

Improving Our Maternity Care Now Through *Doula Support*



September 2022



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Executive summary

Our nation’s maternity care system fails to provide many childbearing women and people* and their newborns with equitable, accessible, respectful, safe, effective, and affordable care. More people die per capita from pregnancy and childbirth in this country than in any other high-income country in the world. Our maternity care system spectacularly fails communities struggling with the burden of structural inequities due to histories of racist oppression and other forms of disadvantage, including Indigenous, Black, and Communities of color; rural communities; and people with low incomes.

Both the maternal mortality rate and the much higher severe maternal morbidity rate (often reflecting a “near miss” of dying) have been increasing, and reveal inequities by race and ethnicity. Relative to white non-Hispanic women, Black women are more than three times as likely, and Indigenous women are more than twice as likely, to experience pregnancy-related deaths. Moreover, Black, Indigenous, Hispanic, and Asian and Pacific Islander women disproportionately experience births with severe maternal morbidity relative to white non-Hispanic women.

This dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate needless harm now.

Fortunately, research shows that specific care models can make a concrete difference in improving maternity care quality and

producing better outcomes, especially for Indigenous, Black and other birthing women and people of color. One such model is **doula support**. This report outlines the evidence that supports the unique value of doula support across different communities, the safety and effectiveness of doula support in improving maternal and infant outcomes, the interest of birthing women and people in use of doula support, and the current availability of, and access to, doula services in the United States. We also provide recommendations for key decisionmakers in public and private sectors to help support and increase access to doula services.

Research shows that doula support during childbirth offers benefits to childbearing families relative to usual care without doula support with respect to many key indicators, including higher rates of spontaneous vaginal birth, fewer cesarean

* We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this report uses both gendered terms, as well as gender-neutral terms such as “people,” “pregnant people,” and “birthing persons.” In referencing studies, we use the typically gendered language of the authors.

births, less use of pain medications, and higher birthing-person satisfaction with care. When extended to support during pregnancy and the postpartum period, doula services have been associated with such benefits as less likelihood of preterm birth and low birthweight, and greater likelihood of initiating breastfeeding. Community-based and -led doula services are especially powerful and are essential components of a just and effective maternity care system. In addition to these important health benefits, a series of analyses suggests that these services are cost-effective. Yet in the United States, the interest of birthing people in access to doula support far exceeds access to and use of this support.

Expanding the availability of doula support is a cost-effective solution to providing better maternal experiences and birth outcomes. Barriers to access to doula

services must be eliminated. These include: lack of funding for doula training; an inadequate supply of doulas and especially doulas that offer culturally congruent support; limited Medicaid and private insurance reimbursement for doula services; unsustainable reimbursement levels for doula services; failure to provide payment, professional support, and conditions of work that enable doulas and their families to thrive and doulas to provide sustained services over time; overly restrictive laws and regulations determining doula eligibility for reimbursement; and the unaffordability of private-pay doula services for many childbearing families. Enabling more birthing people to receive the support of doulas while diversifying and appropriately supporting the doula workforce should be top priorities for decisionmakers at the local, state, and federal levels. To achieve this, we recommend the following:[†]

[†] Please see the main body of the report for more detailed versions of the recommendations.



Federal policymakers:

- Congress and the administration should ensure that all federally funded health insurance and direct health care provision programs cover extended-model doula support.
- Congress and the Health Resources and Services Administration should ensure that community doulas are eligible and encouraged to deliver Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program services.
- Members of Congress should seek support for doula training and service provision programs in their districts through Community Project Funding grants (formerly known as “earmarks”) in appropriations legislation.
- Federal research and evaluation programs should support research to more fully understand effects of community- based and -led doula training and support programs in communities of color and others facing structural precarity. Congress should provide resources for this research.

State and territorial policymakers:

- State legislators should enact, and regulators should provide, guidance for establishing doula services as a covered benefit through Medicaid (both fee-for-service and managed care) and CHIP.
- In parallel with coverage of doula services, states should allocate resources to build, support, and mentor the doula workforce.
- States and tribes should ensure that community-based doulas are eligible and encouraged to deliver MIECHV services.

Private-sector decisionmakers, health care purchasers, and health plans, should:

- Designate doula support as a covered service.
- Require employers to ensure that employees have access to doula support.
- Require Medicaid managed care, hospitals, and other organizations to support community-based organizations in the development and ability to provide doula training programs to increase the doula workforce.
- Philanthropy should support community-based doula models by growing and supporting the doula workforce and reducing barriers to obtaining doula support.
- The Patient-Centered Outcomes Research Institute should support research to more fully understand the effects of community-based and -led doula training and support programs for communities of color and others facing structural precarity.

Introduction

The U.S. maternity care system fails to provide many childbearing women and people* and their newborns with equitable, accessible, respectful, safe, effective, and affordable care.¹ More people die per capita as a result of pregnancy and childbirth in this country than in any other high-income nation.² Our maternity care system spectacularly fails communities struggling with the burden of structural inequities due to histories of racist oppression and other forms of disadvantage, including Indigenous, Black, Communities of color; rural communities; and people with low incomes.³

Rates of maternal death and severe maternal morbidity in the United States have been worsening. In 2020, the rate was 23.8 deaths per 100,000 live births, a significant increase over the maternal mortality rate in 2019 (20.1 per 100,000 live births).⁴ Between 1987 and 2017, pregnancy-related deaths in the United States more than doubled – from 7.2 to 17.3 deaths per 100,000 live births.⁵ Between 2006 and 2015, severe maternal morbidity (SMM), often reflecting a “near miss” of dying, rose by 45 percent, from 101.3 to 146.6 per 10,000 hospitalizations for birth.⁶ Following the 2015 shift to a new clinical coding system (ICD10-CM/PCS), SMM continued to increase, both overall and for people of color, from 2016 to 2019.⁷

In communities of color, the crisis is extreme. Compared to white non-Hispanic women, Black women are more than three times as likely, and Indigenous women are more than

twice as likely, to experience pregnancy-related deaths. Moreover, Hispanic, Black non-Hispanic, and Asian and Pacific Islander non-Hispanic women disproportionately experience births with SMM relative to white non-Hispanic women.⁸ In 2015, relative to white non-Hispanic women, the rate of SMM was 2.1 times higher for Black women, 1.3 times higher for Hispanic women, and 1.2 times higher for Asian and Pacific Islander women.⁹ From 2012 through 2015, Indigenous women experienced 1.8 times the SMM rate of white women.¹⁰

Many factors drive maternal mortality and morbidity and the related deep racial, ethnic, and geographic inequities. These include gaps in health care coverage and access to care; poor quality care, including implicit biases and explicit discrimination; unmet social needs, like safe and stable housing, reliable transportation, paid family and

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medical leave, and time off from paid work for medical visits; and for people of color, the effects of contending with systemic, institutional, and interpersonal racism.¹¹ The terrible impacts of these inequities are unconscionable, especially considering that about 60 percent of pregnancy-related deaths are preventable, and there are opportunities to improve care in a large proportion of people with SMM.¹²

In the long term, we must transform the maternity care system through delivery system and payment reform, performance measurement, consumer engagement,

health professions education, and improving the workforce composition and distribution. However, our dire maternal health crisis, which has been compounded by the COVID-19 pandemic, demands that we mitigate preventable harm now.

Fortunately, research shows that specific care models make a concrete difference in providing higher quality care and improving birth outcomes. Support provided by doulas is one high-performing model that we must make widely available, especially for birthing women, people and families of color.[‡]

Doula support** in the United States

Rise of the private-pay birth doula. The longstanding, widespread tradition of women providing comfort, emotional support, and information to women during childbirth was largely lost in the first half of the 20th century. At that time, childbirth was reframed as a medical condition – as opposed to a family event and physiologic life process –

and moved into the world of male-dominated hospitals. However, over the last half-century, birthing people have increasingly sought to birth without unneeded interventions, to exert more control over their birth experience, and to have supportive companionship while giving birth, including in unfamiliar medical settings. These interests, supported

‡ To learn about three other high-performing maternity care models – midwifery care, “community birth” settings (birth centers and planned home births), and community-led perinatal health worker groups – see our foundational report, *Improving Our Maternity Care Now*, at www.nationalpartnership.org/improvingmaternitycare.

** The word “doula” is widely but not exclusively accepted and used. It was adopted from an ancient Greek term referring to a person who serves, and may have had servile associations (“The Term ‘Doula’ in Modern Greece,” Mamana, <https://www.mamana.gr/en/articles/94-the-term-‘doula’-in-modern-greece>). For this and other reasons, some prefer to avoid this term. For example, the Alaska Native Birthworkers Community prefers “birth helper,” “perinatal support person,” or “labor companion” (“Alaska Native Birthworkers Community Birth Helper Services,” <https://www.nativebirthworkers.org/preg-labor-postpartum>) and Mama Sana Vibrant Woman uses “birth companion” (“Meet the Collective,” <https://www.msvwatx.org/meet-the-collective>). This report uses “doula support” or “doula services” to recognize both the most widely used term for this support person and to distinguish from clinician-provided care.

by research studies showing the benefits of continuous support during labor, helped establish doulas as newer non-clinical maternal support personnel.^{††}

Researchers have distilled four key attributes of the role of birth doulas:

- They **provide information** about childbirth and foster communication between birthing women and people and members of the care team.
- They **play an advocacy role**, helping birthing women and people to achieve their desired experiences.
- They **provide practical support**, through drug-free comfort measures (e.g., with inflatable “birth balls,” hot and cold packs, and position changes) and hands-on support (e.g., massage and acupressure).
- They **provide emotional support** for confidence and a sense of control.¹³

As described in the discussion below on evidence of benefits, these attributes are associated with better childbirth experiences and fewer major interventions.

Initially, doulas supported childbearing people primarily around the time of birth, often meeting near the end of pregnancy to

help build a relationship and understand the birthing person’s preferences for childbirth. These services were largely available only to birthing people who could pay for the services out of their own funds. The private-pay postpartum doula role was also created to support people with recovery from birth, chest/breastfeeding, newborn care, household chores, and other needs after birth. Many private-pay birth and postpartum doulas are educated and certified through various national and local organizations.

The private-pay model is now widely available. The website doulamatch.net provides a searchable directory for prospective birth and postpartum doula clients, by state, zip code, Black and Indigenous doula identity, and for dozens of spoken languages. Fees vary greatly by doula and by region. Doulas offer many services that may include childbirth education, sibling support at birth, lactation support, and babywearing guidance. Services may also include ceremonies such as birthing person blessings and artistic work such as photography and belly castings. Doulas may have expertise in supporting military, surrogacy, and LGBTQ families; individuals experiencing abortion; and families experiencing miscarriage and other pregnancy and infant loss.¹⁴

^{††} Other types of doulas – including abortion, miscarriage, and stillbirth doulas; full-spectrum doulas who provide support across reproductive lives; intensive care unit doulas; and end-of-life doulas – are beyond the scope of this report. With the recent Supreme Court ruling overturning *Roe v. Wade* and ending the constitutional right to abortion, the significance of full-spectrum and abortion doula support is greater than ever. A separate report about these types of doula support later this year from the National Partnership for Women & Families will provide an essential complement to the present report.

Longitudinal community-based doula support. The medical appropriation of childbirth weakened communities' strong traditions of supporting their own childbearing people. More recently, as deficiencies of medical care in meeting community needs and persistently unacceptable birth outcomes have been broadly scrutinized, community-based approaches to doula support have grown and are flourishing. Community doulas help meet the needs of birthing people and families from communities of color and other groups experiencing structural inequities due to racism and other forms of discrimination. This model tends to provide culturally congruent, trauma-informed support for an extended

period, from pregnancy, through birth, and into the postpartum and infant periods.¹⁵ A myriad of community-based organizations, as well as national organizations such as HealthConnect One, offer doula training and continuing education that – in addition to covering the standard skills and knowledge for providing physical, emotional, and informational support – also focuses on birth justice and mitigating the harmful effects of racism and systemic oppression.¹⁶ Studies of doulas of color have found that many are highly motivated to support birthing families with shared racial, ethnic, and cultural backgrounds, and to mitigate inequities in their own communities.¹⁷

WHAT IS BIRTH JUSTICE?

Birth justice is a component of the reproductive justice (RJ) framework. A group of Black women laid out the core tenets of RJ in 1994 by revising the prevailing, white-constructed view of reproductive health and rights. By incorporating a social justice lens, RJ recognizes multiple intersecting oppressions faced by women, Indigenous people, people of color, LGBTQ people, immigrants, people with disabilities, and other historically marginalized groups. RJ emphasizes access to needed services across the full continuum of reproductive health as an essential prerequisite of choice among care options. In 1997, SisterSong was formed as the national women of color RJ collective. SisterSong defines reproductive justice as “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”¹⁸ Implicit in this far-reaching framework is the need for economic, environmental, political, and other types of justice, including birth justice.

Like RJ, birth justice also starts from the position that the movement for birthing rights and care options has neither recognized nor addressed the history and life circumstances of oppressed groups, which greatly compound challenges of childbearing.¹⁹ The birth justice framework and movement recognize that many women and birthing people from communities oppressed by racism and other forms of discrimination navigate between care that can be violent, neglectful, and substandard.²⁰ A vital response has been to develop community-based models that regenerate midwifery care, support (now through the doula role), community birth settings, and other community-led and -focused birthing traditions that were denigrated and suppressed by white male obstetric hegemony.

Community-based doulas and community-led doula programs, collectives, and organizations offer trusted, respectful, often culturally congruent services to a broad range of communities. Many community-based doulas support birthing people in Black, Indigenous, and Communities of color.²¹ Doulas and doula entities also provide tailored support to incarcerated birthing people,²² people with diverse sexual orientations and gender identities,²³ people with disabilities,²⁴ immigrants and refugees,²⁵ and people living in rural areas.²⁶ Standard maternity care often lacks the crucial ability to meet the intersectional needs of childbearing families.

An investigation of the participation of Black and Latina adolescent doula clients in a community-based doula program found that doulas filled social and economic voids in their clients' lives and mitigated stigma, shame, and social isolation during pregnancy, birth, and parenting. The researchers identified seven doula strategies for support and problem-solving: asking, active listening, assuring, affirming, advising, action taking, and advocating.²⁷

Financial support for community doula services varies, and has recently begun to include some coverage through public and private insurance. Services might also be paid by grants, donations, and other fundraising efforts of doula groups. Some services are provided by volunteer staff, including by doula trainees who require experience with a minimum number of clients or births as a condition for certification. Some doulas offer their services on a sliding fee scale based on ability to pay, or through barter agreements. Some hospitals maintain and support doula programs. Clearly, this patchwork approach to financing means that doula services are out of reach to many childbearing women and people who might desire them, including many who would especially benefit from tailored, culturally congruent, trauma-informed support.

To address this challenge, lawmakers in many states have introduced bills to provide more reliable financing, especially through Medicaid.²⁸ Bills in Congress include provisions to grow and diversify the doula workforce, establish a pilot doula program for veterans, provide guidance to states on Medicaid coverage of doulas, and develop a report on Medicaid coverage of doula services.²⁹

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DOULA SUPPORT DURING THE COVID-19 PANDEMIC

Many childbearing people have needed additional support during the COVID-19 pandemic, and doulas have responded with flexibility and innovation.³⁰

During the pandemic, doulas have struggled with hospital policies, as well as evolving state-level policies relating to medical facilities and Medicaid doula programs. Many hospitals have placed constraints on the number of support people who could accompany birthing people, and some doulas have preferred to avoid potential exposure to the virus. Other concerns of doulas were access to personal protective equipment (PPE) and safe childcare arrangements. These resulted in the widespread innovation of virtual doula support around the time of birth via smartphones and other devices. During and after pregnancy, many relied more heavily on text messages, telephone calls, and video calls. In some cases, remote care involved workarounds when clients did not have data plans, relied on landline phones, lacked computers or Internet service, or deferred to school children who needed to use family computers. While remote work offered safety, many doulas found it challenging to forgo the use of touch in their relationships with clients. In addition to virtual client support, many doula trainings shifted to virtual formats.

Studies of community-based doulas supporting Black and Latinx birthing women and people underscored doulas' concerns that the pandemic was deepening racial inequities, that Black people were objects of racialized fear of diseased Black bodies, and that a focus on the virus distracted from the care and attention that birthing people needed. Doulas worried whether hospitals were safe places for their clients due to persistent disrespectful care of Black birthing people and to the pandemic, including possible exposure to the virus, restrictions on companions, overzealous separation of birthing people and their newborns, and overuse of medical interventions. Moreover, some were acutely aware that their communities lacked good, non-hospital birthing options. Another challenge was that COVID tests were administered at hospital admission, and positive results could lead to dismissal of the doula and the routine separation of birthing people and newborns. At this writing, some hospitals still restrict doula presence, and many doulas seek recognition as essential members of the health care team.

In some cases, the pandemic expanded the types of services that doulas provided; for example, shopping for groceries, bringing diapers, and providing PPE, although other doulas provided these types of support prior to the pandemic.

Lastly, financial issues impacted doulas. These included not earning a living wage as a doula; doing other, often unsafe jobs to make ends meet; and financial distress impacting clients' ability to pay.

Doula skills and knowledge for non-doulas.

Providing content from doula trainings is also seen as a way to enhance the effectiveness

of non-doulas, including student nurses,³¹ nurses,³² and friends and family members serving as birth companions.³³

Evidence supports the important benefits and value of doula services

Continuous support *during childbirth* has been evaluated through rigorous randomized controlled trial (RCT) study designs and summarized in systematic reviews for decades.^{**} The *extended model* of doula services that includes prenatal and/or postpartum support has been evaluated more recently through various types of studies, which have not been summarized in systematic reviews. Notably, standard maternity care has struggled to improve upon the consequential and favorable outcomes associated with doula support, including reduced rates of cesarean birth, preterm birth, and low birthweight; increased rates of breastfeeding initiation and duration; and better childbirth experiences.

Evidence about effects of supportive

companions during childbirth. The Cochrane systematic review rigorously evaluates and periodically updates pooled results of RCTs measuring the effects of continuous support during childbirth. The support is variously

The consequential and favorable outcomes associated with doula support, including reduced rates of cesarean birth, preterm birth, and low birthweight; increased rates of breastfeeding initiation and duration; and better childbirth experiences.

^{**} A randomized controlled trial is a type of study that provides high confidence in the ability to measure effects of doula services and other interventions. Because study participants agree to be assigned by chance to the study group (i.e., doula support) or the control group (i.e., usual care without doula support), both groups are very similar, with the exception of the intervention, and any differences in results are likely due to the intervention. A systematic review is a method of assessing the weight of the best available evidence across multiple studies about possible benefits and harms of interventions. An investigation by the Institute of Medicine found that this rigorous methodology is the best way of “knowing what works in health care.” Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation*. (Washington, DC: The National Academies Press, 2008), <https://doi.org/10.17226/12038>

provided by members of the hospital staff; a friend, family member, or someone else in the birthing person's social network; or a doula. In the most recent update, 26 RCTs involving more than 15,000 people have found that, relative to similar people with usual care (no supportive companion), those with a supportive companion experienced crucial benefits. Those with support were **more likely** to:

- Have a **shorter labor**
- Have a **"spontaneous" vaginal birth**, with neither vacuum nor forceps

Those with support were **less likely** to:

- Use any **pain medications**, and **epidural analgesia** in particular
- Have a **cesarean birth**
- Have a newborn with a **low Apgar score** (less than five)
- **Negatively rate childbirth experience**³⁴

Over many updates, this review has never identified a downside of continuous support during childbirth.³⁵

The Cochrane review includes an analysis comparing the effects of continuous support provided by different types of personnel. Of the three types of personnel, people in a doula role had the most and strongest benefits. Support from someone in the mother's social network reduced negative ratings of the childbirth experience but did not impact any other clinical outcome. Personnel in a doula role also reduced negative ratings of the childbirth experience, whereas support from members of the hospital staff did not appear to improve care

experiences. Support provided by hospital staff measurably increased the likelihood of spontaneous vaginal birth, but this outcome was most likely with doula support. Only those with doula-type support experienced reduced likelihood of cesarean birth, and the impact was considerable: Those with support from someone in a doula role were 39 percent less likely to have a cesarean birth than those with no supportive companion.³⁶

Listening to Mothers surveys carried out over the last two decades have found that birthing people increasingly prefer to avoid unneeded childbirth interventions.³⁷ The well-documented clinical outcomes of reducing use of pain medications and cesarean birth, with better experiences, clarify why doulas are an important resource for people seeking physiologic childbearing experiences that support the innate capabilities of birthing people and their fetuses and newborns for labor, birth, transitions after birth, breast/chestfeeding, and attachment.³⁸ For this reason, a Committee Opinion from the American College of Obstetricians and Gynecologists on ways to limit interventions during labor and birth points to the value of continuous support provided by personnel such as a doula.³⁹

Evidence about effects of extended doula support. Adding doula support during pregnancy and/or the postpartum period provides opportunities to improve additional outcomes. To date, individual studies with diverse, largely non-randomized designs have explored effects of this extended model. In addition to results aligned with

the birth doula studies discussed above (i.e., greatly reduced likelihood of cesarean birth), the extended model has been associated with reduced likelihood of preterm birth and low birthweight and improved breastfeeding outcomes.

Individual studies suggest that doula support during pregnancy has the potential to impact preterm birth and low birthweight:

- The By My Side extended doula program in New York City found that, compared to women overall residing in the service area, women participating in the program were **less likely to have a preterm birth** (6 percent, versus 12 percent) **and a low-birthweight baby** (7 percent, versus 11 percent).⁴⁰
- Women with Medicaid coverage who received support through a community-based doula program in the Upper Midwest were **1.5 percent less likely** than Medicaid beneficiaries in the same region **to have a preterm birth**.⁴¹
- Compared with Medicaid beneficiaries nationally, Medicaid members receiving doula support in Minneapolis were **1.2 percent less likely to experience a preterm birth**.⁴²
- A doula program of the YWCA in Greensboro, North Carolina, found that participants were **less likely to have a low-birthweight baby** (2.1 percent) than similar women without doula support (8.6 percent).⁴³

Whereas the Cochrane review suggests that a supportive companion at the time of birth

alone does not impact the likelihood of initiating breastfeeding, or its duration, the extended doula model appears to greatly impact these important outcomes:

- Medicaid beneficiaries with doula support from Minnesota’s Everyday Miracles program were **more likely to initiate breastfeeding** than Medicaid members overall (98 percent, versus 81 percent) and when comparing Black (93 percent, versus 70 percent) and Hispanic (99 percent, versus 92 percent) mothers in both groups.⁴⁴
- Young Black pregnant women with low incomes in Illinois who were randomized to doula home visiting were **more likely to initiate breastfeeding** than those randomized to usual care (64 percent, versus 50 percent) and to **breastfeed beyond six weeks postpartum** (29 percent, versus 17 percent).⁴⁵
- Breastfeeding results from eight community-based doula sites across the country in HealthConnect One’s Doula Data monitoring system, versus results from comparable participants in Pregnancy Risk Assessment Monitoring Systems surveys, included similar breastfeeding initiation rates, but **notably higher breastfeeding exclusivity and duration rates** for both Black and Hispanic mothers with doula support.⁴⁶
- The Greensboro program found **increased initiation of breastfeeding** (79.4 percent) in women with doula support, compared to those with usual care (67.2 percent).⁴⁷

The Greensboro program also found fewer complications in mothers or newborns at childbirth among women with doula support (10.3 percent), compared to those with usual care (19.5 percent).⁴⁸

See also strongly favorable results reported in the Spotlight on Success features, below, for Open Arms Perinatal Services and Tewa Women United.

There is an urgent need to further evaluate the impact of extending the birth doula model to provide meaningful community-based support during pregnancy and in the postpartum and infant periods. In addition to continued evaluation of impact on preterm birth, low birthweight, and breastfeeding, this model has the potential to improve outcomes and mitigate harmful effects of racism. Priority outcomes for investigation include maternal prenatal and postpartum anxiety and depression, maternal confidence and agency, identification and meeting of families' social needs, child development indicators, adverse childhood experiences, and the ability to break cycles of intergenerational trauma. Evaluation needs with respect to doulas themselves include the extent to which doula work is sustainable in financial and other ways over time and provides a pipeline for midwifery and other clinical and support maternal care professions, among other benefits and challenges. Purchasers, payers, and policymakers may be motivated to broaden access if longitudinal economic analyses continue to find a return on investment.

How doula support attains these exemplary outcomes.

How does this non-clinical form of maternal support favorably impact not only experiences but also the likelihood of preterm birth and use of such major interventions as epidural analgesia and cesarean birth, relative to usual care? Available studies suggest that doula support offers benefits to childbearing people in a broad range of social and clinical circumstances.

A research team carried out focus groups among pregnant women with low incomes from diverse backgrounds to understand how the extended model achieves its effects. Most, but not all, participants were receiving doula support during their current pregnancy. Results suggest that doula support helps overcome barriers to a healthy pregnancy. These include meeting social and community needs such as limited health literacy and inadequate social support, and fostering access to quality clinical services, including facilitating effective relationships with clinicians. Helping childbearing people reduce adverse social drivers of health and navigate their clinical care fills a wide gap in standard maternity services.⁴⁹

A study of mothers and doulas found that several emotional support strategies of doulas are similar to reported nursing practices: reassurance, encouragement, praise, and explanation. However, doula strategies also included distinctive aspects that may contribute to their documented effectiveness.

The five additional identified techniques were:

- **Mirroring** to reflect back to the client the situation and the clients' emotions
- **Acceptance** to verbally or non-verbally note the situation or register the client's response without attempting to change or judge it
- **Reinforcing** to support or encourage what the client is doing or feeling
- **Reframing** to create a more positive outlook on the client's situation or abilities, and
- **Debriefing** to review a situation either after a decision has been made (e.g., to have a cesarean) or at various points after clinical care has happened⁵⁰

Researchers have also examined the mechanisms for effects of doula services specifically around the time of birth, both in general and in the context of harsh hospital environments. In general, comfort measures, attention to positioning, emotional support, and other doula labor support practices both enhance the passage of the fetus and reduce a birthing person's fear and anxiety.

Attenuating the stress response enhances healthy physiologic processes and labor progress.⁵¹ Birthing people may be especially vulnerable to adverse effects of harsh childbirth environments, which often involve such institutional challenges as unfamiliar routines and personnel, lack of privacy, and uncomfortable procedures. Doula support likely serves as a buffer to such environments. By aiding birthing women and people in mobilizing their own innate capabilities for childbearing, doulas help avoid major interventions such as epidural analgesia and cesarean birth, as well as the accompanying "cascade of interventions" to monitor, prevent, or treat the side effects of the procedures. These enhance physiologic processes and labor progress.⁵² This role within dominant institutions has been described as holding a space for intimacy, protection, safety, and connection that may not be otherwise available.⁵³

Cost of doula support. Without question, public and private insurance should routinely cover services that provide such valuable benefits and have no known

Public and private insurance should routinely cover services that provide such valuable benefits and have no known downsides.

downsides. However, such coverage is the exception rather than the rule. As noted above, diverse pathways provide some financial access to doula services, and sustainability is a common challenge.

A series of cost analyses strengthen the case for coverage, with evidence of cost savings, including a return on investment. This modeling has primarily focused on implications for Medicaid and labor doulas. It has taken into account reductions in cesarean birth, preterm birth, regional analgesia, and assisted birth with forceps or vacuum.⁵⁴ Some longitudinal modeling recognizes that averting a cesarean in the first birth greatly reduces the likelihood of a cesarean in the second birth and estimates cost savings, including harms of avoidable cesareans, over two births.⁵⁵

Lastly, a case study analysis of two methods of reimbursement for extended doula

support found that the flat-fee-per-client program in question undercompensated doulas (and did not include benefits), whereas hourly or salaried compensation, with benefits, provided a better path to sustainability. The flat-fee reimbursement failed to compensate for trainings and professional development, doulas' positive responses to newly identified client needs, and doulas' own health insurance and other important benefits of employment. Flexibility in payment models is important to be able to pay for doula services provided by both individuals and collectives. Regardless of payment model, conditions of doula work should reflect a birth justice framework that includes adequate compensation for the community doula workforce and all components of their work, which is important for building and retaining the cadre of doulas who can provide culturally congruent care.⁵⁶

Conditions of doula work should reflect a birth justice framework that includes adequate compensation for the community doula workforce and all components of their work, which is important for building and retaining the cadre of doulas who can provide culturally congruent care.

Spotlight on Success

OPEN ARMS PERINATAL SERVICES

Open Arms Perinatal Services illustrates how community doulas who provide extended support from pregnancy through the postpartum and early childhood periods can dramatically improve the health of childbearing women and people and their babies. This program has served families with low incomes in the Puget Sound region of Washington state since 1997. Open Arms hires doulas directly from the communities it serves. By working with a broad range of sponsors and funders, Open Arms is able to provide all programs at no cost to clients. They provide about 300 birthing people annually with doula services and, when possible, match them with culturally and linguistically concordant doulas. Open Arms has offered services in 17 languages.⁵⁷

Open Arms is an accredited community-based doula site of HealthConnect One. Open Arms trains doulas with an emphasis on equity and on helping clients advocate for their health care and educational needs. Open Arms works to provide doulas with a living wage and, as desired, a pathway to other health and social services jobs.⁵⁸

A less intensive Birth Doula program supports birthing women and people with several home visits during pregnancy, support during childbirth, and several early postpartum home visits. Families also have access to a social worker for referrals to needed social services. The longer, more intensive community-based Outreach Doula program provides home visits by the second trimester of pregnancy, continuous support at the time of birth, and home visits and many family support services through two years postpartum. Other available services include group prenatal care, lactation support, childbirth education, and baby supplies.⁵⁹ Examples of the services provided to childbearing people participating in the Outreach Doula program include advocating to ensure that the client's childbirth goals are realized, accompanying the client to social services visits, finding resources of payment for utility bills, and connecting with partner organizations to bring clothes and toys to families.⁶⁰

An independent evaluation of all Latina and Somali mothers and babies enrolled in the more intensive community-based Outreach Doula program between 2008 and 2016 documented a broad range of benefits, including:

- Both Latina and Somali clients had **lower rates of preterm birth (below 4 percent) and low birthweight (5 percent)** compared to King County, Washington, rates.

Continued on the next page.

Spotlight on Success

- **99 percent of clients initiated breastfeeding**, exceeding the King County rate, and 94 percent were still breastfeeding at six months, far exceeding the rate of comparable statewide home visiting program clients (35 percent).
- Babies had high rates of resolution of developmental delays resulting in **low rates of child developmental concerns**.
- **72 percent of clients completed the first year of the outreach doula program**, in comparison with 47 percent completing comparable statewide home visiting programs.⁶¹

The outcomes favoring the Open Arms doula program are even more impressive when considering the challenges facing the program's clients. To be eligible, income must be at or below 200 percent of the federal poverty level. Eighty-nine percent of the clients are people of color, speaking 19 languages, 18 percent are homeless or experience unstable housing, 55 percent are immigrants or refugees, and 63 percent had neither high school diploma nor equivalent. The participation and trust are also notable in the context of immigration raids that took place during most of the evaluation period.⁶²

The outcomes favoring the Open Arms doula program are even more impressive when considering the challenges facing the program's clients.

Birthing women and people's positive experience of doula support

Doulas and other labor companions help communicate the preferences and needs of birthing women and people to clinicians, and in turn, translate medical information to their clients, helping them feel heard and empowered, and assisting them in making informed decisions. A qualitative synthesis of more than 50 studies of women's experience of doulas and other labor companions found that women value their assistance during labor, both as sources of information and in offering myriad nonpharmacologic approaches to comfort and coping. By explaining care options, labor companions help women participate in their care. They help women understand what is happening as labor progresses. They also help women feel confident in their ability to give birth and help them feel in control during labor. Continuous presence and support contribute to women's trust, sense of security, and a calm environment, and are buffers against the coming and going of clinical personnel who are often strangers. The support contributes to a positive birth experience and feelings of safety, strength, security, and confidence. Community doulas can be advocates for immigrant, refugee, and other women who often experience discrimination due to intersectional identities. Community-based doulas can help them feel confident and have a positive experience. Some women appreciate doulas' spiritual support during labor. By contrast, women without a labor companion may feel alone, vulnerable, stressed, and afraid. Women without a companion may also be more vulnerable to mistreatment, neglect, and poor communication.⁶³

Results of an earlier review of qualitative research ("meta-synthesis") were closely aligned with the previous study. The earlier review found that among the various types of providers of continuous support during childbirth, doulas were viewed as the ideal childbirth support person.⁶⁴

Several individual studies of the experience of people who received community-based, often extended doula support have been reported. An independent follow-up of participants in a community doula program found that 96 percent of clients would recommend the program or encourage other women to participate. Ninety-four percent felt well matched with their doula.⁶⁵ A study of teen moms who had experienced an extended model of community-based doula support identified their appreciation of a respectful relationship that imparted coping skills, confidence, and knowledge and skills

Doula support contributes to a positive birth experience and feelings of safety, strength, security, and confidence.

for parenting.⁶⁶ A study of participants in a Healthy Start program who were at risk due to life circumstances, age, reproductive history, and other factors found that 91 percent who received community-based doula services felt that their labor and birth experience had been improved, and 87 percent would use a doula again. Large proportions rated many specific physical and psychosocial support strategies during labor as helpful and appreciated, including massage, hot and cold compresses, eye contact, answering questions, verbal encouragement, and continuous presence.⁶⁷ Lastly, an analysis found that, compared with women undergoing usual care, those with doula support were less likely to report experiencing various types of bias during the hospital stay for childbirth, with stronger effects for women of color and women with Medicaid coverage.⁶⁸

Community doulas are well positioned and highly motivated to support women from their own racial, ethnic, and cultural communities, bringing cultural knowledge and enhancing women's experiences at this

crucial time of transition. Some consider this work to be a calling.⁶⁹ Doulas of color recognize the biases endemic to the health care system and can provide culturally congruent support that helps mitigate the impact of racism. They can also connect women with needed social and community services.⁷⁰ In addition, doulas who support historically marginalized women may help improve food security, housing security, and other life circumstances – services that are not reliably available to women and birthing people undergoing usual care.⁷¹

Among doulas of color, Indigenous doulas play an important role in reclaiming and supporting cultural practices. In response to centuries of colonization of Indigenous lands, cultures, languages, and women's bodies, and centuries of experiences of loss and violence, doulas can offer sovereignty, self-determination, and trauma-informed support at the pivotal time of welcoming new family and community members. Disruption of the colonization of childbirth traditions presents opportunities for intergenerational healing.⁷²

Community doulas are well positioned and highly motivated to support women from their own racial, ethnic, and cultural communities, bringing cultural knowledge and enhancing women's experiences at this crucial time of transition.

Spotlight on Success

TEWA WOMEN UNITED

Tewa Women United (TWU)²³ is a multicultural and multiracial, Indigenous/Tewa-women-created and -led organization located in the ancestral Tewa homelands of northern New Mexico. TWU embodies courageous spaces that center Indigenous women and girls to connect with ancestral knowingness, healing strengths, and lifeways for the well-being of all. TWU is grounded in multi-movements/issues of environmental, gender, reproductive, and healing justice. Central to this work is the Yiya Vi Kagingdi Doula Project, which began in 2008, and the Yiya Vi Kagingdi Full-Spectrum Community Doula Training, which began in 2018 (*Yiya Vi Kagingdi* means “mother’s helper”). Full-spectrum doulas provide support from before conception through all the ways pregnancy ends, including birth, abortion, miscarriage, and stillbirth.

The community-centered Yiya Vi Kagingdi Doula Project was created in response to a survey of women in the six Tewa-speaking pueblos and as one approach to mitigate violence against women, children, and Mother Earth. The program supports birthing people and their families with about three prenatal home visits, continuous support while giving birth, about three postpartum home visits, and lactation support, as well as remote support, all within a birth equity framework. TWU collected data over eight years and found striking benefits for birthing women and people participating in their doula program, including:

- **Preterm birth rate of 2.7 percent**, versus 9.8 percent for New Mexico overall, 8.2 percent for Indigenous New Mexicans, and 9.4 percent for Hispanic New Mexicans
- **Low-birthweight rate of 3.5 percent**, versus 9.1 percent for New Mexico overall, 8.2 percent for Indigenous New Mexicans, and 9.4 percent for Hispanic New Mexicans
- **Primary (initial) cesarean rate of 9.5 percent**, versus 13.7 percent for New Mexico overall, 14.4 percent for Indigenous New Mexicans, and 14.8 percent for Hispanic New Mexicans

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Spotlight on Success

In contrast to mainstream doula training organizations that do not emphasize the value of culturally congruent healing support for trauma survivors, and disproportionately reach affluent white birthing people through a private-pay model, the more encompassing TWU doula training program includes content relating to reproductive justice, decolonization of birth, trauma-informed care and healing, perinatal mental health, social needs, full-spectrum support, and reclaimed Indigenous birthing traditions. The Yiya Vi Kagingdi Doula Project and training also work to address postpartum depression and substance-using parents.

TWU promotes economic justice and reciprocity by training community doulas to do meaningful wellness-focused work, making doula support available to families without undue economic burden, and advocating for living-wage compensation for doula services.

Doula services are provided at low to no cost, and doula training is offered at no cost, in exchange for providing doula services to three families without charge.⁷⁴

Widespread interest and unmet need for doula services

Childbearing women appear to desire doula support greatly out of proportion to actual use of doula services. While recent national data on use and demand are not available, the third national *Listening to Mothers* survey found that whereas 6 percent of women who gave birth in 2011 and 2012 reported having had a birth doula, one in four women would have liked to receive doula support.⁷⁵ Additionally, an estimated 9 percent of respondents to the *Listening to Mothers in California* survey reported having had a doula in 2016. However, most respondents, 57 percent, indicated interest in doula support, either that they would definitely want this (18 percent) or would consider it (39 percent) should they give birth in the future. Two-thirds of Black women expressed interest in doulas, with more than one in four (27 percent) reporting they definitely would want one.⁷⁶

A major reason for this large unmet need is the failure of public and private insurers to reliably pay for the valuable services of doulas. Leaders in Minnesota and Oregon carried out extensive pioneering work to establish Medicaid coverage of doulas. Due to design flaws, these programs were slow to reach implementation. Design flaws in the pioneering Minnesota Medicaid doula reimbursement program included:

- Unsustainable **reimbursement rates**
- **Barriers to doulas becoming enrolled service providers** in managed care organizations
- **Required supervision and billing** through a licensed clinician, even though doulas are not affiliated with specific clinicians and support individual birthing people wherever and with whichever care team they receive maternity services
- **Lack of awareness of doula coverage** among health professionals and Medicaid beneficiaries
- **Lack of information about the program** among health plan customer service representatives
- **Prohibitive costs** to doulas of training, certification, and registration
- **Inadequate racial and ethnic diversity** among doulas and doula trainers
- **Failure to include trauma**, intimate partner violence, and other crucial topics in doula trainings
- **Lack of faith in the state doula registry** by both doulas and managed care organizations.⁷⁷

We should salute the pioneering efforts of the early adopters while developing programs that surmount the problematic features of these programs and above all support birthing families and doulas.

In addition to strong program design, it is a priority to support doula agencies and doulas themselves to have viable, sustainable, rewarding careers of providing exceptional support to childbearing families. Needs identified through pilot programs include support for program administration, data collection, financing and payment, managing relationships with hospitals and clinicians, pandemic-related issues, and support in a fluid and challenging environment for reproductive health.⁷⁸

Continued research about community doula support can assist in designing effective, sustainable programs and policies. University-based researchers recently partnered with community doula leaders to identify and prioritize among such research topics and provide guidance about carrying out such research. The project report presents priority questions relating to the following themes: scope of community doula support; awareness of doula support; doula trainings and certification; workforce development; ethics; compensation and funding; metrics, outcomes, and mechanisms of impact/efficacy; COVID-19; policy and standardization; and integration and interactions with health systems.⁷⁹

Two-thirds of Black women expressed interest in doulas, with more than one in four (27 percent) reporting they definitely would want one.

SUPREME COURT OVERTURNING OF *ROE V. WADE*: IMPLICATIONS FOR BIRTH DOULAS

In June 2022, the Supreme Court upended a 50-year precedent guaranteeing a constitutional right to abortion in the United States, and giving states full authority to determine abortion law. Some states continue to support and are strengthening this right. However, many continue to impose restrictions, including complete or early-pregnancy abortion bans, many of which criminalize providers and others who facilitate access to care, as well as increasing the surveillance and possible criminalization of pregnant people. In this evolving landscape, widespread fear, uncertainty, and new restrictions, are spilling over into the experience of pregnancy and pregnancy care for all people, including those who do not wish to terminate their pregnancies and those carrying out newly forced pregnancies. Many childbearing people are faced with new acute needs for safety, support, and well-being. This lends further urgency to increase access to the services that birth doulas provide from pregnancy onward.

Documented effects of past restrictions, immediate changes with this seismic legal ruling, and predicted impacts impose major new challenges for people who want to carry a pregnancy to term, as well as those who are being involuntarily forced to do so. These concerns include:

- An estimated 100,000 additional forced births will occur annually in the United States as a result of the overturning of *Roe v. Wade*.⁸⁰
 - ◇ Unintended pregnancies and births are associated with increased challenges to the birthing person's physical, emotional, social, and financial well-being.⁸¹
 - ◇ States with the most restrictive abortion access have the weakest maternal and infant health policies and outcomes, and are poorly prepared to support a growing number of pregnant and parenting people and their children.⁸²
- Effects will widen already broad inequities.⁸³
 - ◇ Black women, with ongoing increased health risks rooted in longstanding racism, disproportionately live in states with bans and other restrictions, and face challenges in overcoming distance, financial, and other barriers to needed care.
 - ◇ Hispanic, immigrant, low-income, rural, and non-English-speaking people, among others, will also experience disproportionate harm.

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- In many jurisdictions, legal threats are generating hesitancy and delays in seeking and giving safe, timely care for miscarriage (which occurs in about 10 to 30 percent of pregnancies) and the less common but serious ectopic pregnancy and stillbirth, which may require some of the same medications and procedures as abortion care.⁸⁴
 - ◊ Legal factors – rather than medical considerations and patient preferences – are driving decisions about management of pregnancy loss, jeopardizing women’s health and lives.
 - ◊ Already tenuous trust between people from communities that have been ill-served by reproductive health care and their contemporary clinicians may further erode.
 - ◊ Medical residents in restrictive states, who are important current and future providers of such care, will experience loss of skills in management of pregnancy loss.
- Broadly, fetal personhood will make many women and other pregnant people under a wide range of circumstances newly vulnerable to legal surveillance, civil detention and criminal prosecution, and forced interventions.⁸⁵
 - ◊ The overturning of *Roe* eliminated constitutional protections of pregnant women as full persons, making any pregnant person potentially vulnerable to encroachment on their decisional authority, bodily integrity, and rights to liberty, privacy, and equality.
 - ◊ The timing of the ruling is concurrent with backlash against women and people of color, and mass incarceration and criminalization, portending heightened vulnerability for birthing women and people and deeper entrenchment of structural racism.

Doulas are well positioned to support women and pregnant people in understanding and navigating this complex and difficult terrain, and must also protect themselves from criminalization and other harm.

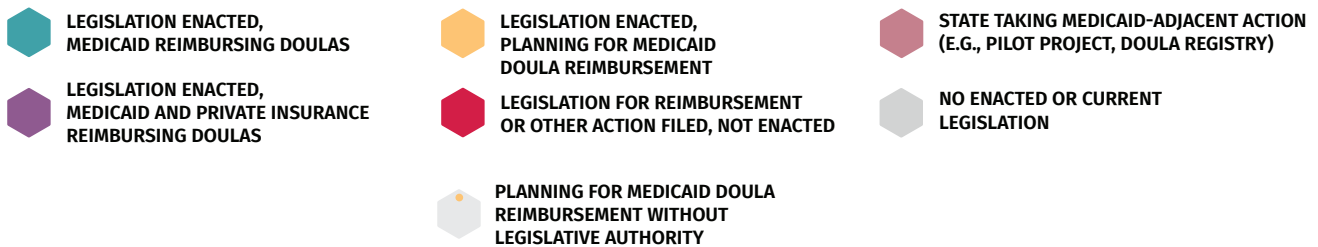
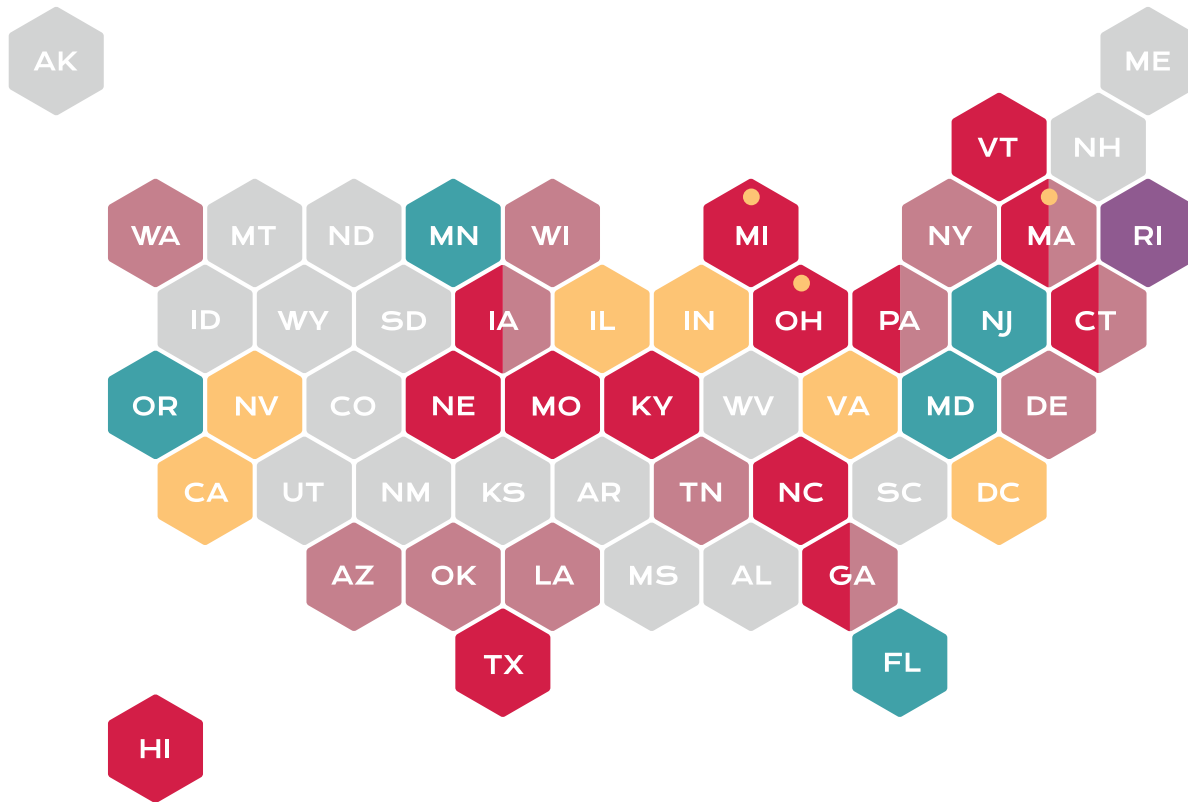
The evolving landscape lends further urgency to increase access to the services that birth doulas provide from pregnancy onward.

Insurance coverage of doula support appears to be at a tipping point. State legislative policy with respect to Medicaid coverage reflects remarkable movement. In recent years, with extensive media coverage of the longstanding maternal health crisis, broad consensus has developed among policymakers and advocates that doulas are a key piece of the solution to this crisis. In 2013, the Centers for Medicare and Medicaid Services revised their policies to permit coverage of preventive services by non-licensed practitioners, at the option of states and when recommended by a licensed practitioner.⁸⁶ At present, about two-thirds of states are exploring, preparing to implement, or using this option to provide access to doula services. Currently, 11 states and the District of Columbia have enacted legislation for Medicaid coverage of doula services, with

some providing access to doula services and others preparing to provide access. Notably, Rhode Island requires coverage of doula services by Medicaid and most commercial insurers, and California's program will reimburse full-spectrum support inclusive of birth, abortion, miscarriage, and stillbirth. Lawmakers in 14 additional states have filed legislation, which has not yet been enacted. Medicaid agencies in three states are planning for Medicaid reimbursement even though their legislatures have not enacted laws requiring this. Thirteen states are in the process of carrying out adjacent initiatives that may lead to enactment of reimbursing legislation. These initiatives include pilot programs and the development of doula registries.⁸⁷ Just 17 states do not appear to be working toward inclusion of doulas as a covered Medicaid service. (See Figure.)

In recent years, with extensive media coverage of the longstanding maternal health crisis, broad consensus has developed among policymakers and advocates that doulas are a key piece of the solution to this crisis.

FIGURE. MEDICAID AND PRIVATE INSURANCE COVERAGE OF DOULA SUPPORT SERVICES



Notes:

1. Independent of legislative mandates, various commercial plans across the country reimburse for doula services, and could not be identified and shown here. States in which one or more health plans separately reimburse for doula services include California, Kentucky, Massachusetts, Missouri, and Texas.
2. Adjacent activity references initiatives related to Medicaid and does not identify non-Medicaid doula-related legislation, such as inclusion in home visiting programs. Adjacent activities include pilot programs, voluntary doula certification, community advisory bodies, scope of practice definition, review of policies of other states, and recommendation of details of prospective state programs.
3. California will cover full-spectrum doula support for abortion, miscarriage, and stillbirth, in addition to birth doula support.
4. Rhode Island-enacted legislation requires coverage of doula services by Medicaid and most private health plans, specifically those that are fully insured and offered by a Rhode Island-licensed insurer.
5. Illinois and Indiana have enacted legislation for Medicaid reimbursement of doulas but have not yet provided funding.
6. MassHealth (the Massachusetts Medicaid program) and the Michigan and Ohio Medicaid agencies are preparing to reimburse for doula services independent of passage of legislation. Virginia is preparing to reimburse following budget amendments.
7. Please consult the source for extensive additional details and updates.

Source:

1. National Health Law Program. Doula Medicaid Project, Current State Doula Medicaid Efforts, <https://healthlaw.org/doulamedicaidproject/> accessed August 12, 2022.

The Biden Administration recently announced the availability of \$4.5 million to support community-based doulas. The funding will increase the number of doula programs within the Healthy Start Initiative of the Health Resources and Services Administration (HRSA) from 25 to approximately 50. Financial support will be available to hire, train, certify, and compensate doulas in communities with a concentration of adverse maternal-infant outcomes.⁸⁸ The extensive network of home visiting programs is another underutilized public service delivery and funding stream that is well-suited to doulas. Most notably, the services are provided through the federal Maternal Infant Early Childhood Home Visitation (MIECHV) program. By providing childbirth support, in addition to prenatal and postpartum support, doulas add value to the standard home visiting model.⁸⁹

The Human Healthy Horizons Medicaid managed care plan⁹⁰ and the Anthem Blue Cross Blue Shield Nevada Medicaid plan⁹¹ are examples of plans that cover doula services in the absence of state legislation. Blue Shield of California is launching a program to both support training and provide access to community doulas for members in three counties with especially poor birth outcomes.⁹²

Simultaneously, some employers are beginning to cover doula services. CVS Health offers a doula service benefit to all employees working 30 or more hours per week. Similarly, Pioneer Construction in Michigan offers a postpartum doula coverage

benefit, in recognition of the importance of employee wellness for workplace safety. Another employee benefit that can be applied to doula services is money held in Health Savings Accounts or Flexible Spending Accounts.⁹³

There are also precedents for employer-based health plans to cover doula services. For example, the Health Connect Plan available to Microsoft employees in Washington state's King and Snohomish counties includes a doula services benefit.⁹⁴ Walmart began to cover doula services within its medical plan for associates in Georgia, and is now expanding this benefit to employees in Illinois, Indiana, and Louisiana.⁹⁵

The current number of trained and active doulas is unknown. Understanding the present availability is especially challenging because many organizations train doulas (one inventory identifies more than 175 entities⁹⁶), many doulas are not members of national organizations, and some trained doulas are inactive. However, there are clearly not enough doulas to support every pregnant person who wants one, and the demographic makeup of the doula workforce does not reflect the diversity of the nation's childbearing population. As a result, priority strategies for increasing access to doula support and mobilizing doula support to mitigate the maternal health crisis must build, diversify, and retain the doula workforce and remove financial and other barriers to birthing women and people being able to choose and receive doula support.

RECOMMENDATIONS TO INCREASE ACCESS TO DOULA SUPPORT

There is a strong evidence base to support including doula services in the standard package of essential maternity care services available to all pregnant, birthing, and parenting women and people. Culturally congruent doulas appear to offer exceptional benefits to women of color and other groups facing structural, institutional, and interpersonal discrimination. Yet doula services are often out of reach for many pregnant people because insurance coverage for these services is limited. Moreover, the number of doulas, including community doulas, is almost certainly inadequate to provide support to those who want it. Given the ongoing maternal health crisis, especially in communities of color, financial support of doula services, as well as support to grow, diversify, and sustain the community doula workforce, are essential policy strategies.

Federal policymakers:

- Congress and the administration should ensure that all federally funded health insurance and direct health care provision programs cover extended-model doula support.
 - ◇ These programs include Medicaid, Medicare, the Child Health Insurance Program (CHIP), the Federal Employee Health Benefits (FEHB) Program, TRICARE, the Veterans Health Administration (VHA), the Indian Health Service (IHS), the Bureau of Prisons, and Department of Homeland Security detention centers. They should ensure that this coverage also applies to external maternal care purchased or referred to by the IHS and VHA.
 - ◇ As desired by pregnant women and people, these services should include pregnancy, birth, and postpartum support.
 - ◇ Eligibility criteria for program participation, covered services, payment model and levels, and other program features should not be overly restrictive and should be determined through close consultation with community doulas, doula organizations, and doula clients. Programs should be designed to attract and

retain these critical birthworkers and to contribute to community development through services and jobs.

- ◇ Doula compensation should provide a thriving wage that reflects the working conditions, scope of services provided, scheduling logistics, realistic caseload of clients, and cost of living.
- ◇ The respective programs should educate beneficiaries about the doula role, the evidence about doulas, and the availability of this covered benefit.
- ◇ Programs should educate health professionals about doula support as a complement to clinical services, the evidence about benefits of doulas for women and birthing families, and availability of this covered benefit.
- Congress and the Health Resources and Services Administration (HRSA) should ensure that community doulas are eligible and encouraged to deliver Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program services.
- Members of Congress should seek support for doula training and service provision programs in their districts through Community Project Funding grants (formerly, “earmarks”) in appropriations legislation.
- The Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services and other federal programs should support research to more fully understand effects of community- based and -led doula training and support programs in communities of color and others facing structural precarity. Congress should provide resources for this research.
- ◇ Outcomes of interest include, but are not limited to, indicators of perinatal mental health, maternal confidence and agency, identification and fulfillment of social needs, child development, adverse childhood experiences, the ability to break cycles of intergenerational trauma, pipeline for midwifery and other maternal care clinical and support professions, other benefits to doulas themselves, and longitudinal economic evaluation of return on investment, as well as continued preterm birth, low birthweight, and breast/chestfeeding research.

- ◇ This research should consistently collect, measure, and publicly report the ability of doula services to advance equity across these outcomes, by race and ethnicity, socioeconomic status, sexual orientation, gender identity, language, and disability status.
- ◇ The research should be co-created and carried out through community-based participatory modalities to strengthen results and avoid overburdening doulas and their provision of crucial services.

State policymakers:

- State legislators should enact, and regulators should provide, guidance for establishing doula services as a covered benefit through Medicaid (both fee-for-service and managed care) and CHIP.
 - ◇ As desired by birthing women and people, these services should include pregnancy, birth, and postpartum support.
 - ◇ Eligibility criteria for program participation, covered services, payment model and levels, and other program features should not be overly restrictive and should be determined through close consultation with community doulas, doula organizations, and doula clients. Programs should be designed to attract and retain these critically important birthworkers and contribute to community development through services and jobs.
 - ◇ Doula compensation should provide a thriving wage that reflects their working conditions, scope of services provided, scheduling logistics, realistic caseload of clients, and cost of living.
 - ◇ States should educate beneficiaries about the doula role, the evidence about doulas, and the availability of this benefit.
 - ◇ The respective programs should educate health professionals about doula support as a complement to clinical services, the evidence about benefits of doulas for women and birthing families, and availability of this covered benefit.
 - ◇ In establishing these programs, states should glean lessons from the successes and challenges of pioneering states (e.g., Minnesota, New Jersey, and Oregon).

- In parallel with coverage of doula services, states should allocate resources to build, support, and mentor the doula workforce.
 - ◇ States should support a diversity of community-based training models and programs and should ensure that doula training is tailored to the needs of the childbearing population (including trauma-informed care, maternal mood disorders, intimate partner violence, social services navigation, birth justice, and understanding and mitigating systemic racism).
 - ◇ States should ensure racial, ethnic, linguistic, and geographic (including rural) diversity in the doula workforce that aligns with the childbearing population covered by Medicaid and CHIP. Every effort should be made to ensure cultural congruence among trainers, doulas in training, doula mentors, and doula clients.
 - ◇ To foster growth and diversity of the doula workforce, states should minimize financial barriers to entry and provide mentorship support.
 - ◇ States should determine eligibility criteria for program participation, covered services, payment model and levels, and other program features in partnership with doulas, doula organizations, and doula clients.
 - ◇ Any doula certifications should be offered through training programs.
- States and tribes should ensure that community doulas are eligible and encouraged to deliver Maternal, Infant, and Early Childhood Home Visiting services.

Private-sector decisionmakers, including health care purchasers, and health plans, should:

- Designate doula support as a covered service.
 - ◇ As desired by birthing women and people, these services should include pregnancy, birth, and postpartum support.
 - ◇ Eligibility criteria for program participation, covered services, payment model and levels, and other program features should not be overly restrictive and should be determined through close consultation with

community doulas, doula organizations, and doula clients. Programs should be designed to attract and retain these critically important birthworkers and contribute to community development through services and jobs.

- ◇ Doula compensation should provide a thriving wage that reflects their working conditions, scope of services provided, scheduling logistics, realistic caseload of clients, and cost of living.
- ◇ Health plans should educate beneficiaries about the doula role, evidence about doula support, and the availability of this covered benefit.
- ◇ Health plans should educate health professionals about doula support as a complement to clinical services, the evidence about benefits of doulas for birthing women and families, and availability of this covered benefit.
- ◇ Health plans should ensure that plan directories maintain up-to-date listings for available doulas or doula agencies.
- Require employers to ensure that employees have access to doula support.
 - ◇ Options for employee access include doula support as a benefit of employment or as a covered service through their contracted health plans.
 - ◇ As desired by birthing women and people, these services should include pregnancy, birth, and postpartum support.
 - ◇ Employers should incorporate clear expectations into purchaser-payer contracts about sustainable plan payment for extended model doula services.
 - ◇ Employers should educate beneficiaries about the doula role, evidence about doula support, and the availability of this covered benefit.
- Require Medicaid managed care, hospitals, and other organizations to support community-based organizations in the development of doula training programs to increase the doula workforce.
 - ◇ In addition to educating about emotional, informational, and hands-on support, curricula should include trauma-informed care, impact

and mitigation of racism, culturally congruent support, birth and reproductive justice, intimate partner violence, perinatal mood disorders, and other skills and knowledge for providing optimal community-focused support.

- ◇ Organizations should ensure racial, ethnic, linguistic, and geographic (including rural) diversity in the doula workforce that aligns with the childbearing population covered by Medicaid and CHIP. Cultural congruence among trainers, doulas in training, doula mentors, and doula clients is optimal.
- ◇ As relevant, community-based training programs should encourage doulas to join Indigenous, Black, Latinx, and Communities of color in reclaiming their birthing traditions.
- ◇ Any doula certifications should be offered through training programs.
- Philanthropy should support community-based doula models by growing and supporting the doula workforce and reducing barriers to obtaining doula support.
 - ◇ Philanthropy should support training programs, access to doula support for those without other sources of coverage, doula mentorship, the development and evaluation of community doula services, infrastructure, organizational capacity building, and other programming to increase access to doula support.
 - ◇ Community doula services should be free or low-cost.
- The Patient-Centered Outcomes Research Institute should support research to more fully understand the effects of community-based and -led doula training and support programs for communities of color and others facing structural precarity.
 - ◇ Outcomes of interest include, but are not limited to, indicators of perinatal mental health, maternal confidence and agency, identification and fulfillment of social needs, child development, adverse childhood experiences, the ability to break cycles of intergenerational trauma, pipeline for midwifery and other maternal care clinical and support professions, other benefits to doulas themselves, and longitudinal economic evaluations of return on

investment, as well as continued research into preterm birth, low birthweight, and breast/chestfeeding.

- ◇ The research should be co-created and carried out through community-based participatory modalities to strengthen results and avoid overburdening doulas and their provision of crucial services.
- ◇ This research should consistently collect, measure, and publicly report the ability of doula services to advance equity across these outcomes, by race and ethnicity, socioeconomic status, sexual orientation, gender identity, language, and disability status.

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- *Routes to Success for Medicaid Coverage of Doula Care*
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About the partnering organizations



The National Partnership for Women & Families

The National Partnership for Women & Families has worked for more than 50 years to advance every major policy impacting the lives of women and families. The National Partnership works for a just and equitable society in which all women and families can live with dignity, respect, and security; every person has the opportunity to achieve their potential; and no person is held back by discrimination or bias. The National Partnership's robust maternal health programming focuses on transforming the maternity care system to be equitable and high-performing, and effectively and respectfully meeting the current needs of childbearing families, especially those experiencing the ongoing effects of centuries of racist and inequitable social policies and conditions.



HealthConnect One

HealthConnect One is a nationally recognized nonprofit training and technical assistance agency that uses innovative, community-based approaches to support direct-service providers in promoting the health of mothers, infants, and birthing families. Together with community-based organizations and advocates, HealthConnect One trains community health workers, connects community-based initiatives, and mobilizes diverse stakeholders to build policies and programs that improve birth equity.



National Health Law Program

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals to access high-quality health care. NHeLP advocates, educates, and litigates at the federal and state levels. We strive to give a voice to low-income individuals and families in federal and state policy making, promote the rights of patients in emerging managed-care health care systems, and advocate for a health care system that will ensure all people have access to quality and comprehensive health care.

Continued on the next page.

About the partnering organizations (continued)



Tewa Women United

Tewa Women United, founded in 1989, transitioned in 2001 from an informal, all-volunteer group to a nonprofit organization to end violence against Native women, girls, and Mother Earth, and to promote a culture of peace in New Mexico. Our mission statement describes Our Collective Journey: Through relational-tivity we embody courageous spaces that center Indigenous women and girls to connect with ancestral knowingness, healing strengths, and lifeways for the wellbeing of All. As Native women leaders we address the primary issues of environmental, health, racial, and social injustices resulting from the trauma of colonization, patriarchy, and white supremacy. Our primary program areas work to change in mind, body, heart, and spirit on individual, family, and community levels: 1) Indigenous Women’s Health and Reproductive Justice, 2) Environmental Health and Justice, 3) Women’s Leadership and Economic Freedom. These areas braid together and address environmental, reproductive, healing, and gender justice. The Sayain’, Circle of Grandmothers, interweaves through TWU’s program areas. Our campaigns struggle to replant a Culture of Peace by reclaiming, revitalizing, and braiding Tewa Ways of knowing with Western knowledge to support connection and belonging for ALL our communities.



Acknowledgments

This report was authored by the following National Partnership for Women & Families staff:

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The following staff of the National Partnership for Women & Families contributed to this report or to the underlying *Improving our Maternity Care Now: Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies* report (in alphabetical order):

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- Nikita Mhatre, Former Health Justice Policy Associate
- Jessi Leigh Swenson, Director, Congressional Relations, Health Justice

We also acknowledge the following professional who helped make this report a reality:

- Evan Potler, Designer

We are extremely grateful for the feedback and other contributions of the following partners, and deeply appreciate the invaluable work their organizations do to increase access to doula support, transform the maternity care system, and improve the lives of birthing women and people, and their infants, families, and communities:

- Twylla Dillion, HealthConnect One
- Fabiola Carrión, Amy Chen, Alexis Robles-Fradet, and interns Mara Greenwald and Sarah Hart, National Health Law Program
- Jessica Lujan and Corrine Sanchez, Tewa Women United

This report was made possible thanks to the generous support of the Yellow Chair Foundation.