Title

Postpartum care for parent—infant dyads: A community midwifery model

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Abstract

Introduction: Postpartum health is in crisis in the United States, with rising pregnancy-related mortality and worsening racial inequities. The World Health Organization recommends four postpartum visits during the six weeks after childbirth, yet standard postpartum care in the US is generally one visit six weeks after birth. We present community midwifery postpartum care in the US as a model concordant with WHO guidelines, describing this model of care and its potential to improve postpartum health for birthing people and babies.

Methods: We conducted semi-structured interviews with 34 community midwives providing care in birth centers and home settings in Oregon and California. A multidisciplinary team analyzed data using reflexive thematic analysis.

Results: Twenty-four participants were Certified Professional Midwives; ten were Certified Nurse-Midwives. Fourteen midwives identified as people of color. Most spoke multiple languages. We describe six key elements of the community midwifery model of postpartum care: 1) multiple visits, including home visits; typically five to eight over 6 weeks postpartum; 2) care for the parent-infant dyad; 3) continuity of personalized care; 4) relationship-centered care; 5) planning and preparation for postpartum; 6) focus on postpartum rest.

Conclusion: The community midwifery model of postpartum care is a guideline-concordant approach to caring for the parent-infant dyad and may address rising pregnancy-related morbidity and mortality in the US.

Keywords: postpartum care; community midwifery; parent-infant dyad; perinatal health equity

Key points:

- Community midwives provide comprehensive postpartum care using an established, guideline-concordant model.
- Community midwives typically provide five to eight visits, including home visits, over 6 weeks postpartum. Their postpartum care model includes 5 key elements 1) care for the parent-infant dyad; 2) continuity of personalized care; 3) relationship-centered care; 4) planning and preparation for postpartum; 5) focus on postpartum rest.
- This model of care has the potential to improve maternal and infant health at the population level if implemented more broadly.

Introduction

In the United States, there is growing acknowledgement of a postpartum health crisis, including rising mortality rates that further increased during the COVID-19 pandemic (Hoyert 2023), worsening racial inequities (Fleszar et al. 2023), and consensus on the need for more

comprehensive care to address universal postpartum experiences (American College of Obstetricians and Gynecologists 2018). Compared with nations of similar wealth, the US provides notably limited postpartum care, and health outcomes are significantly worse. Despite increasing attention to how obstetric racism (Davis 2019) and structural racism shape perinatal health (Owens and Fett 2019), pregnancy-related deaths are rising especially rapidly among Black and Native American birthing women[1] (Hoyert 2023). Given that over half of pregnancy-related deaths happen one week or more after birth (Trost SL, Beauregard J, Njie F, et al. 2022), improving postpartum care is a key element of addressing pregnancy-related mortality as well as universal postpartum needs.

The World Health Organization (WHO) recognizes the postpartum period as a uniquely critical period and recommends at least four visits, preferably including home visits, during the six weeks after birth (World Health Organization 2022). In contrast, standard postpartum care in U.S. obstetrics is generally one visit six weeks after birth. Up to 40% of people in the U.S. attend no postpartum visits, often due to disruption in insurance coverage and other access issues (Attanasio et al. 2022). Low postpartum visit attendance may also reflect the lack of social emphasis on the significance of the postpartum period (Tully, Stuebe, and Verbiest 2017). In 2018, the American College of Obstetrics and Gynecology (ACOG) updated its guidelines to acknowledge the inadequacy of the singular postpartum visit. ACOG now recommends individualized care with at least two clinical visits in the first six weeks (American College of Obstetricians and Gynecologists 2018; Tully and Stuebe 2022). Tt is unclear how widely this change has been implemented, and there are calls to improve upon these guidelines, particularly for Black families (Scott and Davis 2022).

Despite calls for change, postpartum care and support in the U.S. is limited *and* stratified. Families with higher socioeconomic status sometimes supplement obstetric care by paying out of pocket for postpartum doulas, lactation consultants, and other support. Families with lower socioeconomic status may access WIC lactation support, home visiting programs for "at-risk" families, and free or low-cost doulas, although significant barriers to accessing these programs persist (Chen and Berquist* 2022). Where accessible, nurse home visiting programs have been shown to increase breastfeeding rates and six-week postpartum visit attendance, while reducing infant mortality and intimate partner violence (Callaghan-Koru et al., 2022; Mersky et al., 2022; Thorland & Currie, 2017; Thorland et al., 2017). However, eligibility and participation vary widely by program and geography, and these programs do not provide clinical postpartum care.

Research on postpartum care models in the United States has primarily focused on single elements of care (e.g., lactation support), while the potential benefits of more comprehensive postpartum care in the US healthcare context are not well understood (Saldanha et al. 2023b,

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[1] language footnote: Postpartum is a life stage that affects all people who give birth. Most studies cited in this paper use the terms "women" and "maternal" to refer to birthing people and their health. When referencing specific studies or health outcomes of groups of people we employ those terms, but we use the more gender inclusive "birthing people" and specific terms "perinatal" and "pregnancy-related" where appropriate. We advocate for the thoughtful and specific application of language in writing about perinatal health and attempt to model our intentional writing practice in this paper. In the future, more research should explicitly include the experiences of gender diverse people, especially those of color, to obtain a more complete scope of postpartum health.

2023a). Models of postpartum care concordant with WHO and ACOG guidelines exist in the U.S. but are not broadly accessible. There are many reasons for this, one of which is the medicalization of pregnancy and childbirth (Barker 1998; Davis-Floyd 2022). The U.S. has a long history of midwifery, including care provided by Black "grand midwives" from the 1600s to the mid twentieth century (Goode 2014). However, physician and nursing organizations increasingly portrayed midwifery care as unsafe in the early twentieth century, and by the 1990s nearly all pregnant people received physician-led perinatal care (Suarez 2020). Obstetric dominance in the U.S. is a global anomaly (Tikkanen et al., 2020). Around the world, midwives provide the majority of perinatal care using the midwifery model of care, which includes postpartum care for the birthing parent and infant dyad (Davis-Floyd et al. 2009; Katz Rothman, 2016). Midwifery practice globally typically includes continuity of care across the perinatal period, including postpartum home visits and easy and rapid access to midwives (Kennedy et al. n.d.), and has been documented to improve outcomes related to breastfeeding, postpartum depression, parenting, and satisfaction with care (Tikkanen et al., 2020). Positive outcomes may be further enhanced when there is cultural concordance between midwives and birthing people (Hardeman, Karbeah, and Kozhimannil 2020; Karbeah et al. 2019). The midwifery model of care is recognized internationally to have mental, physiologic, and societal value (Churchill and Avery 2023; Sandall et al. 2016) and offer cost savings to health systems (Attanasio, Alarid-Escudero, and Kozhimannil 2020; Daviss, Anderson, and Johnson 2021). Additionally, it reflects historical social norms that the period after birth is a vulnerable time that should "include organized support for the mother" to support rest, nutrition, and lactation (Dennis et al. 2007).

In the U.S., the term *community midwife* describes midwives who provide perinatal care in homes and free-standing birth centers, including Certified Nurse-Midwives (CNMs), Certified Professional Midwives (CPMs), and Certified Midwives (CMs) (Cheyney et al. 2019). While community midwifery has been practiced for centuries, only just over 2% of U.S. births occur in community settings (Declercq and Shah 2024). Community birth rates increased during the initial waves of the COVID-19 pandemic due to labor and delivery units implementing strict visitor restrictions and public concern about the presence of COVID-19 in hospitals (Preis, Mahaffey, and Lobel 2021), and continue to rise. Interest in community midwifery care is rising among people of color, especially Black women, as well as people insured through Medicaid (Sakala et al. 2018; Vedam et al. 2019). A national survey found that community midwives provided at least four postpartum visits in the first six weeks (often including home visits; over half provided six or more visits. These visits included comprehensive assessment of the family unit, including newborn care, and were typically $\geq$ 45 minutes (Cheyney et al. 2015). However, the scope of this survey did not include a detailed description of community midwives' postpartum care model. Responding to growing interest in community midwifery in the U.S., plus its global relevance and potential to address the postpartum health crisis, this qualitative article provides a detailed characterization of this model of care. We explore midwives' experiences through qualitative interviews and describe five key elements of the community midwifery postpartum care model.

Methods

Data Collection: We conducted semi-structured interviews with midwives who had practiced in independent homebirth practices and/or free-standing birth centers in California or Oregon, two states with rates of community birth above 2% (California Health Care Foundation 2023). Of 42 midwives we contacted through professional networks and snowball sampling, 34 participated in the study. Interviews were conducted in-person or via teleconferencing between 2019 and 2023 by authors[anonymized for peer review]. Interviews focused on midwives' perspectives on optimal postpartum care, their current postpartum practice model including physical and mental healthcare, and barriers and facilitators to serving families insured through Medicaid. Length ranged from 45-90 minutes. Verbal consent was recorded, and participants chose whether to use pseudonyms. Methods were approved by [blinded for peer review].

Data analysis: We used reflexive thematic analysis (Braun and Clarke 2020). First, we familiarized ourselves with the data by reviewing interview transcripts for accuracy. Memo-writing on initial impressions, patterns, and meaning in the data immediately followed. We generated 30 initial codes that were data-driven and narrow (e.g., "ideal postpartum care;" "barriers to optimal postpartum care;" "visit schedule"). At least two authors coded each transcript using qualitative data analysis software Dedoose (2021). Discrepancies in the coding process were resolved through group discussion by the first three authors. In the next phase of analysis, we met as a group to sort coded data into themes by reviewing our research questions and discussing impressions of overlapping or interacting codes and the intended impact of this study. We discussed preliminary findings with key midwifery professionals (e.g., people doing policy work to increase access to midwifery care), further honing our themes. Finally, we invited study participants to two member-checking discussions (Birt et al. 2016), where seven midwives shared feedback on preliminary findings and provided additional context.

Researcher reflexivity: In alignment with COREQ guidelines for qualitative data analysis (Booth et al. 2014), we reflected on how researchers approach "data through the lenses of their particular social, cultural, historical, disciplinary, political and ideological positionings." (Braun and Clarke 2020: 12). As a study team we were aware of our own social identities and how they might affect interviewees' comfort in participating in this study. For this reason, we prioritized racial concordance between interviewer and midwife when possible, and shared with study participants that all authors are parents who received community midwifery care and/or are professionally trained as community midwives. We intentionally put together a research team with diversity in identities (e.g., race/ethnicity) and professional training (sociology, public health, epidemiology, somatic psychology, and midwifery, including a Certified Professional Midwife and a Certified Nurse-Midwife).

Results

Of 34 community midwives (see Table 1), 24 practiced in California. Twenty-four were Certified Professional Midwives/Licensed Midwives; ten were Certified Nurse-Midwives. Twenty-three identified as white, five Black, four Latine or Chicana, three Asian, and two Native American or Indigenous[2]. Midwives in the study generally sought reimbursement from insurance

[2] Because some research participants selected multiple racial or ethnic categories, this total amounts to greater than 100%.

companies but received limited reimbursement from many private insurance plans as out of network providers. All had clients who paid for care out of pocket. Twelve had experience as Medicaid providers ; all said they would like to serve people insured through Medicaid.

All participants had experience providing prenatal, intrapartum, and postpartum care. These findings focus on their postpartum clinical practice model. We detail key elements of community midwifery postpartum care, typically provided over (see Figure): five to eight visits through the first six weeks postpartum; 1) care for the parent-infant dyad; 2) continuity of personalized care; 3) relationship-centered care; 4) planning and preparation for postpartum; 5) focus on postpartum rest. In interviews and member checking, midwives highlighted the connections between these elements for their clients' outcomes. In the words of CPM Gingi, "It's the whole way that we're being with clients and our whole model of care… that is what's saving people's life."

Multiple postpartum visits are the foundation of community midwifery postpartum care

Nearly all midwives reported a standard visit schedule of five to eight visits during the first six weeks postpartum, with additional contact as needed via phone call, text, or email. Some offered all postpartum care in home visits; others, particularly birth centers, did a combination of home and office visits. Kate, a CNM, expressed the common sentiment that "Frequency and time is part of the optimal model of postpartum care." The typical visit schedule included a visit the day after birth; two or three more in the first week (e.g., day three and day seven); two weeks postpartum, sometimes a four-week visit, and a six-week visit. A few midwives offered extended care, with visits at eight or twelve weeks. Of those who did not routinely offer extended care, some said clients at this stage often requested support with issues such as mental health or incontinence. In those cases, they offered support and referrals to pelvic floor physical therapy, behavioral healthcare, primary care providers, or other resources. Several birth centers offered new parent groups for the full "fourth trimester" and beyond. Many midwives viewed the postpartum period as a full year and wished they had the resources to provide care for longer.

Notably, midwives tailored the visit schedule to provide more care *or* less care depending on families' needs and preferences. Jane, a CPM, said,

> We see people at one day, three or four days, and one week in their home. And then at two weeks, sometimes four weeks, and definitely six weeks in the office. And there's flexibility to that, so if someone has a major breastfeeding issue going on, we might see them for extra visits, or the four-week visit is something that can be added in.

For families who unexpectedly gave birth in the hospital or had a baby in the neonatal intensive care unit (NICU), midwives would offer postpartum care in whatever form was most supportive, including postpartum visits in the NICU for the birthing parent. A few midwives routinely provided fewer than five postpartum visits or offered virtual visits. Teri, a CPM, explained that for her rural clients who live up to 80 miles from her birth center "it's unrealistic that I'm going to travel or they're going to travel to see me as often." She described her flexible approach that sometimes includes offering fewer postpartum visits:

> My moms who are very experienced—let's say they're having their sixth [baby]—I tell them, 'look, I understand if you do not want to come back until your six week visit because you know that you're doing well, and that maybe coming out of the house at two weeks postpartum is more trouble than you can imagine.' It's more anxiety inducing than it's beneficial. I tell them I have no problem with that.

When midwives reduced their number of in-person visits, they offered virtual visits or phone contact as needed. Fewer visits were more common in practices in rural areas where visits required long drives, families with multiple children who needed minimal lactation support, or those who generally showed few signs of concern.

Finally, several midwives offered this model of postpartum care to people with planned hospital births who desired more comprehensive postpartum care than their obstetric clinicians offered. Sometimes referred to as "co-care," in this model midwives would typically offer five or more visits between hospital discharge and the six-week postpartum visit with a hospital-based clinician.

1. Care for the parent-infant dyad

The community midwifery model of postpartum care is structured, yet flexible and individualized, and involves caring for birthing parents and their babies as a unit. Midwives in this study typically provide care for the parent-infant birthing dyad until six weeks postpartum, unless there is a specific complication that requires transfer to pediatric, obstetric, or specialty care. Jane, a CPM, explained the significance of this approach:

> I think one of the worst things that's happened in our healthcare system is the separation of birthing parents and babies. They...function as a physiologic and social whole for a while after birth. They have been one entity during pregnancy, and it takes a while to separate that out. So, I think when there are well baby visits and maternal postpartum visits and they're separated out, almost all of the problems that I see people having in the postpartum are related.

Community midwives' newborn scope of practice facilitates their ability to provide dyadic care. A postpartum visit, often an hour or longer, includes extensive attention to the birthing parent's physical and emotional health plus well-baby care (see Table 2). Midwives make referrals to lactation consultants, mental health clinicians, and other clinical or community services when concerns arise that are outside their scope of practice. Julie, a CPM, said, "My whole model is designed to preempt complications, to address things as they're arising, talk through them, troubleshoot them, whether it's a mental health thing or a physical wellbeing thing so that things don't snowball into bigger issues. That's the whole midwifery model."

2. "Continuity of personalized care"

Community midwifery care is low volume (i.e., many participants attended one or two births per month), and typically includes continuity of care from the initiation of prenatal care through six weeks postpartum, from one or a small group of midwives. In home birth practice, midwives

are often on call 24 hours a day unless they arrange backup from trusted colleagues. In freestanding birth centers, a small group of midwives typically rotate being on call in shifts. This high-touch, consistent model allows birthing people to readily access a clinician who is familiar with their medical history and personal needs. Midwives reported that this level of continuity facilitates the early identification of complications , supports client engagement in preventative care, and eases referral for additional treatment when needed. As Julie explained, knowing her clients well allows her to understand when something is "not right for this person." Many said that access to a known midwife quickly and seamlessly by phone or text in urgent situations is the best part of community midwifery care, highlighting that this can be lifesaving in postpartum emergencies. Melanie, a CNM, described that continuity of care builds "the trust that [birthing parents] have with us and that they have for themselves and their own bodies around birth. And in the postpartum they know who to call--and they do call!"

State licensing boards determine midwives' scope of practice, which varies by state. In CA and OR, scope of practice is more limited for CPMs than CNMs. Many CPMs said that continuity of care can be limited because they are unable to prescribe basic medications, such as antibiotics for urinary tract infections or mastitis, and in these cases, new parents must see an alternate clinician. Though CNMs have the option of practicing in primary care clinics and hospitals, most hospitals will not give privileges to those practicing in community settings, so they experience some of the same limitations. This causes challenges for patients and can limit hospital staff members' understanding of midwifery care.

Among postpartum complications, midwives frequently brought up postpartum preeclampsia to underscore the importance of continuity of care and frequent postpartum contact. Midwives reported diagnosing many cases of postpartum preeclampsia, some because they had urged new parents to monitor their blood pressure, some at routine postpartum visits, and others when clients called with headaches or other mild symptoms. In many cases, a postpartum preeclampsia diagnosis led to midwives sending clients to the emergency room. However, multiple midwives described emergency room clinicians diagnosing very high blood pressure in a postpartum person as chronic hypertension or anxiety rather than an obstetric emergency, particularly among Black parents. Madeleine, a CPM, shared one such client's story, saying that when her client developed chest pain one week postpartum, she initially reached out to her midwives, who urged her to go to the hospital. Ultimately it became clear that she "had a heart attack….And the ambulance took her to a hospital that didn't have OBs, and the ER doc downloaded the Calm app onto her phone and told her she was having an anxiety attack." Because of continuity of care, the client trusted Madeleine to strongly advocate for a transfer to another hospital, where the patient spent many days in intensive care before ultimately recovering. Not only do such stories raise concerns about the racism and gender-based oppression embedded in healthcare and the lack of integration between community midwives and local hospitals, but they also point to the importance of continuity of care in the uniquely complex postpartum time.

*3. **Relationship-centered Care***

Community midwives describe the care they provide as relationship-centered, with a focus on the relationship between the midwife and the birthing person, as well as the birthing person and their family and close community members. They describe this element of postpartum care with terms such as *connected, biopsychosocial, integrative,* and *whole person*, relating the care

they provide to broader concepts of high-quality care. Margaret, a CPM, explained this approach as,

> Having care where the person being cared for is seen as a whole person and respected about their dignity…being cared for by somebody who understands the context of where they're coming from, so that the support they offer them is appropriate.

Midwives viewed mutually trusting relationships, including racially or culturally congruent care in some cases, as a potentially lifesaving element of preventing and treating complications. Continuity of care and listening closely to their clients were described as essential for building trust. Kate, a CNM, suggested that "the relationship and trust that is built" is a key component of optimal postpartum care. Especially because mental and emotional health are prominent elements of the postpartum transition, multiple midwives reported drawing on their relationships with clients to support this aspect of care. They said that new parents are often "blindsided" by how challenging the postpartum transition is, so they view their role as reflecting what is "normal," validating clients' experiences, and otherwise drawing on their relationship to offer support and resources. For example, Carrie, a CPM, shared, "We've had clients in some domestic violence situations, and we've been the first people they would contact because they trusted us, so we could help get them the resources they need… beyond the medical midwifery kind of stuff."

Nearly all midwives offered home visits for some or all of their care and described many benefits to this. Midwife Francine shared, "I think that postpartum care is always the best when it's in the home of the person who's receiving it because they don't have to get up, get dressed, pack their stuff, get in the car, go someplace, pull over to nurse their baby…[to] minimize the strain on the family in the postpartum time, I think the care would be, should be in the home." Several midwives mentioned how home visits can raise concerns for some people, particularly Black families people insured through Medicaid and other people more likely to be targeted by systems of family policing. Two Black midwives pointed to the difference between being visited at home by "a random [nurse] in scrubs" based in an institution or by a midwife with whom a family has an ongoing relationship. They suggested that while a family might be concerned about exposure to state violence, their concern would be much lower with a midwife who was a trusted community member. Midwives described how they prioritize building trust and safety, and see this as foundational to successful partnership with the family. Relationship-centered care can contribute to the overall well-being of the family unit during early parenthood.

5. Planning and preparation

Community midwives' care involves planning and preparation for the postpartum period, beginning during pregnancy. This involves what Sara, a CNM, described as "understanding [through prenatal care] what it would take to fortify that person in their support structure that then can carry over postpartum," and includes planning for social and practical support from extended family and friends (e.g., arranging for people to bring meals to the family after birth). Julie did this with her clients in a structured way that addressed families' anticipated needs. She said, "I have a worksheet that I complete with everybody around 28 to 30 weeks [about] planning for postpartum, where we literally sit and fill it out. I [am] like, "Okay, who's going to

be your person to call if there's a question about the baby?" "Who's your mental health practitioner you're going to call?" Melanie explained how she does this as part of birth preparation:

> Usually around thirty-six, thirty-seven weeks we have a birth team meeting with everyone who's going to be at the birth….[We talk about] what do you bring to the table? How are you gonna support this person?...The ideas look like meal trains, doing their laundry, you know, not coming over just to see the baby, can you sweep, can you do a dish?.... Maybe they just moved here, and all of their family lives out of town….I really like to dispel the myths around what asking for help looks like and make them feel good about asking for help. Because a lot of people want to help, but they really don't know how because our community has forgotten.

This approach to leaning on extended networks was something midwives described as being common historically and cross-culturally, yet sometimes unfamiliar to their clients. Some midwives noted they have clients who lack access to extended networks or other supportive resources. Gingi, a CPM, explained the essential role of the midwife in these cases: "For these people, these postpartum services are… Literally saving a postpartum mom's life so that they can emotionally feel well enough to carry on and continue to thrive and be a mother that they would like to be."

Postpartum preparation also included comprehensive information about physical recovery from birth, infant care, plans for infant feeding, sleep, potential mental health support needs, postpartum nutritional needs, and relationships between partners and other family members. Long prenatal visits, generally 30-45 minutes in birth centers and often an hour or longer with home birth midwives, facilitate in-depth postpartum preparation; one participant who operates a birth center invites clients to attend the facility's postpartum support group beginning at 34 weeks of pregnancy to facilitate peer connections and exposure to postpartum experiences and information.

6. Focus on postpartum rest

Community midwives generally advise that birthing parents practice what they call "deep rest," cocooning, lying-in, or *cuarentena* (a Spanish term for 40 days of postpartum rest). In contrast to common ideology in the U.S. that women should "snap back," "bounce back quickly," and "get your body back" soon after birth, midwives promote extensive rest and support postpartum by drawing on cultural norms and midwife-led clinical models from around the world.

Michelle, a CPM, was one of many midwives who described deep rest as preventing concerns ranging from immediate lactation issues to postpartum mental health challenges to long-term incontinence. Explaining in detail what she recommends and why, she said,

> The person that gave birth is horizontal, or nearly horizontal with their baby on their skin all of the time, unless they're peeing, showering, going to the bathroom--and there's this gradual emergence as they move towards the end of the six weeks where they might be up and about a little more in the house, or walking around the block and getting some fresh air. Generally, they're not doing any work except the work of direct newborn care and self-care... When people are able to do that, I tend not to see mastitis or newborns that can't figure out how to latch. [I'm] not seeing babies with issues gaining enough weight, not seeing someone who continues to bleed weeks and weeks after they give birth. What I generally say to people is the issues that can arise don't tend to arise when you're able to do this much resting with support.

This level of rest required planning for postpartum support, as described above. Midwives' specific recommendations varied and were tailored to individual family situations and their own and their clients' ancestral traditions related to nutrition and other practices. Midwives recognized that extended rest is not possible for all their clients. Michelle explained, "it depends on the person not having to go back to work in less than six weeks. Sometimes they have two weeks and we're like "okay, we're going to do as much deep rest in two weeks as we can do.' That's really valuable also." In general, all advised slowing down after birth, resting, prioritizing skin-to-skin contact with the baby, and educating clients about how these practices help immediate recovery and long-term pelvic floor health.

Some midwives also include a focus on spirituality in the transition to parenthood if this is an important part of families' lives, for example, offering a spiritual ceremony in the six-week postpartum visit. Maya, a CPM, described "something special at that six-week visit…whether it's like some sort of a ritual or ceremony, or we share a meal," while others described massage, healing baths, or other practices. Biola, a CPM, explained this approach to the closing of midwifery care as a time to "listen to [the mother's] new intentions for herself moving forward and…witness it as a community. And then we say goodbye."

A primary barrier to deep rest was the lack of paid family leave for birthing people, their partners, and other close family members. Midwives were clear that structural change to provide universal paid leave is necessary for many reasons, including postpartum recovery. Sandra, a CPM, said, "One of the things I find most astonishing, in the worst way, is the fact that maternity leave is not mandatory at every job." Michelle contrasted the US with many other countries, saying, "One year parental leave feels really basic." The lack of paid parental leave tended to be more drastic for parents with low wage jobs who were frequently required to return to work before six weeks postpartum, as well as for single parents, people with minimal social support, and those without access to affordable childcare.

Discussion

It is widely acknowledged that improving perinatal and infant health in the United States will require change at a variety of levels of the system. Given that most postpartum care in the U.S. does not follow WHO guidelines, it is important to acknowledge and document existing models of guideline-concordant postpartum care, and explore its capacity to address universal postpartum needs and reduce pregnancy-related morbidity and mortality. In this study, we describe the community midwifery postpartum care model using qualitative data from interviews

with midwives. Our findings are consistent with the only existing quantitative analysis of community midwifery postpartum care (Cheyney et al. 2015), and expand on these findings by detailing key elements of the care model. Across 34 midwives, we found a consistent yet flexible model of care including six key elements: five to eight visits in the first six weeks postpartum; care for the parent-infant dyad; continuity of care; relationship-based care; planning and preparation for postpartum; and focus on rest. The community midwifery model meets WHO guidelines and exceeds the ACOG recommendation of two or more postpartum visits. It also exceeds the number of visits recommended by the American Academy of Pediatrics (a newborn exam followed by two well-baby visits in the first six weeks)(2017). Importantly, this model reflects patient-centered care approaches while addressing specific postpartum needs, including the interconnected relationship between the wellbeing of the birthing parent and infant.

Our findings point to how low insurance reimbursement, limitations on midwives' scope of practice, and sociocultural marginalization of community midwifery are critical to address to implement guideline-concordant postpartum care more widely in the U.S. Currently, U.S. perinatal care privileges physicians, and there is a well-documented shortage of midwives (as well as primary care clinicians of all kinds) with wide variation in midwife licensing and scope of practice by state (Vedam et al. 2018). As a result, a relatively small number of families receive guideline-concordant postpartum care from community midwives, and the majority of these are higher-income, white families with private insurance or wealth to pay for care out of pocket (Alliman et al. 2019; Cheyney et al. 2014). Exclusion of community midwives from public and private insurance networks and limited insurance reimbursement has negative consequences on birthing people's access to care, as well as on midwives' wellbeing. Continuity of care is a community midwifery ethos, but it is sometimes in tension with the sustainability of midwifery practice because insurance reimbursement is too low to make ongoing practice feasible. It will not be possible to substantively expand access to this model of care without growing the midwifery workforce, changing licensing practices, and achieving equitable reimbursement practices.

Given data showing that the highest interest in community midwifery care is among Black birthing people, other people of color, and people insured through Medicaid, there is an urgent need to shift policy so that community midwives can serve a wider range of people (Sakala, Hernández-Cancio, and Wei 2022). The midwifery workforce is currently mostly white, even as multiple studies discuss the benefits of racially and culturally concordant care (Altman et al. 2020; Jeffers et al. 2023). Expanded funding for midwifery education and increased reimbursement are key to diversifying the midwifery workforce to better reflect U.S. birthing families (Mehra et al. 2022). Further research should explore physical and mental health outcomes of community midwifery postpartum care including experience of care, quality of life indicators, morbidity, and mortality.. Additionally, it is important to understand what factors support community midwives to continue to practice over time and to identify changes that are needed so midwives receive a living wage while serving families across the socioeconomic spectrum.

Community midwives are part of a broader ecosystem of perinatal care and support, including hospital-based care for complications and high-risk pregnancies, and programs that help promote parent and infant health. These include Centering Parenting and other group medical visits that provide clinical care to parents and infants together; postpartum doulas who typically provide non-clinical support in the home, and programs that address psychosocial needs

(Bloomfield and Rising 2013; Chen 2022; Reyes et al. 2021). Midwives in this study also identified the need for structural changes, including universal healthcare, paid family leave, and universal basic income, to support wellbeing and prevent pregnancy-related death, particularly among Black and Indigenous families (Black Mamas Matter Alliance 2023).

This study includes midwives practicing in two states, which may limit generalizability of findings. Future research could include midwives from a wider range of states, including those that do not license CPMs, and those with greater numbers of community midwives who are Medicaid providers. Within the geographic area of our study, we had high recruitment responses and participant engagement. Qualitative methods allowed for detailed and nuanced description of the model of care.

Conclusion

In the United States, the postpartum phase of life is under-supported, despite it being the highest risk period for pregnancy-related health complications. The phrase “postpartum storm” has been used as “an analogy to describe the forces - racism, sexism, individualism, the erasure of traditional wisdom, and a profit-driven health care system - that are the root causes of the worsening maternal mortality crisis in the U.S.” (Mothers to Mothers Postpartum Justice Project n.d.). Healthcare for postpartum families must attend to this “postpartum storm,” to improve maternal and infant health, increase breastfeeding rates, and address postpartum mental health. Though it has not been widely documented despite its long history, the community midwifery model in the U.S. is a comprehensive model of postpartum care, and increasing access to it is one pathway toward perinatal health equity. In light of widening, persistent and unconscionable inequities in US reproductive health, there is an urgent need for midwives to be licensed in all states and appropriately compensated for the care they provide (Anon 2023), thus reducing barriers to the expansion and accessibility of community midwifery.

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Table 1. Study participant characteristics (N=34)

Characteristic	N (%)
Clinician type	
Certified professional midwife (CPM)	24 (71)
Certified nurse midwife (CNM)	10 (29)
Location by state	
California	24 (71)
Oregon	10 (29)
Type of community served	
Urban	24 (70)
Suburban	2 (6)
Rural	3 (9)
Mixed location	5 (15)
Forms of payment accepted*	
Medicaid & self-pay with sliding scale	12 (34)
Private insurance & self-pay with sliding scale	25 (74)
Self-pay only	2 (6)
Age	
30-40 years	13 (38)
41-50 years	18 (53)
51-60 years	2 (6)
>60 years	1 (3)
Gender	
Cisgender woman	33 (97)
Non-binary	1 (3)
Race and Ethnicity*	
Black	5 (15)
White	23 (68)
Asian	3 (9)
Latine	4 (12)
American Indian/Alaskan Native	2 (6)
Languages spoken*	
English only	14 (44)
English & Spanish	17 (47)
English & other	5 (18)
Years in practice	
0-10	13 (38)
11-20	16 (47)
21-30	3 (9)
31-40	2 (6)

* total is greater than 100% because participants could select multiple options.

Table 2: Community Midwifery Postpartum Visit Content

Components of Community Midwifery Postpartum Visits
Physical health of parent • assess physical recovery from birth including bleeding, perineal lacerations or cesearean incision, provide parameters for normal healing and recovery vs danger signs • Screen for postpartum complications • pelvic floor healing • provide nutrition education • medication to prevent Rh incompatibility and vaccines if indicated • contraception education and discussion, prescription per scope • order labs if needed • pap smear & other well-person care if needed • Comprehensive ongoing education on healing and warning signs • Discuss sexuality, and offer guidance on resumption of intercourse and pain if present • Conduct diabetes screening if indicated
Mental & emotional health of parent • Debrief birth experience • screen for postpartum mood disorders • discuss stress, and adjustment to parenting • discuss substance use as needed
Well-baby checkups • test for genetic conditions • weight check • physical exams • discus of parenting & infant care
Lactation/infant feeding support • Assess comfort and confidence with lactation • Screen and manage lactation-associated pain • assess newborn intake and output • provide lactation support and refer to IBCLC as needed
Overall family well-being • discuss sleep & fatigue • discuss social support & family relationships • assess social needs (e.g., housing, utilities, food, transportation)
Referrals to additional services as needed • pediatric care • lactation consultants • mental health clinicians

- pelvic floor physical therapists
- community resources for social needs
- primary care for parent

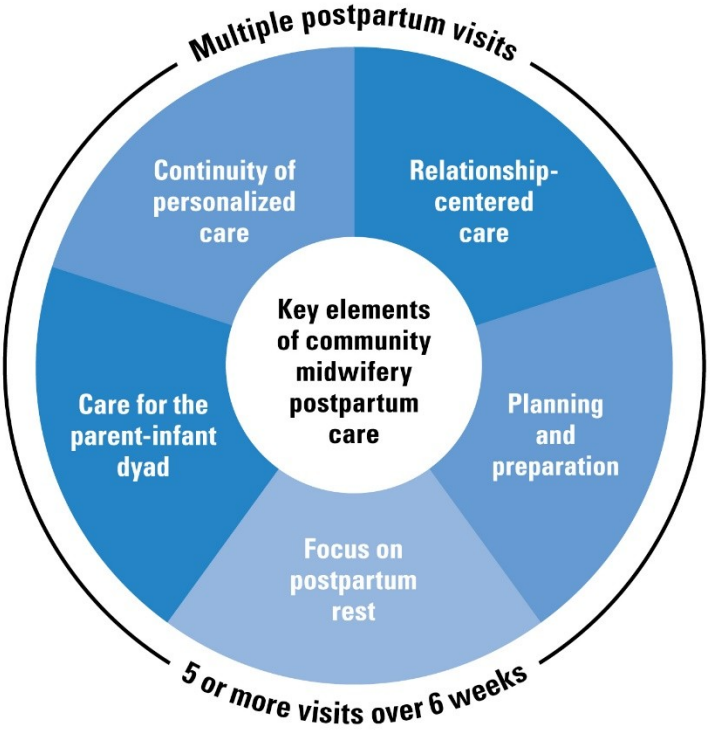

Figure Legend:

Figure 1: Elements of Community Midwifery Postpartum Care