3.52$, $p < 0.001$) and helpless ($t = 2.12$, $p < 0.042$) in their working models of caregiving after birth compared with mothers who used Lamaze birth preparation. Those in the doula group also rated their infants as less fussy than did those in the Lamaze group ($t = 2.35$, $p < 0.025$).[50]
- A randomized controlled trial of 248 women who received doula support through a community doula program found that program participants showed more encouragement and guidance of their infants at four months than those who received routine care ($p < 0.01$). Women with doula support were also more likely to promptly respond to their infants' distress ($p < 0.05$).[51]
- A randomized controlled trial of 312 women found that those who received home visits from a doula had nearly 10 times greater odds of attending childbirth classes ($p < 0.01$), 1.6 times greater odds of putting infants on their backs to sleep ($p < 0.05$) and three times greater odds of using car seats at three weeks ($p < 0.05$), compared with those who did not receive visits.[52]

Reduced Need for Anesthesia or Analgesia

- A meta-analysis of 15 trials showed that women with continuous, one-to-one support were 10% less likely to have intrapartum analgesia (RR 0.90, 95% CI 0.84 to 0.96).[53]

- A randomized study of 412 nulliparous women who were laboring found that 7.8% of those supported by a doula required anesthesia, compared with 22.6% of those observed and 55.3% of those who received routine care ($p < 0.001$).[54]
- A randomized controlled trial of 420 nulliparous women who were laboring with the support of their male partner found that 64.7% of those who also had a doula required epidural analgesia, compared with 76.0% of those without a doula ($p = 0.008$).[55]
- A randomized controlled trial of 531 primigravid women found that 6.3% of those with doula support required an epidural, compared with 87.7% of those in an epidural group, 26.8% of those in a narcotic pain relief group and 64.0% of those in a chart review group, who received routine hospital care ($p < 0.001$).[56]
- A prospective cohort study of 141 low-income primiparous women found that 67.7% of those with doula support were below the median exposure to labor analgesia of 5.7 hours, compared with 42.3% of those without support (AOR 2.96, 95% CI 1.16 to 7.53).[57]
- A randomized study of 314 nulliparous women in three hospitals found that 54.4% of those with doula support had an epidural, compared with 66.1% of those without support ($p < 0.05$).[58]

Shorter Labors

- A meta-analysis of 13 trials showed that women with continuous, one-to-one support had shorter labors by an average of 41 minutes than those without support (MD -0.69 hours, 95% CI -1.04 to -0.34).[59]
- A randomized study of 412 nulliparous women who were laboring found that those supported by a doula had an average labor length of 7.4 hours, compared with 8.4 hours among those observed and 9.4 hours among of those who received routine care ($p = 0.001$).[60]
- A randomized controlled trial of 40 primigravid, intervention-free, vaginal births found that women with the continuous support of an untrained woman had an average labor length of 8.7 hours, compared with 19.3 hours among those who received routine care ($p < 0.001$).[61]
- A prospective cohort study of 141 low-income primiparous women found that 66.7% of those with doula support had a second-stage labor (pushing) of less than an hour, compared with 46.7% of those without support (AOR 3.07, 95% CI 1.19 to 7.0).[62]
- A randomized controlled trial of 598 nulliparous women found that those supported by a friend trained as a doula had a mean labor length of 10.4 hours, compared with 11.7 hours among those without doula support.[63]
- A randomized controlled trial in Iran of 150 women found that those with doula support had shorter labors by an average of 124 minutes during the first stage of labor and an average 69.5 minutes during the second stage of labor, compared with those who received routine care ($p < 0.001$).[64]

Fewer Vacuum or Forceps Births (More Spontaneous Vaginal Births)

- A meta-analysis of 19 trials showed that women with continuous, one-to-one support were 10% less likely to have an instrumental vaginal birth compared with those without support (RR 0.90, 95% CI 0.85 to 0.96).[65]
- A randomized study of 412 nulliparous, laboring women found that those with doula support were 23% more likely to have a spontaneous vaginal birth

compared with those who received routine care (RR 1.23, 95% CI 1.10 to 1.38).[66]

- A randomized controlled trial of 531 primigravid women found that 12.2% of those with doula support had an instrumental birth, compared with 24.8% of those in an epidural group, 17.2% of those in a narcotic pain relief group and 29.3% of those in a chart review group, who received routine hospital care ($p < 0.001$).[67]
- A prospective cohort study of 141 low-income primiparous women found that among women who delivered vaginally, those with doula support had an almost fivefold increase in odds of having a spontaneous vaginal delivery compared with those without support (AOR 4.68, 95% CI 1.14 to 19.28).[68]

Less Need for Pitocin

- A randomized controlled trial of 531 primigravid women found that 25.2% of those with doula support required Pitocin, compared with 45.8% of those in an epidural group, 42.8% of those in a narcotic pain relief group and 65.8% of those in a chart review group, who received routine hospital care ($p < 0.001$).[69]
- A randomized study in Mexico of 100 nulliparous women in active labor who had received no childbirth preparation found that of those assigned to a childbirth educator trained as a doula, 42% received Pitocin, compared with 96% of those receiving standard care ($p < 0.001$).[70]

Higher Apgar Scores

- A meta-analysis of 14 trials showed that women with continuous, one-to-one support were 38% less likely to have a baby with a low five-minute Apgar score than those without support (RR 0.62, 95% CI 0.46 to 0.85).[71]
- A prospective cohort study of 141 low-income primiparous women found that 56.8% of those with doula support had a baby with a one-minute Apgar score of 9 or greater, compared with 35.0% of those without support.[72]
- A randomized controlled trial of 586 nulliparous women found that 99.7% of those with doula support had a five-minute Apgar score higher than 6, compared with 97% of those without support ($p < 0.006$).[73]
- A randomized controlled trial in Iran of 150 women found that 86% and 98% of those with doula support had a baby with a one-minute and five-minute APGAR score of 8 or higher, compared with 40% and 78% of those who received routine care ($p < 0.001$).[74]

More Positive Feelings About the Birth

- A meta-analysis of 11 trials showed that women with continuous, one-to-one support were 31% less likely to report negative feeling about their birth experience (RR 0.69, 95% CI 0.59 to 0.79).[75]
- A randomized controlled trial of 189 nulliparous women found that those with doula support were more likely to report that they coped well during labor (59% compared with 24%, $p = 0.0001$).[76]
- A randomized controlled trial of 600 nulliparous women found that those with doula support were more likely to report a better overall rating of their birth experience than those without support (very good: 59%, compared with 26%; good: 33%, compared with 56%; average, poor or very poor: 8%, compared with 18%; $p < 0.001$).[77]
- A randomized study of 314 nulliparous women in three hospitals found that 82.5% of those with doula support reported a good birth experience, compared with 67.4% of those without support.[78]

Appendix 2: Doula Organizations in New York

Ancient Song
Service areas: All NYC and Northern New Jersey
Languages available: English, Spanish, Haitian Creole, Chinese (Mandarin), French, Arabic, Hebrew
Contact: 347-480-9504, **info@ancientsongdoulaservices.com**
Website: ancientsongdoulaservices.com

Ashe Birthing Services
Service areas: Bronx, Brooklyn, Manhattan, Queens, Long Island, Northern New Jersey, Westchester County, Southern Connecticut
Languages available: English, Spanish, French
Contact: ashebirthingservices@gmail.com
Website: ashebirthingservices.com

Baby Caravan
Service areas: All NYC
Languages available: English, Spanish, French, Italian, Portuguese
Contact: Jen Mayer, founder – 646-617-9927, **jen@babycaravan.com**
Website: babycaravan.com

Beautiful Birth Choices
Service areas: Rochester
Languages available: English
Contact: 585-484-1972, **info@bbcroc.com**
Website: bbcroc.com/bbc

The Birthing Place
Service areas: NYC
Contact: hello@thebirthplace.co
Website: thebirthingplace.co

BirthNet
Service areas: Albany metro region, including Troy, Schenectady, Rensselaer, Latham, Colonie, Saratoga, and East and North Greenbush
Languages available: English
Contact: 518-362-8462, **birthnetnewyork@gmail.com**
Website: birthnewyork.org/community-doulas

Brooklyn Perinatal Network
Service areas: Most clients live in Central Brooklyn and neighboring communities
Languages available: English, Spanish, African dialects, Haitian Creole, French Creole
Contact: Denise West, deputy executive director – 718-643-8258, extension 21; **dwest@bpnetework.org**
Website: bpnetwork.org

Buffalo Doula Collective
Service areas: Buffalo and Hamburg areas
Contact: 716-238-0708, **buffalodoulacollective@gmail.com**
Website: buffalodoulacollective.com

Bx (Re)Birth and Progress Collective
Service areas: All NYC, with a strong focus on the Bronx
Languages available: English, Spanish
Contact: bronxrebirth@gmail.com
Website: bxrebirth.org

By My Side Birth Support Program
Service areas: Underserved areas of Brooklyn, especially Bedford-Stuyvesant, Ocean Hill-Brownsville, Bushwick and East New York
Languages available: English, Spanish, Haitian Creole; services may be available in other languages when requested
Contact: Regina Conceiçaõ – **healthystartbrooklyn@health.nyc.gov**

Calming Nature Doula Service and Center
Service areas: Buffalo
Languages available: English
Contact: 716-768-4758, **info@calmingnaturedoula.com**
Website: calmingnaturedoula.com

Caribbean Women's Health Association
Service areas: All NYC
Languages available: English, Spanish, Haitian Creole, French, Russian, Twi, Fante, Ga, Afrikaans, Ukrainian
Contact: CWHA Doula Team – **cwhadoulas@cwha.org**

Carriage House Birth
Service areas: All NYC, Westchester County, Hudson Valley and Northern New Jersey
Languages available: English, Spanish, French, Italian, basic Farsi
Contact: Lindsey Bliss, co-founder – 646-234-8253, **info@carriagehousebirth.com**
Website: carriagehousebirth.com

Children's Health and Research Foundation Inc. – Lower Hudson Valley Perinatal Network
Service areas: Westchester and Rockland Counties
Contact: Laura Achkar – **achkarl@lhvpn.net**; 914-922-2240, **supportwest@lhvpn.net**

Citywide Doula Initiative
The Citywide Doula Initiative is made up of eight community-based doula programs: Ancient Song, By My Side Birth Support Program, Caribbean Women's Health Association, Community Health Center of Richmond, Hope and Healing Family Center, Mama Glow Foundation, the Mothership, and Northern Manhattan Perinatal Partnership.
Website: nyc.gov/health/cdi
Contact: cdi@health.nyc.gov

Community Health Center of Richmond
Service areas: Staten Island
Languages available: Spanish, English, Russian, several African dialects
Contact: Gracie-Ann Roberts-Harris – 917-830-1200, **gharris@chcrichmond.org**
Website: chcrichmond.org

Doulas en Español
Service areas: Bronx, Brooklyn, Manhattan, Queens, Westchester County
Languages available: English and Spanish
Contact: Maya Hernandez – **doulasenespanol@gmail.com**

The Doula Project
Service areas: All NYC and Southern Westchester County
Languages available: English, Spanish, Haitian Creole, French
Contact: Vicki Bloom – **birth@doulaproject.org**
Website: nycdoulaproject.org

East River Doula Collective
Service areas: All NYC, Westchester County, Western Long Island (Nassau County)
Website: eastriverdoulas.nyc

Healthy Women, Healthy Futures
Healthy Women, Healthy Futures is a citywide doula initiative, with coordination provided by Brooklyn Perinatal Network, Caribbean Women's Health Association and Community Health Center of Richmond.

Hope and Healing Family Center
Service areas: Brownsville, Bedford-Stuyvesant, Bushwick, East New York
Languages available: English, Spanish
Contact: Suzette Jules-Jack – 347-384-1494, **sjulesjack@hhfamilycenter.org**; **hhfc01@ymail.com**

HoPE Doula Care Program
For people receiving care at H+H/Elmhurst or Queens Hospitals
In partnership with Family Connect, Caribbean Women's Health Association and Ancient Song
Contact: 646-619-6721
You can also ask your prenatal provider for a referral to the HoPE Doula Care Program.

Hudson Valley Family Doulas
Service areas: Hudson Valley, Long Island, Western Connecticut
Contact: 845- 288-1985
Website: hudsonvalleyfamilydoulas.com

Long Island Doula Association Inc.
Service areas: East Islip
Contact: 631-574-2205, **info@lidoulas.com**

The Maimonides Doula Program
Service areas: All NYC
Website: maimonidesmed.org/obstetrics-and-gynecology/obstetrics/having-a-baby-at-maimonides/free-doula-program

Mama Glow
Service areas: All NYC and the New York metropolitan area, as well as select areas throughout the U.S.
Languages available: English, Spanish, Haitian Creole, French, Portuguese, Arabic
Contact: General information – **info@mamaglow.com**; Mama Glow Foundation – **info@mamaglowfoundation.org**
Website: mamaglow.com; **mamaglowfoundation.org**

The Mothership
Service areas: Harlem, Washington Heights, Inwood
Languages available: English, Spanish
Contact: Miranda Padilla – 646-683-6463, **mom@themothershipnyc.com**
Website: themothershipnyc.com

The New York Baby
Service areas: All NYC, Jersey City, Hoboken, sometimes Long Island or Connecticut
Languages available: English, German, French, Dutch, Spanish
Contact: Stephanie Heintzeler – 347-257-5157, **stephanie@thenewyorkbaby.com**
Website: thenewyorkbaby.com

Northern Manhattan Perinatal Partnership
Service areas: NYC ZIP codes 10025, 10026, 10027, 10029, 10030, 10031, 10032, 10033, 10034, 10035, 10037, 10039, 10040, 10451, 10452, 10453, 10454, 10455, 10456, 10458, 10463, 10466, 10467, 10468, 10472 and 10473
Languages available: English, Spanish, French
Contact: Fajah Ferrer – **fajah.ferrer@nmppcares.org**
Website: nmppcares.org

NYC Birth Village
Service areas: Bronx, Brooklyn, Queens, Manhattan, Westchester County, Eastern New Jersey
Languages available: English, Spanish, Hebrew, Dutch
Contact: Narchi Jovic and Karla Pippa – **nycbirthvillage@gmail.com**

NYC Doula Collective
Service areas: Bronx, Brooklyn, Queens, Manhattan, Jersey City
Languages available: English, Spanish
Contact: Raychel Franzen – **nycdcdirector@gmail.com**

Priscilla Project at Jericho Road Community Health Center
Service areas: Buffalo
Contact: 716-886-0771
Website: jrchc.org/priscilla-project

Royalty Birth Services
Service areas: Primarily serving the Rochester area
Languages available: English
Contact: 585-969-6133, **royaltybirthservices@gmail.com**

Sankofa Reproductive Health and Healing Center
Service areas: Primarily serving Syracuse and Central New York
Languages available: English
Contact: 315-920-2787

Village Birth International
Service Areas: Syracuse/Central New York
Contact: For Syracuse, 315-920-2787; for NYC, New Jersey and elsewhere, 347-423-9507. General information – **info@villagebirthinternational.org**

Wyld Birth and Postpartum
No- and low-cost options available
Service areas: Orange, Ulster, Westchester, Putnam and Dutchess counties, New York; Fairfield County, Connecticut
Contact: hello@wyldbirthandpostpartum.com

Disclaimer: This list is neither exclusive nor exhaustive. The NYC Health Department is providing this information to assist New Yorkers in locating services and general information but does not make any representation or warranty concerning the quality or accuracy of the services provided by these identified establishments. Contact information is subject to change; check with the establishment for up-to-date information.

Appendix 3: Sample Doula Policy

Subject: Doula Policy
Date: January 4, 2021

Definition: A doula is a trained birth assistant, requested by the pregnant patient (the doula's client), who supports the pregnant person prenatally, during labor and birth, and/or during the postpartum period. Hospital [Name] recognizes the advantages of doula services and the positive impact that they have on the birthing experience and on maternal and neonatal outcomes.

Policy: A doula is not to be considered a staff member and has no medical role or responsibility, but rather is to be considered an important support for the mother. The doula will provide continuous labor support, which includes fostering the mother's physical comfort, providing emotional guidance, sharing information (nonmedical) and advocating for their client's choices surrounding birth preferences.

Elements of continuous labor support include but are not limited to:

1. Enhancing physical comfort, including by comforting touch, and guiding with movements and positioning
2. Providing emotional support by praise, reassurance, encouragement and continuous presence, as well as providing guidance and emotional support for the laboring person's partner or loved ones
3. Sharing information (nonmedical), explaining procedures and assisting in navigating hospital protocols
4. Facilitating communication between the laboring person and hospital staff to assist in making informed decisions
5. Encouraging patient to consult the medical team about any care concerns

A doula may not:

1. Perform clinical or medical tasks, such as taking blood pressure or temperature or performing fetal heart tone checks, vaginal examinations or postpartum clinical care
2. Give medical advice
3. Document in a patient's medical record
4. Participate in or perform lab tests
5. Make medical decisions for the patient
6. Interfere with medical treatment plans or any emergency intervention
7. Share patient information unless patient gives permission

Purpose: To outline doula services on the labor and delivery unit and to provide staff with knowledge of the role and scope of doula services for holistic care for patients who are identified as in need of continuous support throughout the birthing process and the immediate postpartum period.

Procedure: Doulas must identify themselves to the patient's health care team and must wear a visible ID badge stating their name and the name of the doula group they represent. In case of an emergency where the doula does not yet have an ID badge, they should provide a state or city ID.

Actions to be performed by the responsible staff primary registered nurse:

1. On admission to labor and delivery, inquire from the patient about presence of doula and/or family support.
2. Review expectations with patient, family and the doula on the labor and delivery process, operating room guidelines, and postpartum care.

3. Provide unit orientation and reinforce expectations of the doula's role. Support both in-person and virtual doula support.
4. Provide the doula with a copy of the hospital doula policy.
5. Include the doula's name on the patient's whiteboard.
6. Document the presence of the doula, including the doula's name, in a note within the electronic health record.
7. Allow the doula's presence in triage, birth, delivery and recovery as requested by the patient, absent a compelling medical reason.
8. Foster a collaborative relationship with the doula in support of the patient and their family.
9. Allow and support nonmedical comfort techniques for labor, including but not limited to various position movements, such as ambulation outside of the bed, as allowed, breathing techniques, nonflammable aromatherapy, guided imagery, comforting touch, and use of a peanut ball or birthing ball based on the patient's condition.
10. Facilitate the doula's presence for continuous calming support as well as support during procedures (such as epidurals and some cesarean delivery cases), absent a compelling medical reason otherwise.
11. Ensure doula adherence to patient confidentiality.
12. Encourage and support doula assistance with initial breastfeeding during the first hours after birth and the postpartum hospital stay.

Reporting Protocol: The charge nurse/nurse manager is to be contacted if a doula encounters an issue with a provider or staff. The doula supervisor is to be contacted if a provider encounters an issue with a doula. Both will address and resolve issues with involved staff and work collaboratively to institute any necessary policies or practices as a solution. The nurse manager or designee has ultimate responsibility for the patient care.

Doula Certification: Doulas serve in a nonmedical capacity. As such, they are not required to have specific credentials to practice (licensure, certification or other).

Appendix 4: Letter to Colleagues on Doula Support

June 14, 2021

Dear Colleague,

As you may know, on December 15, 2020, the New York State Department of Health (NYSDOH) issued an advisory to all birthing facilities statewide, clarifying some details about Governor Andrew M. Cuomo's Executive Order 202.25 from April 29, 2020. A subsequent advisory was issued on March 25, 2021, updating hospital visitation guidance, including by doulas.

The two documents affirm the right of all birthing people to be accompanied by a doula during labor, delivery and the postpartum period, "until discharge to home."

I am writing, first, to make sure you are aware of the NYSDOH advisories, and second, to offer some ideas for operationalizing Executive Order 202.25 to best serve your patients and their families in the childbirth experience:

- Ensure support from leadership, and have hospital and unit leadership deliver the initial communication about the advisories to staff.
- Share the advisories with all relevant staff, as well as with affiliate practices that provide care to pregnant and postpartum patients – such as satellite clinics, attending physicians and midwives, nurses, and patient care navigators.
- On-site, share information about the advisories with all clinical staff, security staff, and anyone else who interacts with visitors to the facility and/or to the labor and delivery floor or postpartum unit.
- Discuss the order and advisories at staff meetings. Brainstorm ways to overcome any barriers that staff may foresee, and address any staff concerns.
- Instruct security and clinical staff that proof of certification from doulas who are accompanying or meeting their clients at the facility is not appropriate or necessary.
- Instruct security and clinical staff that doulas should be admitted if they return to the hospital to provide postpartum support in the days immediately following the birth.
- Post the doula-support advisory (or a bullet-point version of it) at the security officer's desk, in the reception area, at the nurses station, on the labor and delivery bulletin board, and anywhere else that staff may need to refer to it.
- On the facility's website, clarify that the birthing person is allowed two support people, including a doula if desired.

If you have additional suggestions, or best practices that we may share with your colleagues at other birthing facilities, please contact us.

The care you provide to birthing New Yorkers every day, and especially your hard work amid the challenges of the COVID-19 pandemic, are deeply appreciated. If we may be of support in any way, or if you want to offer any feedback, do let us know.

Sincerely,

Michelle Morse, MD, MPH
Chief Medical Officer
Deputy Commissioner, Center for Health Equity and Community Wellness
New York City Department of Health and Mental Hygiene

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Montefiore Medical Center

Health Leads

The Bridge Directory

Bx (Re)Birth and Progress Collective

Ancient Song

Hope and Healing Family Center

Citywide Doula Initiative

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Ashe Birthing Services

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Sierra Flournoy, Full-Spectrum Doula

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Northern Manhattan Perinatal Partnership

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Guidebook Image Captions

Page 3: A laboring mother ambulates on the labor and delivery floor while using a wireless fetal monitor. She is accompanied by her doula and sister for additional support.

Page 6: A diverse group of health care providers engage attentively in a collaborative meeting, highlighting teamwork and inclusion.

Page 11: During a prenatal visit, a caring health care provider gently examines the belly of a smiling pregnant person, ensuring both comfort and safety during the consultation.

Page 12: An expectant parent engages in conversation with their OB-GYN during a regularly scheduled prenatal visit.

Page 17: Health care providers gather to assess, discuss and implement strategies for enhancing doula friendliness in hospital settings, aiming to improve maternal care.

Page 19: A new mother holds her baby in a loving skin-to-skin embrace, fostering an immediate and deep connection in the hospital delivery room.

Page 21: Health care providers gather around a table, collaborating on hospital policies to enhance doula-friendly birthing experiences and improve birth outcomes.

Page 23: A new mother looks over at her new baby in admiration while medical staff examine the baby following a successful cesarean birth.

Page 24: A doula performs a "tug of war" technique to assist her client through the pushing stage of labor. The birthing person is comforted by her partner who applies a cold, wet cloth to her forehead. Two health care providers stand close by, patiently observing this activity.

Page 28: A doula stands at her client's hospital bedside, observing as her client nurses her baby, ready to provide guidance as needed.

Page 31: A laboring mother, accompanied by her partner, uses a birth ball while being given hip squeezes by her doula.

Page 33: A compassionate health care provider holds a patient's hand, offering reassurance and comfort before a cesarean birth.

Pages 36 to 37: A woman who has just given birth receives hands-on assistance from her doula as she tries to breastfeed her newborn baby. Her nurse stands at her bedside ready and willing to provide additional support. Her partner looks on in appreciation.

Page 38: A pregnant person is shown an image of her growing baby in utero during a prenatal ultrasound appointment. Her health care provider points to a computer screen to identify various body parts.

Page 41: A mother beastfeeds their newborn baby shortly after birth.

Page 45: A pregnant person shares a joyful moment with her partner while seated together as he cradles her belly.

Page 47: A pregnant client and their doula enjoy a laugh during a prenatal visit.

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NYC Health

NYC Public Schools
Chancellor Melissa Aviles-Ramos

Testimony of NYC Public Schools

Before the NYC Council Committee on Women & Gender Equity

June 3, 2025

Intro 691-2024

Testimony of Nicole Williams, Executive Director of STEM

Overview of STEM

Good morning, Chair Louis and members of the Committee on Women and Gender Equity. My name is Nicole Williams, the Executive Director for STEM at New York City Public Schools and former CS4 All Principal. Tunisia Mitchell, the Interim Executive Director, 21st Century Skills, joins me today. Thank you for the opportunity to testify on Intro 691, a bill related to reporting on STEM education in New York City Public Schools.

This administration is committed to STEM education for all students. We believe that every student should be engaged in grade-level math and science standards every day. Through our ongoing efforts since 2022, we have seen more than 15 points of Math proficiency growth in grades 3-8 and, for the first time, NYC moved ahead of New York State in overall Math proficiency. The gaps between Black and Latino students and their white peers have decreased by three points. In addition, boys are performing at 54% proficiency while girls are performing at 53%. Still, two-thirds of Black and Latino students are not performing at grade level in math. Students in temporary housing and students who have formal gaps in their education are falling behind. Students of color, students living in poverty, students with disabilities, and multilingual learners are scoring well below our citywide average.

To ensure we are closing these gaps and disparities, NYCPS released the Mathematics Instructional Shifts and launched NYC Solves during the 2024-2025 school year. Phasing in over the next few years, NYC Solves will require high school and middle school math classrooms to adopt a single, pre-approved uniform curriculum. The goal is to ensure that all New York City students develop strong math skills, a critical requirement for educational, career, and lifetime success. NYC Solves is an evidence-based initiative that will ensure students are engaged with high-quality curricula taught by well-trained teachers. Currently, NYC Solves reaches an estimated 99,000 students at 509 high schools and middle schools in 20 districts.

According to the 2023-2024 NYCPS Science data, 75% of Black and Latino students were not proficient on the Grade 8 Science State Examination. The pass rate for the Living Environment Regents was less than 50% for Black and Latino students. Meanwhile, the Living Environment Regents pass rate was 56% for girls and 55% for boys. We need to change the ways in which we teach Science so that all students have access to high-quality instructional materials and all teachers understand the necessary instructional shifts.

During the 2023-2024 school year, NYCPS adopted a new Science Curriculum in Biology and Earth and Space Science. Beginning in 2025-2026, NYCPS will adopt a new Science Curriculum for Chemistry and Physics to ensure every student has access to rigorous higher level Science Courses.

Student Pathways

The Office of Student Pathways, led by Chief Jane Martínez Dowling, works to close opportunity gaps and address persistent inequities—enabling NYCPS students to graduate with a strong foundation of academic excellence, real-world skills and experience, a head start on college and career, and a high-quality postsecondary plan.

New York City STEM employment grew by about 130,000 jobs over the past decade, a growth rate of 67%, higher than the overall private-sector growth rate (14%) and the growth rate for STEM employment nationally (32%). Still, New York has a long way to go to achieve equity. For example, Black and Hispanic workers make up 43% of New York City's overall workforce but hold just one-in-five tech sector jobs. Overall, men hold three quarters (76%) of the city's tech jobs, while women hold less than one quarter (24%).

Our Pathways work is informed by current and former students' data, postsecondary outcomes, and broader NYC labor market trends. We developed two key initiatives – FutureReadyNYC and CS4All – in direct response to disparities we see in college and career pathways, particularly those related to STEM.

The FutureReadyNYC program integrates the best of college and career preparation to successfully launch students into strong careers in high-wage, high-demand sectors. Next year, FutureReadyNYC will grow to 180 high schools. Participating schools have the opportunity to implement multiple pathways, including the following focused on STEM:

- FutureReadyNYC Healthcare: offers a comprehensive route for individuals aspiring to join the Healthcare profession consisting of two primary pathways - Diagnostic Medicine and Pre-Nursing.
- FutureReadyNYC Tech: equips students with the knowledge and confidence to pursue a career and/or higher education in a technology-related field and consists of three primary pathways - software development, cybersecurity, and data analytics.
- FutureReadyNYC HVAC and Decarbonization: introduces students to green jobs and engages students in fundamentals of electrical theory towards careers as construction engineers, electricians, plumbers and Heating, Ventilation, Air Conditioning and Refrigeration technicians.

New York City Public Schools has a strong commitment to computer science education as evidenced by the Computer Science for All (CS4All). CS4All was developed to support all NYCPS students in learning computer science (CS), with an emphasis on students who

identify as girls, Black and Latino students. Since its launch in 2015, the percentage of schools offering computer science tripled from 15% during the first year of the initiative to 45% in the 2023-2024 school year. Based on data, we found that taking CS was associated with improved computational thinking skills and CS-related attitudes, especially among elementary students. CS course-taking in high school was associated with an increased likelihood of going on to declare a CS major in college and, importantly, with smaller gender and race/ethnicity gaps in the pursuit of CS degrees. In response to data and lessons learned, we continue to develop strategies to integrate computer science and computational thinking within grades Pre-K through 12.

Proposed Legislation

We support the intent of this bill to track student participation in STEM. However, given that Math and Science courses are required for high school graduation, reporting on student course-taking may not provide useful insights, so we would like to work with the Council to develop meaningful reporting around STEM disparities for students.

Given that STEM disparities are a well-researched area, an annual poll of students is not the best method to learn more about the drivers of these disparities. We look forward to further conversations and working with the Council to determine the best methods for reporting on STEM participation and gathering additional information outside of the poll format.

CALLEN-LORDE

NEW YORK CITY COUNCIL BUDGET and OVERSIGHT HEARING
COMMITTEE ON WOMEN & GENDER EQUITY
June 3, 2025

WRITTEN TESTIMONY ON BEHALF OF CALLEN-LORDE
Submitted by Alexander B. Harris, MPH, CPH
Interim Manager for Public Policy and Advocacy

Good afternoon and thank you to Chairperson Louis and Members of the Committee. My name is Alexander Harris, and I am the Interim Manager for Public Policy and Advocacy at Callen-Lorde Community Health Center. I use he or they pronouns. Feel free to call me Ali. Thank you for the opportunity to testify today on behalf of our patients and staff.

Callen-Lorde is a global leader in LGBTQ+ healthcare, providing sensitive and quality care to more than 23,000 LGBTQ+ New Yorkers as well as individuals in the surrounding region, regardless of their ability to pay. As a Federally Qualified Health Center, Callen-Lorde is a safety net provider that offers essential services such as primary care, behavioral health, dental, care coordination, and health insurance navigation, and referrals to appropriate external services. In 2024, we served more than 8,000 transgender and gender non-binary patients, which is 37 percent of our total patient population. More than 70 percent of our patients who are 13 to 24 years old are transgender and gender nonbinary. We have received international recognition for our expertise in transgender health and have helped set the international standards for gender-affirming care through clinical policy development, public policy and advocacy, and community stakeholder mobilization. Our practice is also the largest non-hospital-based HIV service provider in New York, with 19 percent of our patients living with HIV. We provide 15 percent of the state's PrEP prescriptions. Over 40 percent of our patients are beneficiaries of Medicaid, and 24 percent are homeless or unstably housed. Callen-Lorde serves communities that have been systemically excluded from healthcare, housing, and economic stability. These are our people and our staff is representative of those we serve.

I would like to focus my testimony today on proposed bill Int. No. 1258-2025, which requires the Department of Health and Mental Hygiene to issue death certificates with sex designations that are consistent with the gender identity indicated on documentation of gender transition and to establish a procedure to request correction of the sex designation on a death certificate. Callen-Lorde **strongly supports** Int. No. 1258-2025 to preserve the dignity of all people in death and dying, but especially for transgender, non-binary, and gender diverse (TGNCNBGD) New Yorkers, who regularly face posthumous misgendering in public records.

States including California, New Jersey, and Rhode Island have already passed laws requiring respect for gender identity on death certificates, which allows those states to not only have more accurate health surveillance reporting but may better assist public health officials to better understand health trends in TGNCNBGD broadly. The New York City Department of Health and

Mental Hygiene has already established mechanisms for meaningfully recording trans experience in a corrected birth record process (via Bureau of Vital Statistics), and health surveillance data for HIV, sexually transmitted infections, and other health conditions. Allowing for corrected gender markers on death certificates will further strengthen the integrity of our citywide data collection, let alone, improve our ability to better understand mortality trends amongst TGNCNBGD New Yorkers. The New York Times recently reported that the absence of any LGBTQ+ identifiers in death data hinders suicide prevention efforts, as no one knows how many LGBTQ+ people die by suicide each year—a crisis of invisibility with deadly consequences.[1]

At present, the Center for Disease Control Standard Certificate of Death which forms the basis of many state and local death certificates, has not yet incorporated fields for SOGI data, creating a blind spot in national mortality tracking and therefore, has yet to create standards around correcting gender identity-based errors on death certificates.[2] Current evidence shows how misgendering TGNCNBGD people in death serves no one, particularly, those who must contend with how these errors often humiliate our deceased community members and distract from mourning their lives. A 2022 landmark study out of Oregon found that over 60% of transgender and nonbinary individuals were misgendered on their death certificates between 2011 and 2021. **Among transgender women, the misidentification rate was especially high — 20 out of 33 were listed as male on their death certificates**.[3] As Dr. Kimberly Repp, a chief epidemiologist and study co-author, noted: *"When a population is not counted, it is erased."* Misclassification distorts mortality statistics, impairs public health planning, and undermines access to resources for already-marginalized communities.

Currently, New York City's own *Application for Correction of a Death Certificate* does not include gender as a field eligible for correction. As a result, surviving partners, chosen family and family of origin members, and advocates are left without recourse when gender identities are erased - an omission that compounds grief with injustice and can retraumatize loved ones by perpetuating harmful myths that trans identities are not real or legitimate. This bill corrects that by mandating a transparent, documented, and inclusive process for issuing or amending death certificates to match the decedent's gender identity. Callen-Lorde especially commends the provision that ensures corrected death certificates do not include markings indicating they were amended. This critical detail protects the privacy and dignity of the individual while preventing further marginalization.

Callen-Lorde appreciates how the bill allows multiple forms of supporting documentation, from legal and medical records to prior identity documents and written declarations. However, we will raise that there is concern for deceased TGNCNBGD New Yorkers who do not have supporting evidence, whether that they never pursued legal changes or gender-affirming care, or, are marginally housed at the time of death, where documentation may not be available. **We ask that City Council consider providing guidance alongside Int. No. 1258-2025 so that death certificate changes are as accessible as possible.**

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[1] Ghorayshi, A. (2023, June 1). *U.S. collects data on LGBTQ+ suicides for the first time*. The New York Times. https://www.nytimes.com/2023/06/01/health/lgbtq-suicide-data.html

[2] National Center for Health Statistics. (2003). *Medical examiners' and coroners' handbook on death registration and fetal death reporting* (HHS Publication No. 2003–1110). U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf

[3] Walters, J. K., Mew, M. C., & Repp, K. K. (2023). Transgender and Nonbinary Deaths Investigated by the State Medical Examiner in the Portland, Oregon, Metro Area and Their Concordance With Vital Records, 2011-2021. Journal of public health management and practice : JPHMP, 29(1), 64–70. https://doi.org/10.1097/PHH.0000000000001582

We urge this Committee and the full Council to pass the Int. No. 1258-2025 without delay. Let New York City be a national leader in affirming trans lives—in life, and in legacy.

Thank you for your time and consideration. I am happy to answer any questions you may have.

NEW YORK TRANSGENDER ADVOCACY GROUP

New York Transgender Advocacy Group (NYTAG)
118 E 28th St, Suite 805 New York, NY 10016

Re: Support for Int. 1258-2025 – Respectful and Accurate Death Certificates for Trans and Gender Expansive New Yorkers

Dear Members of the New York City Council,

On behalf of the New York Transgender Advocacy Group (NYTAG), I write to urge your full support for Int. 1258-2025, a crucial piece of legislation sponsored by Council Member Crystal Hudson. This bill would require the New York City Department of Health and Mental Hygiene to issue death certificates with sex designations that align with an individual's affirmed gender identity and to establish a clear process for correcting those designations when they are inaccurate.

Transgender and gender expansive New Yorkers deserve dignity not only in life, but in how we are remembered. Due to a lack of demographic death data, the scope of posthumous misgendering in New York City is not well documented. However, data from other jurisdictions is sobering. A study published in the *Journal of Public Health Management & Practice* found that more than half of the transgender individuals in the study—29 out of 47—were misgendered on their death certificates, with the highest rate of error among transgender women.

In New York City, the current *Application for the Correction of a Death Certificate* does not allow for corrections to the sex designation. This leaves families, partners, and loved ones without an official path to correct inaccuracies. Stripping away the identity of the deceased and compounding the grief of those who survive them.

Int. 1258-2025 is an urgently needed solution. It affirms that everyone deserves to be recognized for who they are, both in life and in death. In a time when trans and gender expansive people are facing coordinated attacks nationwide, this legislation is a clear opportunity for New York City to lead with compassion, truth, and justice.

Let us be honored when we are alive, and let us be honored when we pass on. NYTAG stands in full support of this legislation and we call on you to do the same.

Sincerely,

Yanery Cruz
Director of Advocacy and Programs
New York Transgender Advocacy Group (NYTAG)

NEW YORK TRANSGENDER ADVOCACY GROUP

New York Transgender Advocacy Group (NYTAG)
118 E 28th St, Suite 805 New York, NY 10016

Re: – Calling on NYS to Pass S.1532/A.4756 for Trans-Inclusive School Policies

Dear Members of the New York City Council,

On behalf of the New York Transgender Advocacy Group (NYTAG), I write in strong support of Resolution 0141-2024, introduced by Council Member Tiffany Cabán and co-sponsored by members of the Council and the Public Advocate. This resolution urges the New York State Legislature to pass, and the Governor to sign, S.1532/A.4756, which would require school districts to establish policies and procedures for the treatment of transgender and gender non-conforming students.

As an organization led by and for transgender people, NYTAG believes that all students deserve a safe, affirming, and equitable educational environment. While the Dignity for All Students Act (DASA) protects against discrimination, there are currently no statewide standards for how school districts must support transgender and gender non-conforming youth. This lack of uniform policy may allow school leadership's personal bias to influence how a student is treated, creating vastly different school experiences based on geography. This leads to harm and unnecessary barriers for students simply trying to learn and thrive.

S.1532/A.4756 would change that by requiring all school districts to adopt clearly defined procedures. These would include the use of chosen names and pronouns, privacy protections, access to gender-affirming spaces and activities, and the ability to update school records without requiring a medical diagnosis. It is within this great State's best interest to ensure our scholars are being set up for success. Ensuring we close the gaps on barriers to education for all students may allow generations of future professionals to flourish in the fields they choose.

We thank the New York City Council for recognizing the urgency and importance of this legislation. Your collective support sends a powerful message to transgender and gender non-conforming youth across the city: that they matter, they belong, and their futures are worth fighting for.

Sincerely,

Yanery Cruz
Director of Advocacy and Programs
New York Transgender Advocacy Group (NYTAG)

NEW YORK TRANSGENDER ADVOCACY GROUP

New York Transgender Advocacy Group (NYTAG)
118 E 28th St, Suite 805 New York, NY 10016

Re: Support for Res. 0817-2025 – Resolution Calling on the New York State Legislature to Fund Accessible Gender-Affirming Care in NYC

Dear Members of the New York City Council,

On behalf of the New York Transgender Advocacy Group (NYTAG), I write in strong support of Resolution 0817-2025 sponsored by Council Member Tiffany Caban, urging the New York State Legislature to provide the necessary funds to ensure that hospital and healthcare provider services for gender-affirming care remain accessible for all people in New York City.

Transgender, nonbinary, and gender-expansive people are facing a relentless and disproportionate wave of attacks across the country. Amid this national hostility, New York must be unwavering in its commitment to protecting our communities.

Most recently, Executive Order 14187 attempted to undermine gender-affirming care for youth. As a direct result, care was disrupted and surgeries were canceled right here in New York. Thankfully, our Attorney General responded swiftly, reaffirming that such actions are illegal in our state and demanding that services continue as required under existing law. While we are grateful for this leadership, the fact remains: the attempt was made, and it exposed vulnerabilities that must now be addressed.

This resolution cites various federal actions but we must also look ahead. The "Big Beautiful Bill" that passed the House is now moving toward the Senate, posing further threats to our community's access to care. We cannot afford to wait for the worst-case scenario to act. New York must take the offensive by securing a stable, resilient infrastructure for gender-affirming services now.

That means fully funding the hospitals, clinics, and community health providers who offer gender-affirming care. It means making sure providers are equipped to continue this work without fear, without delay, and without any rollback in access. No matter what happens nationally.

The New York City Council must send a clear message to the Governor. We cannot wait for federal attacks to escalate. We must demand the creation of a **Gender-Affirming Care Contingency Fund** to safeguard access to care, support our healthcare providers, and guarantee that this lifesaving care continues uninterrupted.

New Yorkers have already spoken. When we passed the Equal Rights Amendment (Proposition 1), we made it clear that our state must defend the rights and dignity of transgender and gender-expansive people. That includes access to gender-affirming care.

New York must respond. And not with reactionary panic, but with bold, proactive investment.

We urge the City Council to pass Resolution 0817-2025 and stand firm in its commitment to our communities. Now is the time to act.

In solidarity,

Yanery Cruz
Director of Advocacy
New York Transgender Advocacy Group (NYTAG)

TESTIMONY

New York City Council
Committee on Women and Gender Equity
Testimony in Support of Intro. 1258
Tuesday, June 3rd 2025 at 10:00 AM

Submitted by:
MJ Okma

Good morning, Chair Louis and members of the Women and Gender Equity Committee. My name is MJ Okma, founder and principal of Okma Strategic Consulting and a member of Equality New York's Advisory Council, and I am here today in strong support of Council Member Hudson's Intro. 1258: The Death Certificate Gender Identity Recognition Act.

In the transgender community, we understand too well the pain of having parts of our history lost, forgotten, and destroyed. One example of that that brings us here today is that transgender, gender non-conforming and non-binary (TGNCNB) people are more often than not misgendered on their death certificates.[i] This misgendering directly feeds into the dangerous systematic pattern of TGNCNB people being erased from the public record.

The fear of being misgendered after death is a heavy burden, especially for those of us without supportive families or resources to change our documentation. From a public health perspective, medical examiners and coroners are often the first to document emerging health threats. Their data cannot and will not be adequate if it does not accurately report the identities of TGNCNB New Yorkers. Discrepancies in official death records also have a fiscal impact, as death certificates are used for reporting a region's vital statistics, which are directly linked to the allocation of state and federal funding for social services and public health programs.

The Death Certificate Gender Identity Recognition Act also would mandate the New York City Department of Health and Mental Hygiene to establish a procedure to correct inaccurate sex designations on death records. This is urgently needed as there is currently no established system to process such requests. Page 2 of the *Application for the Correction of an NYC Death Certificate* on NYC's vital records website lists "item(s) to be corrected" alongside the "type of certified/original documentation applicant must submit," however, correcting the sex designation is absent from this list.[ii] This must be addressed in order to ensure that corrections can be made when New Yorkers are misgendered on their death certificates.

Intro. 1258 is a common sense bill. Accurate vital records for TGNCNB people in the United States have historically been a bipartisan issue, and statutes for accurate and affirming vital records predate all sodomy law repeals and marriage equality recognitions.[iii] Illinois became the first state that allowed transgender people to correct their birth certificates in 1955 and Louisiana passed and signed into law a similar law in the summer of 1968, one year before the Stonewall Riots.[iv]

In total, 28 states, the District of Columbia, Guam, and the Northern Mariana Islands all enacted similar laws between 1955-2011, with absolutely no correlation between any state or territory's geography or political party in power.[v] Despite the onslaught of lies rooted in anti-TGNCNB extremism and attempts to erode hard-fought progress, these laws historically were and remain a simple matter of understanding the importance of maintaining accurate vital records and public health data.

BACKGROUND: A lack of demographic death data across the board on LGBTQIA+ people means that it is impossible to know how many TGNCNB people are misgendered after death in New York City. However, there was a recent first-of-its-kind study out of the State of Oregon that put this issue into harrowing perspective when it found that 60% of TGNCNB people who passed away during the time of the study were misgendered on their death certificates.[vi] While this study took place across the country, Oregon has the same nondiscrimination and identity documents laws and policies as New York, making this data relevant to our city and state.[vii]

These staggering numbers are, in part, because individual funeral directors and death investigators must make decisions within a system that was not designed with TGNCNB people in mind and often results in defaulting to what is listed on one's birth certificate or making reductive assumptions based on a person's body. Another issue is unsupportive families who may actively seek to erase the decedent's identity.

To prevent this nonconsensual detransitioning by family members, funeral home directors, medical examiners, coroners, and death investigators must have the authority to use gender identifying documentation enacted by the decedent prior to their death. This is already done in some cases through those who appoint an Agent to Control the Disposition of Remains[viii] pursuant to the provisions of New York State Section 4201 of the Public Health Law. However, the appointment of agent is not compulsory, and not everyone does so prior to their death or is aware of that possibility. Intro. 1258 would expand the types of documentation that can be used to ensure the death certificate is filed correctly even if the person did not appoint an Agent to Control the Disposition of Remains.

NOTE ON GENDER MARKER CHANGES: In New York, TGNCNB people experience substantial barriers to possessing accurate identity documents. This is why it is vital Intro. 1258 currently includes an expansion of the documents accepted to ensure a death certificate is filed correctly. Only accepting an updated birth certificate or State and Federal is insufficient. Obtaining these documents range from being impossible depending on where the individual was born to inaccessible due burden of cost and time needed to go through the process even when it is technically possible to do so. Safety is and fear of surveillance is also an additional concern in the current political environment.

TGNCNB people who live or were born in states where it is possible to update sex designation on government-issued documents, are more likely to have IDs with the correct gender marker than those in states with the policy barriers in place. However, even in supportive states like New York, only 46.5% of those living full time in a gender different from their sex assigned at birth have corrected the gender markers on their driver's licenses, and even less have updated birth certificates.[ix]

This is why it is vital that Intro. 1258 includes a more expansive list of accepted documents, including proof of clinical treatment for gender transition, an advance healthcare directive, written instructions from the person who passed away, and/or local identification card such as IDNYC, which are one of the easiest affirming IDs for TGNCNB New Yorkers to obtain.

PROPOSED AMENDMENTS: The following amendments would strengthen the ability of Intro. 1258 to ensure that TGNCNB New Yorkers are recognized as their true selves on their death certificates.

- **Update the definition of gender identity**. The definitions of gender and gender identity must be clear across New York City legislation and policy. Typically, the model language is that of the New York City Administrative Code, Title 8 on Civil Rights: "The term "gender" includes actual or perceived sex, gender identity and gender expression, including a person's actual or perceived gender-related self-image, appearance, behavior, expression or other gender-related characteristic, regardless of the sex assigned to that person at birth."
- **Add language that directly states surgery and/or an updated birth certificate are not required.** These benchmarks are not feasible, affordable, or desirable for many TGNCNB individuals. Yet, they are the most common reasons for misgendering to occur on death certificates, making it essential to state that they are not explicitly required.
- **Include Agents to Control Disposition of Remains:** Currently, Agents to Control Disposition of Remains is one of the only resources for TGNCNB New Yorkers who are proactively working to ensure they are not misgendered after death. This bill must not risk interference with established systems, only expand the options available to ensure vital records are accurate.

CONCLUSION: Intro. 1258, the Death Certificate Gender Identity Recognition Act, is an important bill that helps ensure everyone's true self is reflected in public records after their death and requires the New York City Department of Health and Mental Hygiene to establish a process to correct misgendering on death certificates when it occurs.

As the federal government is actively working to erase the TGNCNB community and target our history, we must take every step we can to ensure records of TGNCNB New Yorkers are not lost, forgotten, or destroyed. I urge the New York City Council to support the amendments outlined above and pass Intro. 1258.

Thank you, Chair Louis, members of this committee, Speaker Adams, and all New York City Council Members who have taken decisive actions to support TGNCNB New Yorkers.

MJ Okma
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[i] Multnomah County; *Transgender, nonbinary people often misgendered on death certificates, first-of-a-kind study finds*, October 2022 https://multco.us/news/transgender-nonbinary-people-often-misgendered-death-certificates-first-kind-study-finds

[ii] New York City Department of Health; *Application for the Correction of an NYC Death Certificate* https://www.nyc.gov/assets/doh/downloads/pdf/vr/dcorrect.pdf

[iii] Rose, Katrina Cordray, *Forgotten paths: American transgender legal history, 1955-2009,* University of Iowa, May 2018 https://iro.uiowa.edu/esploro/outputs/doctoral/Forgotten-paths-American-transgender-legal-history/9983777392102771 (page viii)

[iv] Id. (page 53)

[v] Id.

[vi] Walters, Jaime K. MPH; Mew, Molly C. MPH; Repp, Kimberly K. PhD, MPH; *Transgender and Nonbinary Deaths Investigated by the State Medical Examiner in the Portland, Oregon, Metro Area and Their Concordance With Vital Records, 2011-2021*, Journal of Public Health Management and Practice, February 2023 https://journals.lww.com/jphmp/abstract/2023/01000/transgender_and_nonbinary_deaths_investigated_by.11.aspx#1937021290

[vii] Movement Advancement Project, *Identity Document Laws and Policies,* June 2025 https://www.lgbtmap.org/equality-maps/identity_document_laws

[viii] Order of the Good Death; *Dying Trans: Preserving Identity in Death*, January 1017 https://www.orderofthegooddeath.com/article/dying-trans-preserving-identity-in-death

[ix] Williams Institute; *Gender Marker Changes on State ID Documents: State-Level Policy Impacts,* June 2021 https://williamsinstitute.law.ucla.edu/publications/gender-marker-policies/

The Research Alliance for New York City Schools

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Testimony of Cheri Fancsali, Ph.D.
Executive Director, Research Alliance for New York City Schools
In support of Bill Int 0691-2024 —
Annual reporting on racial and gender disparities in STEM education for high school students

June 3rd, 2025

On behalf of the Research Alliance for New York City Schools, I would like to thank Chair Farah N. Louis and members of the Committee on Women and Gender Equity for extending me an invitation to provide testimony for the hearing on Int. 0691-2024 a bill to "Require annual reporting on racial and gender disparities in STEM education for high school students." I am the executive director of the Research Alliance for New York City Schools, an independent research center housed at New York University. Our mission is to conduct rigorous studies on topics that matter to the City's public school system. We are dedicated to advancing equity and excellence in education by providing credible, nonpartisan evidence about policies and practices that promote students' development and academic success.

Since our inception, the Research Alliance has conducted a variety of studies examining conditions and trends in NYC schools, and assessing the impact of various policies, programs and initiatives, including work focused on students' social and emotional well-being, high school choice, college and career preparation, school improvement, and accountability. We have amassed a substantial body of work in the realm of STEM education, especially in the area of computer science. We recently served as the external evaluator of NYC's CS4All initiative, a multi-year effort to expand access and participation in computer science, with a focus on students who have been historically underrepresented in the field, including girls and Black, and Latinx students.[1] As the principal investigator for the evaluation of CS4All, I am pleased to provide the testimony below based on our research to date.

The New York City public school system is an incredibly diverse environment, serving students from all racial and class backgrounds. Yet despite the wide array of students our schools serve, there are significant gaps in educational offerings and outcomes, which are particularly

[1] Research Alliance, Fancsali, C., Mark, J., Hill, K., Li, X., Lee, J., Jain, R., & Flores, M. (2024, December). Expanding Computer Science Education for All. NYU Steinhardt. Retrieved from https://steinhardt.nyu.edu/research-alliance/research/expanding-computer-science-education-all

pronounced in STEM fields. Within computer science, Black and Latinx students have been substantially less likely than their White and Asian peers to receive CS instruction. For example, in 2016–17, 8% of Black and Latinx students received CS, compared with 13% of White and 14% of Asian students.[2] As a result of continued implementation of CS4All, exposure to CS has grown across the board, yet gaps still persist among racial groups. In 2022-23, the percentage of Black and Latinx students taking CS had increased to 16% and 20% respectively, compared with 23% of White students and 28% of Asian students (see Figure 1 on last page). In addition, girls are consistently less likely to receive CS education (see Figure 2) with Black girls falling the most behind.[3] For both race/ethnicity and gender, disparities are greater at the middle and high school levels than elementary school. Through surveys conducted with students participating in CS4All course offerings, the Research Alliance also found that Black girls report lower rates of feeling like they belong in CS spaces despite having similar levels of interest in CS, family and peer support for CS, and valuing CS, compared with other students.

It is notable that the individual-level differences in CS participation were driven at least in part by differences in access, because schools were not equally able to implement CS. Our study found that schools with the greatest improvements in CS offerings from 2018-2022 enrolled fewer Black and Latinx students on average.[4]

These findings demonstrate the systemic nature of racial and gender disparities within CS education, which is a microcosm of other, larger inequities. Research has underscored that expanding STEM course offerings alone will not correct educational disparities. School leaders, policymakers, and government officials must attend to both student- and school-level factors—racial climate, strength of student-teacher relationships, administrative support, guidance counselor awareness and support, competing demands on educators' time— that also contribute to differentiated outcomes amongst students. High-quality data is essential to locate

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[2] Fancsali, C., Mark, J., Hill, K., Li, X., Lee, J., Jain, R., & Flores, M. (2024, December). Expanding Computer Science Education for All. NYU Steinhardt. Retrieved from https://steinhardt.nyu.edu/research-alliance/research/expanding-computer-science-education-all

Fancsali, C., & Lee, J. (2024, April 5). *Moving the Needle on Equity in Computer Science Education: Lessons from New York City*. Urban Institute. Retrieved from https://www.urban.org/research/publication/moving-needle-equity-computer-science-education-lessons-new-york-city

[3] Mirakhur, Z., Fancsali, C., & Hill, K. (2024). Outsiders Within: How Do Black Girls Fit into Computer Science for All? *ACM Transactions on Computing Education*, *24*(2), 1-23. https://doi.org/10.1145/3633464

[4] Fancsali, C. (2022). CS4All: Examining Equity in Computer Science Access and Participation in NYC Schools. *Research Alliance for New York City Schools*. Retrieved from https://steinhardt.nyu.edu/research-alliance/research/cs4all-examining-equity

where specific gaps and barriers exist and to develop and test potential solutions to these problems.

A key finding from our evaluation of CS4All relates to the importance of context. CS4All implementation tended to vary depending on whether schools had prior infrastructure to support CS classes, as well as the degree of buy-in from teachers and administrations. To address this, NYCPS designed and provided assistance based on where schools are in their CS4All journey. This included support tailored to helping elementary schools integrate high-quality CS curricula and activities within other subject areas, and helping high schools grapple with such issues as teacher certification and aligning CS courses with graduation requirements. It is imperative that when creating policy solutions to bridge gaps in STEM education access, participation, and experience, we meet schools where they are. This is one area in which increased data collection that pays attention to both participation numbers and the experiences of students and teachers can inform these efforts in important ways. In our research we found that schools with the strongest CS implementation had ties to strong professional communities of CS teachers, support from school and district leaders, dedicated planning time, and a positive school culture around CS.[5] These findings emerged through interviews, focus groups, surveys, and analysis of CS participation data, and demonstrate the potential of research and evaluation to inform practice.

Through our data sharing agreement with NYC Public Schools and our years-long evaluation of CS4All, our research showed large gains CS4All made in improving access to and participation in CS education across the city, while also identifying where inequities remained, and the factors that contributed to those inequities. Ongoing data collection is necessary for both addressing historic inequities and providing transparency to stakeholders, while supplying the tools and information needed to provide quality education for all students.

Local data collection is especially important in the wake of widespread cuts to federal research grants and data collection efforts. This is particularly true when it comes to measuring racial and gender equity. Such efforts provide information needed to ensure that all students have access to high-quality educational opportunities that nurture their development and prepare them to be successful, engaged citizens. With the expansion of reporting to encompass STEM education, policymakers are in a stronger position to make better decisions and allocate resources more effectively.

For additional information and findings from our CS4ALL evaluation please see related publications on our website. Thank you again to the Committee on Women and Gender Equity

[5] Hill, K., Flores, M., Jain, R., Rivera-Cash, E. (2025). Building School Capacity to Scale Up Computer Science Participation Insights from NYC's CS4All Initiative. Retrieved from https://steinhardt.nyu.edu/research-alliance/research/building-school-capacity-scale-computer-science-participation

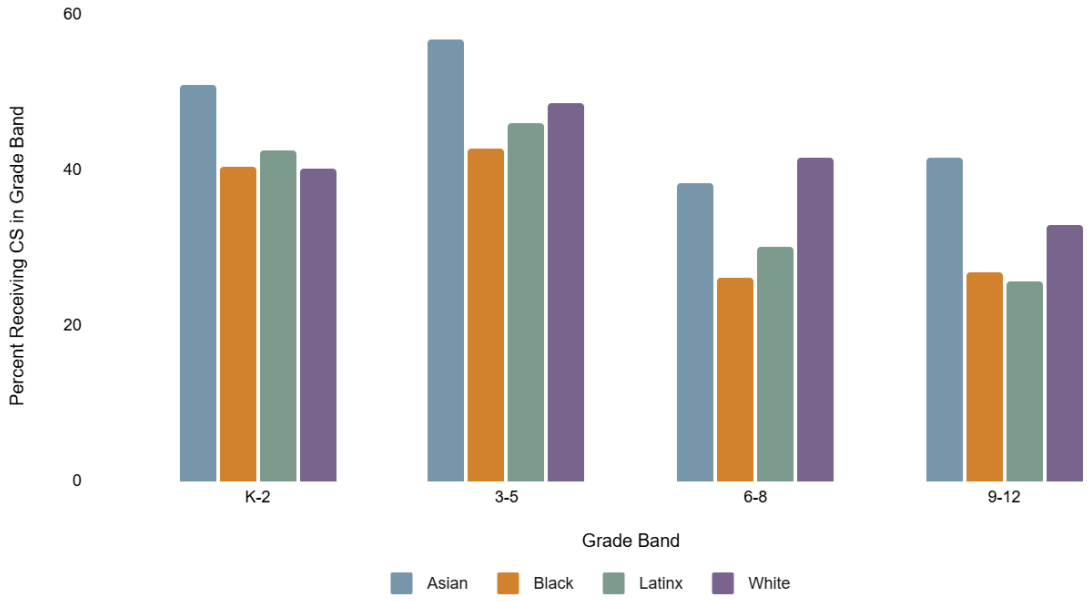
for the opportunity to provide this testimony. Please feel free to contact me at CF94@nyu.edu with any questions about our research.

Sincerely,

Cheri Fancsali, Ph.D.
Executive Director
Research Alliance for NYC Schools

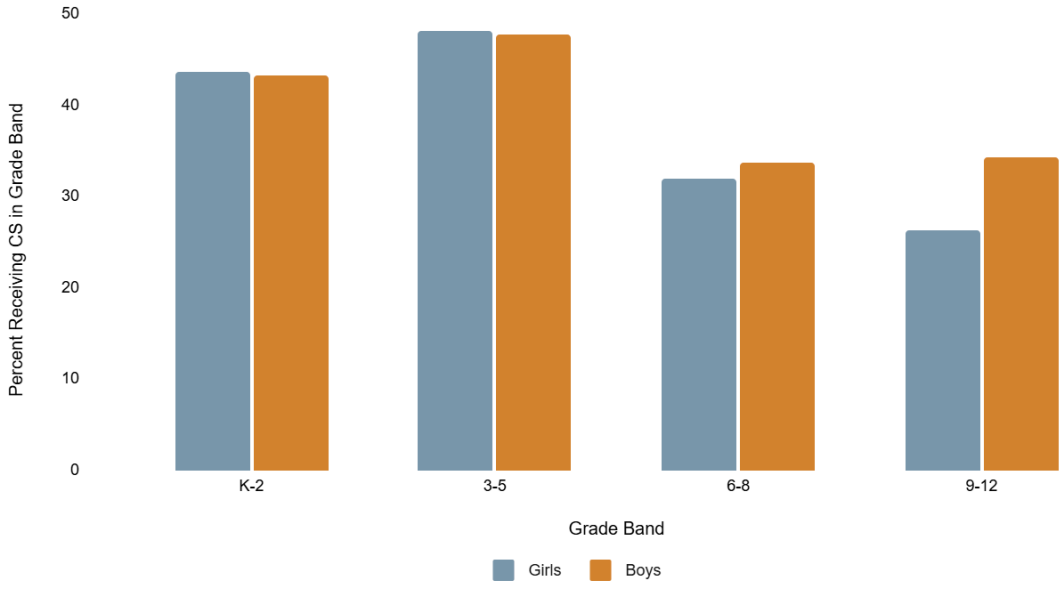
This testimony was prepared with the assistance of Humyra Karim.

Figure 1: CS Participation Rates in 2022-23, by Grade Band and Race/Ethnicity



Source: Research Alliance calculations on data provided by NYCPS.
Notes: This analysis is based on data from students in community school districts 1-32. Students from special and alternative districts 75, 79, 84, and 88 are not included in these results. Additionally, data from Indigenous students and students with multiple ethnicities are not displayed due to the small numbers of their enrollment in NYC public schools.

Figure 2: CS Participation Rates in 2022-23, by Grade Band and Gender



Source: Research Alliance calculations on data provided by NYCPS.
Notes: This analysis is based on data from students in community school districts 1-32. Students from special and alternative districts 75, 79, 84, and 88 are not included in these results.

RIGHT TO BE

30 3RD AVENUE #800B,
BROOKLYN, NY, 11217

Testimony: New York City Council Committee on Women and Gender Equity hearing on Tuesday, June 3rd 2025.

Good afternoon, my name is Emily May and I'm the President, Co-Founder, and Lead Executive Officer of Right To Be, (formerly Hollaback)!. I want to thank you for the opportunity to provide testimony in support of Int. 0691-2024, 1094-2024, 1258-2025 and Resolutions 0141-2024, 0599-2024, 0817-2025. These legislative actions address important issues affecting our communities, as New Yorkers and as an organization supporting folks who experience identity based harm. Founded in Brooklyn in 2005 - Right To Be's work addresses all forms of hate and harassment, including harm that targets youth, women, trans, and gender expansive folks.

Our work focuses on turning the care we have for each other into simple, creative, effective action. Every day, we train hundreds of people to respond to, intervene in, and heal from hate & harassment. We hold space for people experiencing hate & harassment to share their stories for affirmation and support. And we prepare new leaders to create workplaces, schools and communities around our city and around the world that are filled with humanity.

Today we would like to offer our support for the proposed legislative actions as they support communities that are targeted by the federal government through the entrenchment of racism and sexism into funding cuts and laws. Our city government should stand strong in undoing the wrongs affecting marginalized New Yorkers – creating a better and more equitable society for all.

Also as supported of New York City's Transgender, Gender Non-confirming and NonBinary community, and supporters of the Trans and Queer Political Advocacy Coalition, we join in asking these three specific demands for NYC:

1. New York City Council increases the Trans Equity Fund Initiative $3,250,000 to $10,000,000 and prioritizes including trans-led organizations.

2. The Mayor and City Council provide $15,000,000 to backstop health care providers that are being stripped of their funding by the White House and DOGE so

that providers can maintain medically-necessary healthcare for TGNB New Yorkers.

3. The Mayor and City Council provide $10,000,000 to support providers caring for runaway and homeless trans and queer youth.

We know that combating racism and sexism takes individuals showing up every day, and we are currently providing free and virtual bystander intervention training to address anti-LGBTQIA+ hate.

But increasingly, BIPOC communities, girls, LGBTQ+, immigrant youth, and young people with disabilities face increased harassment targeting their identities, with long-term negative impacts on their health, confidence, economic/school success, and safety. According to the HRC, "In 2023, for the first time in their 40+ year history, the Human Rights Campaign declared a National State of Emergency for LGBTQ+ Americans, in response to the over 550 anti-LGBTQ+ bills introduced into state houses across the country, more than 85 of which were passed into law. This trend continued into 2024, where over 500 additional anti-LGBTQ+ bills were introduced, and over 40 passed into law across 14 states." We must not let a culture of cruelty and dehumanization infiltrate our city's institutions, our health services, our community spaces, and even our classrooms.

That is why combatting racism, transphobia, and sexism takes the work of our government to ensure that citizens are cared for by the laws we pass, not negatively targeted. We celebrate Int. 0691-2024, 1094-2024, 1258-2025 and Resolutions 0141-2024, 0599-2024, 0817-2025 as impactful and needed steps towards progress and equity, in the midst of national attacks on our community's human rights.

Our support for marginalized communities starts in New York, but also extends country-wide, and with partners like Advocates for Trans Equality (formerly NCTE), and the Pride Center San Antonio, we've adapted our training and approach to address the specific experiences of Trans and LGBTQIA+ people. Our training works to empower anyone and everyone to take safe and effective action; 98% of people who take our training say that there is at least one thing they think they could do and 6 months later 78% say they have used the training in their day to day.

We trust that our city will lead the response nationwide to the current attack on Trans rights, and we are ready to support the efforts brought forward by the city's council members. Please do not hesitate to reach out to us.

Thank you for the opportunity to testify today, and for your commitment to making New York City a great place for all New Yorkers.

sage | Advocacy & Services for LGBT Elders
We refuse to be invisible®

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Testimony

New York City Council Committee on Women & Gender Equity

June 3rd 2025

Good afternoon, Chair Hudson and members of the New York City Council Committee on Aging. My name is Bryan Ellicott-Cook (They/He), and I serve as the Director of Government Relations at SAGE—the nation's oldest and largest organization dedicated to improving the lives of LGBTQ+ older adults.

Since our founding in 1978, SAGE has been a tireless advocate for LGBTQ+ elders, fighting for policies and programs that enable them to age with dignity, security, and support. Through national advocacy and local direct services, SAGE has remained at the forefront of efforts to combat social isolation, housing insecurity, and healthcare disparities affecting our communities.

We submit this testimony in *strong support* of Intro 1258, which affirms the dignity and lived truth of trans and nonbinary New Yorkers at every stage of life—including after death.

For too long, transgender and nonbinary people have faced systemic erasure, including through misgendering on death certificates. This not only disrespects the deceased—it causes further pain to surviving loved ones, undermines the deceased's identity, and perpetuates stigma. For LGBTQ+ elders who spent their lives fighting for recognition and basic human rights, the final record of their lives should honor who they were—not revert to outdated or incorrect documentation.

This legislation takes a compassionate and pragmatic approach by:

- Requiring the Department of Health to make best efforts to reflect a decedent's gender identity on death records;
- Allowing supporting documentation to guide accurate gender designation;
- Establishing a clear and accessible correction process that includes the option for an amended or entirely new death certificate, with no visible mark of amendment.

These are best practices rooted in dignity, privacy, and respect. They align with national standards and build upon existing New York City policies that affirm self-determination in identity documents.

In our work, we hear from trans elders who fear not being remembered as they truly are. This fear is not hypothetical—misgendering in death certificates can affect not only emotional closure but also legal matters related to insurance, estates, and burial decisions. We urge the Council to pass this legislation without delay to ensure all New Yorkers are granted the dignity they deserve in death, just as we strive to support and affirm them in life.

SAGE commends the sponsors of this bill for recognizing that our elders' identities do not end at death. This is a meaningful, respectful, and overdue measure that centers upon humanity and affirms truth.

Thank you for your leadership and commitment to justice and dignity for all.

For questions or further information, please contact Bryan Ellicott-Cook, Director of Government Relations at SAGE, at **bellicott@sageusa.org**.

Sauti Yetu
CENTER FOR AFRICAN WOMEN AND FAMILIES
Giving Voice To Our Potential

Testimony by Zeinab Eyega,
Executive Director
Sauti Yetu Center for African Women, Inc.

Submitted to: New York City Council, June 3rd, 2025

Committees: Women & Gender Equity Committee

Testimony

Good morning, Chairwoman and esteemed members of the Committees on Women and Gender Equity. My name is Zeinab Eyega, and I serve as the Executive Director of Sauti Yetu Center for African Women. I am honored to present testimony today on behalf of Sauti Yetu and The Collective, a coalition of gender-based violence organizations dedicated to serving immigrant communities, including Sakhi for South Asian Survivors, Violence Intervention Program, Womankind, and Korean Family Services Center. We are grateful for this opportunity to address these committees.

Sauti Yetu, which translates to "our voice" in Swahili, has been at the forefront of addressing female genital cutting (FGC) in New York City since our establishment in 2004. We are recognized as one of the few organizations providing direct services and assistance to both survivors and their families. Our work encompasses community outreach to raise awareness about FGC and other gender-based violence issues affecting women and girls. We also develop educational materials and resources tailored for various community sectors, including youth, fathers, and community leaders. Furthermore, we firmly believe that effective services and policies must be informed by accurate data and up-to-date research. To this end, Sauti Yetu conducts participatory action research to document evolving dynamics within New York City's diverse African immigrant communities.

Int. No. 1094 represents a pivotal step in safeguarding individuals from the devastating impacts of FGM/C. By providing a clear and comprehensive definition of FGM/C, Int. No. 1094 offers essential clarity for both medical professionals and the broader public. The bill's definition accurately encompasses the various forms of FGM/C, explicitly distinguishing it from medically necessary procedures or gender-affirming treatments performed by licensed practitioners, as well as medical procedures related to labor and birth. This precision is vital for effective identification and intervention. Crucially, the bill mandates culturally competent training for staff across a wide array of "relevant agencies". This includes the Department of Education, the Department of Health, the Police Department, the Administration for Children's Services, the Mayor's Office to End Domestic and Gender-Based Violence, and contracted service providers. This comprehensive scope ensures that professionals most likely to encounter individuals at risk of or affected by FGM/C are equipped with the necessary knowledge and tools. The emphasis on culturally competent training is paramount. FGM/C is a deeply sensitive issue, often rooted in complex cultural contexts. This training will empower staff to recognize the signs of FGM/C with an understanding of these nuances, fostering more effective and respectful interventions. Furthermore, the bill thoughtfully requires that this training

include information on resources for individuals who have experienced physical or psychological trauma, ensuring a holistic approach to survivor support.

While we commend the Women and Gender Equity Committee for recognizing the critical need to prevent FGC and support survivors, it is essential to acknowledge the significant concerns among many African immigrant communities, particularly given the current political climate. Their apprehension is understandable and valid.

Challenges in Identifying Signs of FGC
A key consideration is how city agencies will develop the capacity and expertise to provide training for identifying signs of FGC. What constitutes these "signs," and who will define them? FGC is a diverse communal practice, particularly in the African context, varying significantly in form and the age at which girls undergo the procedure. Common forms include clitoridectomy and infibulation, yet the age of practice is highly variable. For instance, in The Gambia, the procedure may occur soon after birth; in Sudan, it typically takes place in early childhood; and in Sierra Leone, it is common for girls to undergo the practice in early to mid-adolescence or even early twenties. This diversity underscores the complexity of standardized identification.

Concerns Regarding Targeted Profiling and Surveillance
Immigrant communities and communities of color are disproportionately subjected to surveillance by various city agencies, including but not limited to child welfare systems, the Police Department, and the Department of Education. It is critical to consider how individuals and families will be protected from being unfairly targeted, and what recourse for redress will be available if and when families are surveilled.

We commend Council Member Louis for your commitment to preventing FGC and supporting survivors by advocating for identification and assistance from city agencies. However, we suggest that city agencies alone may not be the most appropriate entities to address cultural practices within specific communities across the city. To prevent profiling and unfair targeting of individuals and families within immigrant communities, we strongly recommend enhancing collaborations between city agencies and culturally specific community-based organizations, such as the members of The Collective.

Thank you for the opportunity to provide this testimony today. I am available to answer any questions you may have.

Aisha Umar
Committee on Women and Gender Equity
June 2nd, 2025

I am a Doula, specifically a community Doula, who has trained with the amazing Mama Glow organization, headed by Latham Thomas. I completed my training and began working as a Doula the end of Nov. 2022. My very first client I worked with was through the Citywide Doula Initiative.

My name is, Aisha Umar, and i am testifying regarding the need for the continuation of programs i.e. the Citywide Doula Initiative. I understand this is a pilot program, which was created to provide support for Mothers, pregnant people, who are in need and who live in areas where support and services are lacking.

I have attended 25 births as of Sunday, May 25th, 2025. This journey has and continues to teach me so many things. As a Doula, specifically, a community Doula, I have supported many Mothers, particularly Mothers who are lacking support. I have had clients who are Mothers with special needs, Mothers who are in shelters, and Mothers who have very little family to support them. ...having a doula was basically the only support they had.

The clients benefit from all the support, care and knowledge we provide. The numbers show how such support helps the clients before, during and after they give birth.

I feel very strongly about the Citywide Doula Initiative program and how successful it has been. ...continuing this program in the long run will keep costs down...by supporting and educating the client's. This can keep the number of days babies spend in NICU and keep Mothers from having to suddenly return to the hospital.

While I do understand paperwork is necessary, and budgets are needed, if there were a way Doulas within the program are able to focus more on the client's this would be wonderful.

We Doulas do witness first hand how successful this program is. ...many of the client's do return. It was an absolute honor for me to attend the birth of one of my client's third baby. I attended the birth of her second baby, which was my first birth.

My hope is this program is seen as an asset and will be viewed as one of the ways to assist with Women and Gender Equity.

I wish to thank Councilmembers and I thank the chair of the Committee.

I truly hope you consider my testimony.

Thank you All again.

Testimony of Monique Jaques
Director of Doula Capacity, Citywide Doula Initiative
7/3/2025

Good Morning, and thank you for the opportunity to speak today.

My name is Monique Jaques, and I have had the privilege of serving as the Director of Doula Capacity at Mama Glow- one of the CBO's contracted to work under the Citywide Doula Initiative for the past two and a half years. During this time, I have witnessed firsthand the profound impact this program has had on birthing people and families across New York City.

Since its inception, the Mama Glow Foundation through the Citywide Doula Initiative has served over 1,460 clients, providing culturally responsive, community-based doula care to individuals who might otherwise lack access to this critical support. I have spoken to the majority of these clients, who come from a range of backgrounds and experiences- they may be birthing alone or are new to this country, they may have been ignored or pushed aside during their previous birth, or they may be recovering from a traumatic birth. All of these clients are grateful for the support the CDI has provided them.These services have not only improved individual birth experiences, but they have also contributed to demonstrably better health outcomes and increased trust in maternal health systems.

As we continue to address the stark maternal health disparities—particularly those affecting Black and Brown communities—this initiative stands as a model for what is possible when we invest in community-rooted care. Doulas do more than support births; they advocate, educate, and empower families during some of the most vulnerable moments in their lives.

The success of this program is measured not only in numbers, but in stories: families who felt seen and heard, birthing people who entered their experience with confidence rather than fear, and doulas who are finally being recognized and resourced for their critical work.

I am incredibly proud of what we've accomplished and even more hopeful about what lies ahead. Thank you for your continued support of this essential initiative.

Neisha Streete
[redacted]
Bronx, NY 10475
[redacted]

Re: Codify the CDI Doula Program

For generations, BIPOC communities—especially Black women—have faced deep-rooted discrimination and dehumanization in reproductive healthcare. They've been ignored, disbelieved, and stripped of autonomy—harsh legacies that trace back to slavery and unethical medical experimentation. These injustices, though disproportionately affecting some, were too often accepted by the broader public as just the way things were.

But when harm becomes normalized for a few, it eventually spreads to all.

Today, far too many birthing people—regardless of race, class, or background—report feeling coerced, dismissed, or dehumanized during labor. It looks like this:

- Being pressured into interventions like inductions or C-sections without fully informed consent.
- Not being listened to when expressing pain, discomfort, or fear.
- Being denied basic rights like movement during labor or immediate skin-to-skin contact.

The system now harms everyone—but it still harms Black, Brown, Indigenous, poor, disabled, and LGBTQ+ people the most. What once happened quietly to the most vulnerable has now become standard practice. The mistreatment of some wasn't an exception—it was a warning. And now, we are all feeling its consequences.

If we truly want to fix this, we have to confront the racism, classism, and misogyny that built this system. We must invest in systemic change. Initiatives like the Citywide Doula Initiative, community birth centers, midwifery models of care, and anti-racism education are part of that change. Most importantly, we must listen—really listen—to those who have been most harmed.

Birth trauma doesn't end in the delivery room. It lingers as anxiety, depression, and unresolved pain—and that trauma can echo across generations. Let's take the baby steps to correct this now. Let's normalize education about our bodies and choices. Let's ensure that free, skilled doulas remain accessible to those who need them most.

Because where else will people learn their rights? How many times do we hear stories of traumatic births followed by the words: "I didn't know I could say no"?

Doulas are a solution.

- We bridge communication between patients and providers, fostering shared decision-making and trauma-informed care.
- We create more respectful, empowering birth experiences.
- We teach advocacy—a skill that ripples beyond birth into every area of life: relationships, workplaces, schools, etc.
- We help reduce preventable issues like hypertension and preterm birth.
- We lower rates of anxiety, depression, and PTSD.
- We reduce healthcare costs by avoiding unnecessary interventions and improving outcomes.
- And we do so much more.

It doesn't feel good to be unheard, unsupported, gaslit, and uninformed—especially when we're entrusting our lives and the lives of our babies to systems that don't always take the time to see us. As I doula, I cannot make promises of outcomes. I do promise however, that anyone who I work with will understand the processes and how we arrived at the outcome.

We've all experienced some version of unheard. Now imagine it happening at the most vulnerable moment of your life—and no one wants to hear you.

The Citywide Doula Initiative isn't just a program. It's a step toward justice. It's a declaration that we will no longer accept a system that only works for some. It's a promise to listen, to support, and to restore dignity to the sacred process of birth—for everyone.

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☑ in favor ☐ in opposition

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I represent: _____

Address: _____

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Address: _____

I represent: Sauti Yetu Center for African Women

Address: _____

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Name: Monique Jagues

Address: [redacted]

I represent: Mama Glow Foundation

Address: 205 N. 7th St

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Date: June 3, 2025

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Name: Jamirah McNatt

Address: _____

I represent: DOHMH

Address: 485 Throop Avenue

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Name: Tesa Arozqueta DC of External Affairs and Community Initiatives

Address:

I represent: END GBV

Address:

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Name: Tunisia Mitchell, interim ED, 21st Century Skills

Address:

I represent: NYC Public School

Address:

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Name: Nicole Williams, ED for STEM

Address:

I represent: NYC Public School

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Name: Dr. Zahirah McNatt DC for Center for Health Equity and Community Wellness

Address:

I represent: DOHMH

Address:

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Name: Dr. Gretchen Van, NYC Chief Epidemiologist

Address:

I represent: DOHMH

Address:

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I intend to appear and speak on Int. No. 601-2024 Res. No. 817-2025

☑ in favor ☐ in opposition

Date: 6/3/25

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Name: SARAH ENJARDO

Address: Flushing, Queens

I represent: Korean American Family Services Center

Address:

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