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"We Are All There to Make Sure the Baby Comes Out Healthy":

A Qualitative Study of Doulas' and Licensed Providers' Views on Doula Care

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Abstract

Policymakers are exploring ways to expand access to doula care to address persistent inequities in maternal and infant health across the United States. Doulas are non-medical professionals who provide physical, emotional, and informational support to birthing people before, during and after childbirth. Growing evidence supports the role of doulas in improved birth outcomes. Delaware is among several states moving towards Medicaid reimbursement for doula care to serve those most at risk. ***Objective:*** To gain an in-depth understanding of key stakeholders' knowledge, attitudes, beliefs and experiences regarding doula training and certification, relationships among providers, and other potential needs related to infrastructure to identify areas of agreement and inform policy change in the state of Delaware. ***Methods:*** We conducted focus groups with 11 doulas and key-informant interviews with 12 licensed providers practicing in Delaware, including six nurses, four physicians and two certified nurse midwives. Qualitative data was collected via Zoom (video conferencing) between September 2022 and April 2023. ***Results:*** Analysis revealed themes related to training, credentials and competencies of doulas, including cultural competence; logistical, administrative, and financial considerations for policy and practice change; and the whole care team—relationships between doulas and medical partners, and opportunities for growth. ***Conclusions:*** Doulas and licensed providers agree on key elements of doula training, the value of certification, the need for financial support, and the importance of relationship-building across the care team. ***Policy implications:*** Areas of agreement among stakeholders provide a foundation for state leaders to move forward to ensure the delivery of the most accessible, high quality, and culturally competent doula care for birthing people in Delaware.

Introduction

Infant and maternal mortality rates in the United States (U.S.) are among the worst in the developed world and affect Black women at strikingly disproportionate rates. In Delaware, the overall infant mortality rate has declined over the past two decades from 9.3 deaths per 1,000 live births in 2000-2004 to 6.5 deaths per 1,000 live births in 2016-2020.[1] However, these data mask a significant racial disparity. The non-Hispanic Black infant mortality rate of 11.6 was three times higher than the non-Hispanic White rate of 3.8 deaths per 1,000 live births, and nearly two times higher than the Hispanic rate of 6.3 deaths per 1,000 live births, during the 2016-2020 period.[1] Further, the Delaware non-Hispanic Black infant mortality rate is higher than the national rate of 10.8 deaths per 1,000 live births.[1]

Like U.S. trends, maternal morbidity and mortality are on the rise in Delaware and Black women are particularly at risk.[2] Between 2018 and 2022 in Delaware, 11 maternal deaths occurred, seven among women of color and nine of which were determined to be potentially preventable.[3] While the numbers of maternal deaths each year are relatively small, it has been well established

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that persons of color have the highest rate of maternal death compared to their White counterparts.[4] Reasons for these inequities are complex and related to a myriad of social and economic factors, including structural racism.[5,6]

There is growing evidence that doulas contribute to improved outcomes, particularly among women most at risk.[7–9] Doulas are professionals who provide physical, emotional, and informational support to mothers before, during, and after childbirth. They also act as advocates,[10] promote self-advocacy for birthing people,[11] and may help mediate the negative impacts of social determinants of health, including implicit bias in healthcare.[12] In addition, doula care has the potential to reduce unnecessary medical interventions and can reduce costs.[7,9] Despite evidence of improved outcomes and a positive return on investment, few birthing people use doulas. Data regarding doula care in Delaware is limited. However, a large national survey of women found that only 6% engaged with a doula during labor[13] and women of color and low-income women face several barriers to access.

Given the potential benefits of doulas and the importance of policy change to help address gaps in practice,[7] several states have started to reimburse providers for doula services through their Medicaid programs.[14] Support for policy change is also growing at the federal level, as the U.S. Department of Health and Human Services is engaging in several efforts to expand access to doula care, including providing guidance on ways to reimburse doulas through Medicaid.[10] As many states, including Delaware, work to improve access to doula care many outstanding issues must be resolved, including qualifications and training requirements for doulas, the role of doulas in relation to other members of the care team, and other infrastructure and system needs and supports.

While doulas are expected to understand the physiological processes associated with pregnancy, birth, and postpartum health, they are not medically trained. Further, doulas' expertise is often grounded in generational, ancestral, and experiential knowledge shared among lay birth workers, and many resist certification as it resides within what is often considered an over-medicalized approach to childbirth. At the same time, the doula community is not homogenous, and doulas bring different educational backgrounds, models, traditions, and practices to this work. Further, no standardized training or certification currently exists for doulas. Federal Medicaid policy provides states with flexibility to determine requirements for training and certification.

Beyond ensuring adequate training and qualifications for doulas, positive working relationships between doulas and other members of the maternity care team are needed to ensure quality, integrated care. Anecdotal evidence from Delaware suggests that current working relationships may be tenuous, and more systematic research in other areas finds that many licensed providers are unaware of the benefits of doulas and/or may resist the integration of doulas as part of the care team.[15] Further, doulas cite lack of respect from clinicians as a workplace challenge,[16] while licensed providers have reported difficult working relationships when they perceive doulas as interfering with clinical decision-making in ways that could be harmful to the patient.[17]

Finally, evidence from other states that have expanded access to doula services demonstrates the need to identify and prepare for potential logistical challenges associated with implementation of policy and practice changes, such as Medicaid coverage.[18–20] For example, other states have experienced difficulties in supporting doulas to become certified or in helping prepare doulas for navigating the Medicaid billing process. While the experience of others is informative, states

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have unique healthcare system issues, resources and existing policies, making it difficult to fully anticipate potential barriers to implementation in Delaware.

Given this context, our research purpose was to engage stakeholders, including doulas and other licensed providers of maternal healthcare, from across the state and gather their insights related to these and other policy and practice issues meant to increase access to quality doula care for women most at risk of poor birth outcomes. Specifically, we aimed to gain an in-depth understanding of key informants' knowledge, attitudes, beliefs, and experiences regarding doula training and certification, relationships among providers, and other perceived infrastructure needs to inform state policy change. This research was supported by state-level partners, including the Delaware Healthy Mother and Infant Consortium (DHMIC) Doula Ad Hoc Committee; and the Delaware Department of Health and Social Services (DHSS) who funded the development of two comprehensive reports documenting this work.[21,22] This paper extrapolates on these reports by highlighting areas of agreement across stakeholder groups, to provide practical recommendations for state and healthcare system leaders and further contribute to the evidence for positive change.

This research is grounded in a philosophy of community engagement and a belief that those most affected by public health policies and practices should have a say in decisions that affect them.

The researchers recognize, respect, and value the knowledge and perspectives that doulas and other providers have gained through their experience serving birthing people in Delaware. We believe it is critical to listen to, and learn from, a variety of stakeholders to inform policy development and ensure the delivery of the most accessible, high quality, and culturally competent care for birthing people.

Methods

Researchers used a cross-sectional research design employing a combination of key informant interviews and focus groups to engage two stakeholder groups—doulas and licensed providers of maternal healthcare (i.e., nurses, midwives and physicians). Key informant interviews provide in-depth information on a given topic from the perspective of individuals who have relevant, first-hand knowledge, experience and/or expertise.[23] As such, key informants can offer insight into the nature of problems and important contextual factors, as well as recommendations for solutions. A focus group is a type of interview, offering the same research benefits, including an in-depth understanding of participants' attitudes, beliefs, and experiences.[23] However, the group interaction that occurs through focus group discussions can elicit additional understanding that might not be revealed through individual interviews. These qualitative research methods are especially useful for informing policy and practice changes and may help to advance equity, as it allows researchers to gather rich contextual insights about a particular issue from different perspectives grounded in disparate lived experiences.[24]

Our overarching research questions were:

1. How does each stakeholder group perceive the role and value of a doula?
2. How does each stakeholder group perceive training and certification requirements for doulas, including what core competencies should be included in approved training programs to meet the needs of women from low-income communities and women of color in Delaware?

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3. With respect to doula care, what is needed to better serve birthing people enrolled in Medicaid in Delaware?

Data Collection

Focus groups were conducted via Zoom (online video conferencing) with doulas across the state of Delaware between September and November 2022. Based on a review of websites and provider directories, approximately 40 eligible doulas were identified in the state at the time of recruitment. Recruitment occurred through established networks and doula organizations, including DHMIC, the Healthy Women, Healthy Babies (HWHB) Network, and Black Mothers in Power. Research participants were encouraged to share information with their colleagues, and the sample grew through a snowball sampling technique. All individuals who met the following inclusion criteria (determined through a REDCap screening survey) were invited to participate:

a. Any "doula" currently practicing in Delaware. A "doula" is defined as an individual who supports a birthing person during the prenatal, labor/delivery, and/or postpartum period.

b. Given the recent Coronavirus 2019 (COVID-19) pandemic, doulas who were not currently seeing clients, but practiced at any time since July 1, 2019, were also eligible.

c. Any individual who was trained as a doula through the DHSS, Division of Public Health's HWHB Zones Mini-Grant program over the past two years, but may not yet be practicing, was also eligible.

Birth workers who do not consider themselves to be "doulas" and doulas who do not serve state-based clients were excluded. Also excluded were doulas who do not provide support during the prenatal, labor/delivery, and/or postpartum periods (e.g., death doulas, transition doulas, and abortions doulas).

Focus groups were limited to no more than eight individuals and were relatively homogenous (according to demographic profiles such as race, ethnicity, and geography) to encourage participation but also allow for diverse opinions.[23] Each focus group lasted approximately one hour, and subjects received a $50 electronic gift card for their participation.

Because of challenges associated with scheduling focus groups with licensed providers, we conducted individual semi-structured interviews with this stakeholder group. Interviews were conducted via Zoom with licensed providers (i.e., nurses, midwives, and physicians) between March and April 2023. We used purposeful sampling, with an aim of interviewing different types of licensed providers representing the range of maternity care hospitals and health centers across the state. Partners at the DHSS Division of Public Health and Division of Medicaid and Medical Assistance contacted all Delaware hospitals that provide maternity care services to request assistance in recruitment. Similarly, the team contacted provider networks, including DHMIC, HWHB, the Delaware section of The American College of Obstetricians and Gynecologists, and the Delaware Health Care Association to share recruitment information. Leaders within these organizations were asked to personally invite potential participants whom they identified as having relevant experience. Potential research participants were required to contact the lead researcher, who determined eligibility and shared additional information, including an informed consent document. Like the focus groups, interviewees were encouraged to share information with their colleagues, to recruit additional participants through snowball sampling. Providers

who were not licensed in Delaware and/or not currently affiliated with a maternity care hospital or birth center in the state were excluded. Interviews lasted approximately 30 to 60 minutes.

All focus groups and interviews were conducted by the lead researcher and recorded after securing informed consent from each participant (via an electronic REDCap survey). Data collection was facilitated using interview guides, which included high-level questions that were asked in all focus group meetings and all interviews, as well as prompts that varied depending on the nature of the conversations. This semi-structured approach allowed for flexibility and ensured that the key topics were covered in every session.[25] Participants were encouraged (but not required) to turn on their video cameras. Zoom recordings were automatically transcribed and data were manually cleaned for analysis.

Data Analysis

Focus group transcripts were analyzed separately from the provider interviews, in order to be able to reflect upon the unique perspectives of each stakeholder group. Transcripts were analyzed using a combination of inductive and deductive approaches.[23] First, the lead researcher reviewed transcripts and post-focus group reflection memos to develop an understanding of the key messages that emerged from focus group conversations.[23] Data were then organized into categories which served as structured codes from which we were able to explore deeper meaning. This initial deductive analysis was informed by a review of relevant literature and the interview guide. The inductive analysis resulted in themes that emerged across all three focus groups, as well as findings that were unique to one or two groups.

While it is not uncommon for different ideas to emerge from different groups, the relatively small number of respondents may have limited the analysis. For instance, if the study had more participants, these relatively "unique" ideas may have been confirmed through additional focus group discussions, such that we could call them themes. Therefore, to explore whether there was agreement (or not) related to these unique ideas, member checking was added to our methodology. Member checking is an important qualitative method for establishing trustworthiness, whereby interpretations and conclusions are tested with study participants who have an opportunity to confirm, deny, or add to the interpretations.[26] In addition to addressing potential limitations related to the number of respondents, member checking gave doulas an opportunity to provide additional comments, as appropriate; to build upon ideas described in the summary; and/or to raise concerns related to our interpretation of the focus group conversations. In this way, member checking is consistent with the team’s interest in ensuring the voices of doulas themselves are prioritized and respected.

The process of member checking involved sharing a draft report of preliminary findings with all participants and asking them to respond to the following questions[27] by email, telephone, or zoom: (1) Do our findings match your experience? (2) Do you want to change anything, or is there anything that you disagree with? And (3) Do you want to add anything? Participants were given two weeks to respond and were sent one reminder. Three participants responded within the allotted time and their responses validated the findings. No new information was offered.

Provider interview transcripts were analyzed using the same combination of inductive and deductive approaches, resulting in themes that were evident across interviews. Member checking was deemed unnecessary, but to improve the trustworthiness of the study, a second investigator participated in the analysis.[26] Specifically, the lead researcher and co-investigator jointly

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conducted the analysis, working together to discuss initial patterns, test alternate explanations, and refine the resulting themes. Through this process, we were able to creatively organize the data while maintaining rigor by reading and re-examining interview data, memos, and categories into assertions supported by data excerpts.[28] Finally, the themes from both the focus groups and interviews are "supported by evidence from the data set in the form of excerpts from interviews that link the researchers' assertions to what was said by speakers in interview contexts".[28] This connection between researcher interpretation and the data also increases the trustworthiness of the findings.

The research was approved by the West Chester University Institutional Review Board.

Results

The final sample of focus group participants consisted of 11 doulas, of which nine self-identified as "Black or African American," one as "mixed" race, and one as "White". Delaware's three counties (New Castle, Kent, and Sussex) were represented in the sample. All participants had some type of formal training, including for example, from DONA (Doulas of North America) International, or from one of the community-based organizations in Delaware that received funding to train doulas through a mini-grant from DPH and DHMIC. Most were currently practicing the full continuum of doula care from prenatal through postpartum care. Most were relatively new to birth work (i.e., had started within the past five years) and two participants had recently gone through formal training but were not yet practicing at the time of the focus group. Finally, the majority of participants reported that they serve women of color.

The final sample of interviewees consisted of 12 licensed providers: six nurses, four physicians, and two certified nurse midwives. Six hospitals and/or healthcare systems were represented across all three Delaware counties. Four providers held positions that allowed them to participate in policy or practice at the state level (e.g., on a statewide committee or board), and three were formally trained as doulas, though were not currently practicing as doulas.

Findings are organized below according to three major categories: training, credentials, and competencies; logistical considerations for policy and practice change; and the whole care team—relationships between doulas and medical partners. Within each category, themes are expressed relying heavily on direct quotes from research participants to promote authenticity. Additional vignettes supporting the major themes can be seen in this paper's supplemental appendix.

Category 1: Training, Credentials, and Competencies

Doulas participating in the focus groups had experience with many types of training programs, which covered a range of topics. Training format, length, and sponsoring organizations varied quite a bit, but focus group participants generally agreed that initial training, as well as ongoing professional development, is important for their practice. In conversations with licensed providers, it was clear that credentialing or certification, as well as training in specific skills and competencies, would lead to much higher acceptance of doulas in the hospital system. One such competency identified by study participants was cultural competence, with doulas emphasizing this as critically important for the population they serve. Providers also emphasized that race/ethnicity and socioeconomic status play a role in the lived experiences of birth parents when

it comes to social support, expectations, and language barriers to name but three factors. Doulas can provide value in this regard, but effectively serving this population is not without challenges.

Theme 1: Cultural Competence and Supporting Vulnerable Populations

As most focus group participants identified as women of color, who primarily serve birthing people of color, in a predominantly white healthcare system, it was not surprising to find that cultural competence was identified as a critical training element for delivering quality care. Doula participants recognized that cultural competence training is essential for serving minority communities. As one doula explained, “It needs to be mandatory because the only way that people are really going to lean into that is if they are made aware.” Another focus group participant emphasized the importance of cultural competence when working with birthing people who come from communities already marginalized by structural inequities, arguing:

> If you’re not made aware, or if you’re not familiar with it, if you’re not comfortable with information that’s out there, with the information that’s needed in order to properly serve, then you run the risk of literally causing more harm or more trauma in a person’s birth space.

Doulas expressed not only the need for such training but also the opportunity and benefits that cultural competence training affords. Additionally, participants recognized that cultural competence training should not be limited to issues of race or ethnicity, and that learning about other communities within the umbrella of cultural diversity are also important, including topics related to nontraditional families and transgender communities.

The benefit of having doulas who are representative of the patients for whom they are providing care was also stressed. One participating provider connected this to training considerations, stating, “I think it's really important too to make the training programs available to women from those communities so that people are being supported by other people within the community.”

Further, providers acknowledged that many of the birthing people who would be affected by potential policy change live in fear of the birth process. Thus, the doula becomes even more valuable for those birthing people from communities that have been marginalized and those with the highest risk of poor outcomes. The following interview vignettes show providers’ view of this value:

> We have a very large population of people that either arrive with no prenatal care like they're dumped off in the car, or they have folks that are severely underprivileged, severely underserved. They don't have a lot of help, and sometimes they're there by themselves. That's where a good doula will earn her keep.

> I think the real value in doulas in low-income populations is support. I mean, women are scared to give birth. And because of what they read and what they hear, and statistics, they are scared to give birth, and I think knowing that they have that support and have a doula is really important. And in my view, that's probably the most important thing, just peace of mind.

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Theme 2: Perspectives on Credentialing and Certification Policy

Participating doulas highlighted the idea that training should be comprehensive and include attention to reproductive health generally, and the full perinatal period (prenatal through postpartum). One doula explained, “I think you need a full spectrum training, something that kind of prepares you all the way from even preconception and fertility to postpartum.” Another participant elaborated:

> Doula support doesn’t just start with labor, and pregnancy is a process… we typically start working with the client before, like at the beginning of their prenatal care. So that part is important. Knowing what’s normal, how a client can manage their health, and monitor their health in a way that it’s not like a last-minute emergency for something that could have been prevented.

Many focus group participants were relatively new to practicing as a doula and expressed concerns that they did not initially feel prepared to practice independently after participating in just one or two brief training programs. Several participants recognized the limitations of training and the value of practice as a complement to formal training. These points were also emphasized by licensed providers who discussed the specific skills and competencies that should be included in training. They stated that doula training should include both content and skill development and be broad in scope. Additionally, many doulas emphasized that learning is an ongoing process whereby opportunities for regular professional development are warranted.

While doula participants recognized the value of informal training, generational knowledge, and experience, none seemed to resist the idea of a certification process with formal training requirements. One doula explained, “We don't want just anybody subscribing to and saying, ‘Yeah, I'm a doula.’ No, there absolutely does need to be some kind of certification.” However, when discussing specific training programs or sponsoring organizations, there was a clear sense that no one program was superior and that training requirements for state certification should be flexible and allow for different sponsoring organizations. While there was not a strong resistance to formal training as part of a certification process, there was a feeling that certification was a necessary hurdle but potentially in conflict with the culture and essence of doula work.

Licensed providers considered the point that certification or credentialing could lend credibility to doulas. In the words of one provider, “If [doulas are] going to get credibility in hospitals, particularly, there has to be a level of credentialing that needs to occur.” According to providers, the trustworthiness of doulas working in the hospital system would be increased by a standardized certification or credentialing process. Such a process would allow clinical care teams to feel safer and more accepting of working with doulas, as seen in the vignettes below:

> From my perspective I think that doulas need to demonstrate a level of competency by having a certification from an organization ... they want to present themselves with the best credentials that they can, so that they can feel like they're part of the team and so that they can be accepted as part of the team.

> If everyone has ... at least the same certification ... you know they've met a certain level of competency. And you can feel safe that they are doing what they should be doing for the patient.

Category 2: Logistical Considerations for Policy & Practice Change

Should all doulas who aim to support birthing parents acquire the necessary credentials and training, there are still logistical considerations that participating providers and doulas raised. Doulas often described their work as a calling or a mission to serve, which frequently translated into providing care to clients with limited means, resulting in limited income for doulas themselves. The added financial burden that may accompany certification training requirements was acknowledged by both doulas and licensed providers. Findings from focus groups and interviews also revealed concerns about the potential administrative burden of Medicaid billing and the need for more support in this area, particularly if the goal is to increase access to doula care.

Theme 1: Financial Considerations

Several doulas discussed financial stresses they face with their work, as well as the added financial burden that may accompany any certification training requirements. One doula even described this as an access issue, stating "I think there is a huge barrier to entry with training costs." This concern was shared by providers, who presented the option of potentially covering certification and/or training fees:

> I think what we've heard from the doulas that the certification is expensive. Some of them have said they haven't gotten the certification because it's expensive. If that's the case, then the State could support that.

Doulas also identified the benefits that can come from addressing these financial concerns, as seen in the following vignettes:

> We need to be able to sustain our own households because a lot of times as a doula, we can't show up for our clients when we are being mentally drained and burnt out ourselves because we can't even pay our own bills.

> I have a lot of Black young women who would love a doula. A nineteen-year-old right now, and I looked at her, and I was like, 'Listen, this is something that you need. This is not a luxury. This is a necessity'…. So, if we have more money being funneled into programs like this on top of having those who do have access to Medicaid, this is not an extra expense, but this is something that is a part of the package.

Licensed providers shared this concern, particularly regarding how doulas would be reimbursed. Providers discussed the nuance in care that doulas provide given the unique nature of childbirth and expressed apprehension surrounding the adequacy of compensation for that care. One provider explained that depending on the nature of the labor and delivery process, compensation could become complicated:

> A labor can last a really long time 48, 56 hours. That doula may need to hand off to another doula. Does that mean that she misses out on reimbursement because she's needed to do that hand off? ... And also, what does the postpartum coverage look like? ... Can we

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> engage doulas to become postpartum doulas, and potentially help specifically like our first-time families, or those with the lower socioeconomic status? Or, again, just those without resources. I think that that would be an amazing thing to be able to explore.

Theme 2: Administrative and Legal Concerns And Assistance

Focus group discussions also revealed concerns about the potential administrative burden of Medicaid billing and the need for more support in this area, particularly if the goal is to increase access to care. One doula explained that administrative support is necessary to prevent the creation of additional barriers. Another discussed this support, and ease of billing requirements, in relation to equity and diversity in the workforce, arguing:

> Historically, it's been very challenging for people of color to get ahead when it comes to certain things…if for Medicaid billing [we] have to jump through hoops and file this paperwork that it's ridiculous, and it's just kind of another form of discrimination. And some people may say that it's not, but it really is. It keeps us from achieving the goals that we really are set out to achieve. So, it would be nice if there were certain forms that need to be filled out… It needs to be minimum, and it needs to be very well compensated for all that we do.

When discussing these issues with licensed providers, ease of billing and administrative processes, and/or support for those processes was believed to be important. Additionally, providers suggested a proactive approach to legal concerns such as grievances and medical legal responsibility:

> And there's a lot of medical legal stuff going on there. So if you have a lay doula in the community, what's the medical legal responsibility when they walk into the hospital because now the hospital takes responsibility to some degree. Unless by legislation you remove hospital responsibility, that's a problem.

Category 3: The Whole Care Team—Relationships Between Doulas and Medical Partners

Many licensed providers had relatively limited direct experience working with doulas but expressed a willingness to do so. Concerns they shared were usually based on a single negative experience or a story from a colleague. The nature of their experiences also varied depending on the circumstance, but they were generally positive about the role and value of doulas. Discussions about working with other care providers also emerged in every doula focus group. Doula participants had a variety of experiences practicing alongside other licensed providers, and while some doulas recounted positive interactions, many described challenging relationships with other providers. This tension was typically perceived by doulas as being grounded in a lack of awareness and understanding of the role that they play. Still, all participants appeared genuinely interested in building positive working relationships, thereby improving quality of care and providing a better patient experience.

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Theme 1: Building Cooperative and Collaborative Relationships

Focus group participants clearly saw themselves as part of a team with a single focus on ensuring a positive birth experience and outcome. One doula stated, "We are all here literally to do the same job. Get this baby first, and make sure that the birthing person is safe. Period. Period." Another doula echoed this sentiment:

> To be honest, we are all a team, the mother, the father, or whoever our support person is, the doctor, the nurse, the doula. We are all there for one particular thing, that is to make sure the baby comes out healthy. So, we are all together in this one hundred and fifty percent.

Licensed providers emphasized the importance of the doula's presence on the care team to help connect patients to care by acting as a sort of interpreter or translator; someone who can promote better health literacy, and in doing so ensure the birthing person understands the information that providers are trying to communicate. One provider acknowledged that the doula can "serve as a liaison between the clinical providers, who kind of spit out a lot of medical jargon, and help to ensure that the birth parent understands what that jargon means, so that they can make an informed decision." Another provider explained, "A doula is very valuable because they're interacting with the patient; they're in many ways a 'go between' between the patient and the medical team."

According to doula focus group participants, providing licensed providers with training as well as opportunities to get to know doulas are ways to support relationship-building across the care team. Again, this was grounded in the perception that most providers simply did not understand the role that doulas play, including the value that doulas potentially offer in addressing health inequities. Doulas were generally optimistic about how both training and other relationship-building activities could support a more collaborative environment. Several participants suggested that strategies for getting to know one another better, outside the labor and delivery room, could be beneficial. For instance, as described by one doula:

> I don't want to call them 'meet & greets,' but something where providers are introduced to the role of doulas as well as meet doulas ... You actually sit down and talk to us. We can have an open back and forth discussion so everything can get laid out ... making sure that we come together, and having that open dialogue, I believe would be helpful.

Providers offered some of the same suggestions about ways that doulas and the clinical team can become more cooperative and better able to function together, such as meet-and-greets and other relationship-building opportunities. As one provider saw it, "If a doula is coming into the hospital, they should have some idea of the hospital system." Others acknowledged that as doulas need to learn more about licensed providers and the way that the system currently functions, providers and hospital systems need to learn more about doulas. One provider explained, "You have to get together and be part of the community that's caring for the patient."

Finally, some licensed providers acknowledged that lack of awareness about the value of doulas (including lack of awareness of the evidence base regarding doulas) was a barrier to integration that could be addressed through education:

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> Start with educating the team and having that general understanding of ... the service that [doulas] provide, and fully understanding the benefits to it, and how we can partner together…. And once you understand it, then that's how you would be able to form a partnership to be able to provide this service for the patients.

> I think provider and care team education [is important] because there is definitely going to be a huge differing of opinions about doulas. And you know another thing in medicine that we view as the end all be all is evidence-based. So I know there's evidence that doulas improve birth outcomes ... I think the medical community is always more likely to embrace things that [are] evidence-based so I think that really educating… would be really important.

Importantly, many participants recognized that relationship-building, and especially trust-building, takes time. This suggests that meet-and-greets, while an important first step, may have limited value until practice becomes more common.

Theme 2: The Role of a Doula

As previously identified, doulas highlighted the need for education for other licensed providers to include building an understanding of the doula's role as advocate for their client, particularly when working with communities who may feel marginalized in the healthcare system. Focus group conversations reflected an understanding of the need for such advocacy when supporting women of color, as they often experience a lack of power in relationships with their providers and a diminished ability to make decisions for themselves. Doulas can help address this power dynamic through their role as advocates.

Licensed providers also saw the role of the doula in this way. They expressed how doulas can help ensure the birthing person understands information that providers are sharing and empower them to ask questions when they do not understand, and to find and use their voice during labor and delivery. Providers see a particular value in the relationship between the birthing person and the doula, as this generates trust which helps to reduce fear and anxiety. One participant explained that doulas provide a "consistent presence of someone who is supportive, and who they trust and that the family trusts, which reduces the patient's anxiety, reduces the patient's fear, and it makes just for a calmer birthing experience." Another provider shared this sentiment by explaining how that trust between a doula and birthing person can also translate into more thoughtful decision-making:

> If [doulas] develop a bond with a patient who's scared… with the comfort of a doula that they know and says, "Okay, just remember, these were the things we talked about from pain control perspective. We talked about breathing, we talked about nitrous, we talked about IV medication, and we talked about the epidural," in the moment when a nurse is saying, "Okay, your pain's a 7 all of a sudden, are you thinking you want an epidural?" If you don't have someone to kind of bring them back to what their full options are, they might take that as a suggestion instead [of a question].

Importantly, this support was not described as a replacement for other providers or in conflict with the role of other providers, but rather as extra support for the birthing person. One licensed provider described it like so:

> I like to think of [the role of the doula] as social capital. Somebody to listen to what a provider may be saying, and a second ear at times, or to run things by, or to give primary advice to a mom. I think that works well in the labor process. It's an extra level of support and comfort for that patient ... to help guide that mom if she needs to get to an obstetrician or if she doesn't need to get to an obstetrician, or to run something by about the normalcy of certain findings.

Doulas echoed this sentiment, as seen in a quote from one doula who described her role in relation to licensed providers:

> I'm not here to cut your pockets. I'm not here to undermine your authority. I'm not here to change, or even question your knowledge…you know your expertise. I'm just here to also offer extra because this is what the client is asking for.

Discussion & Public Health Implications

This study revealed valuable insights about what is needed to support increased access to quality doula care in Delaware—in terms of training and certification, logistical considerations, and relationship-building—from the perspective of key stakeholders. Previous research highlights areas of tension between doulas and licensed providers of maternal healthcare, as well as opportunities for promoting positive working relationships.[7,16,17,29] Our research elicited similar concerns and challenges[21,22]; however, areas of agreement between these stakeholder groups highlighted in this paper provide a strong foundation for the state to move forward with policy and practice changes. Most notably, we heard both doulas and licensed providers share their commitment to doing what is best for their patients, and an interest in finding ways to ensure the delivery of quality care in a mutually supportive team environment. Grounded in this understanding, and in alignment with corroborating studies cited below, we offer a number of important considerations for state and healthcare system leaders.

First, while more research is needed to identify all the core competencies that should be included in doula training, any training required for Medicaid reimbursement should include the full spectrum of doula care, from prenatal to postpartum. Key competencies and skills, attained through structured training programs, are needed to improve access to quality doula care and integrate doulas into care teams. Further, continuing professional development for doulas may be warranted given their perception that competence is developed over time and through experience.[30] Finally, cultural competence training should be an essential component of any training program that is required for doulas seeking Medicaid reimbursement.[19,31]

Certification is an important avenue for promoting quality care and it helps assure licensed providers that doulas are knowledgeable about pregnancy, childbirth, and postpartum care. In this way, certification may increase the perception of doulas' legitimacy in the clinical setting and promote quality by building trust and respect across the care team.[32] Doulas in our study also acknowledged the legitimacy that certification provided, even as they shared an understanding

that it may be somewhat counter to the culture and essence of the care they provide. This is consistent with findings from Young,[30] who reported that doulas may feel some ambivalence about certification; on one hand it legitimizes their role, but on the other the work of a doula does not require such validation. Some flexibility in training requirements, including allowing different training programs and/or sponsoring organizations, similar to many other states' policies,[14] may help address doula concerns about training and empower them to choose a program that most closely aligns with their approach to supporting birthing people. Financial support for doula training and certification should be considered, particularly as the state aims to improve outcomes for its most vulnerable populations.[16,18]

In addition to financial concerns related to training and certification, consideration of other logistical challenges is warranted. Stakeholders identified concerns related to doulas' abilities to navigate the Medicaid reimbursement process. Training and ongoing technical assistance may be needed, and ease of processes should be prioritized.[19] This is especially important for ensuring access to culturally competent care and promoting reimbursement for doulas of color, both of which are critical to addressing health inequities in birth outcomes. Further, this is consistent with research by Van Eijk and colleagues,[33] who raised concerns that Medicaid reimbursement could potentially perpetuate systemic racism in the healthcare system if securing such reimbursement discouraged doulas of color from participating. Consideration may also need to be given to potential legal issues related to more fully integrating doulas into the hospital setting. To our knowledge this concern has not been identified in other research, but whether real or perceived, acknowledging and addressing these concerns from licensed providers may help to allay any persistent tension and ease the path to more positive relationship-building.

Our findings also suggest that consideration should be given to concerted efforts that support relation-building among doulas and other members of the care team. This includes opportunities for doulas to become better oriented to the systems within which they are working, as well as opportunities for licensed providers to become better acquainted with the role and value of doulas. Providers' views of a doula's role on the care team as a "liaison" or "bridge" is consistent with recent research in California, which found evidence of bidirectional feedback between doulas and licensed providers and noted that providers viewed doulas as a bridge to address gaps in care for pregnant and birthing people.[34] Importantly, several providers in our study acknowledged that they found it difficult to build relationships with doulas when they only worked with them occasionally, which is consistent with research by Roth and colleagues,[32] which found that nurses who worked with doulas more often had more positive perceptions of doulas. Therefore, education and relationship-building should be an ongoing process. There are many potential benefits of "meet-and-greets" and institutional orientations to help doulas and other licensed providers get to know each other. While hospital-based education and orientation sessions may be useful, state agencies and professional associations may have a role to play in promoting a positive culture for the integration of doulas on care teams, particularly as new doulas are trained and certified and/or new providers are established within the local healthcare system.[19]

Finally, it is important to acknowledge that the conclusions we have drawn from this study outlined above are based upon an appreciation of the critical role of stakeholder engagement in effective, equitable policymaking,[24] and an assumption that diverse stakeholder perspectives should carry equal weight. Said differently, we aimed to identify areas of agreement between doulas and licensed providers and the considerations outlined above do not give preference to

either voice. In clinical practice, however, the healthcare system is inherently hierarchical with physicians invariably possessing the greatest power in healthcare decision-making and the delivery of care.[35] While potentially justified in the clinical setting given differential levels of training, care must be taken to ensure that this power imbalance does not permeate the boundaries of clinical practice. Specifically, as policymakers consider how to expand access to doula care and improve the birth experience for the communities they serve, the voices of doulas should be prioritized. Practically, this means that additional consideration should be given to finding ways to ensure doula representation in ongoing policymaking from planning through implementation. In addition, the perspectives of birthing people—especially those who experience health inequities—should be sought and included in future research and policy discussions.

Limitations

We believe this study generated valuable knowledge to inform the ongoing development of policies and practices to improve access to doula care among communities of color and others at risk of poor birth outcomes. However, the research was not without limitations. First, the study included a relatively small number of doulas and those who participated were identified through established networks. Such networks were often connected to formal training programs, which means that the findings may not reflect perspectives of doulas who have not engaged in formal training. More research with a larger and potentially more diverse sample could offer additional insights.

In regard to the provider interviews, the sample was purposeful; while common in qualitative research the findings may not represent all varied perspectives of licensed providers in the state. Further, we did not collect demographic information about licensed providers (beyond provider type and affiliation) which limited any conclusions that could be drawn based on their race/ethnicity. In addition, our analytical approach also did not allow researchers to draw conclusions based upon factors such as the type and gender of provider, location of service, length of time practicing, or other demographic information that may influence providers' perceptions of doulas. Future investigations should aim for a more diverse sample given the focus of the state's efforts to expand doula access particularly for birthing people of color and those from low-income communities.

Conclusion

Given the potential of doulas to improve birth outcomes, reduce inequities, and lower costs, many states across the U.S. are exploring policy strategies, including Medicaid reimbursement, to increase access to doula care. For policy change to be most effective, leaders must resolve a number of questions related to doula training and certification, relationships among providers, and other practical issues. This study provides important insights about these questions from the perspective of doulas and licensed providers practicing in the state of Delaware. The findings from this work, particularly areas of agreement among stakeholders, provide a strong foundation for policymakers and healthcare organizations to move forward to ensure the delivery of the most accessible, high quality, and culturally competent care for birthing people in Delaware and beyond.

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Appendix.

Categories, Themes, and Corresponding Vignettes from Doula Focus Groups & Licensed Provider Interviews

<table>
<tr>
<td rowspan="2">Category 1: Training, credentials, and competencies

Theme 1: Cultural competence and supporting vulnerable populations</td>
<td>Doula vignettes:

Regardless of the type of training that they've already taken, [doulas] absolutely should have some type of cultural competence training, and they should definitely be aware of how to support Black and brown people, especially since we have the highest rate of mortality in the state. You can't properly serve any birthing people if you don't know how to properly serve the ones that need the most support. So, if that's not within the requirements of Medicaid reimbursement, then it's definitely doing a disservice to the state, because a lot of our Black and brown families are using Medicaid.

If you're not made aware, or if you're not familiar with it, if you're not comfortable with information that's out there, with the information that's needed in order to properly serve, then you run the risk of literally causing more harm or more trauma in a person's birth space.

She's going to be able to support in a way that is needed, because she knows what's going on, and she actually cares about what's going on, because she sees it. I think a lot of the time people don't see it and not because they don't want to see it, because they can't really relate to it. So, I think that should definitely be something added to the training so that they can understand what's going on. This is not us just complaining or anything. This is really happening to our sisters here, and we're dying at an alarming rate for things that could have been prevented.

In addition, there needs to be some kind of measure in place to show that the people are actually absorbing what is being taught to them, and not on a low level, but on a high level, because as I've mentioned before, about my nursing school textbooks… there is biased information still present in the book. So, if you have someone who is not familiar with people of color, and then they read whatever in the book, or they learn whatever, or they don't learn whatever in a doula training, then they're not necessarily going to get out here and know how to support people of color. So, I would definitely say, making sure that there's some kind of teach back or test or something to make sure that they get it.

I've not yet worked with a trans person, and I would not take an opportunity to. I receive a person as a client, and say, 'oh, sure I'll be happy to come and help' and use that as my opportunity to learn... That's not the proper time to do that. We need to be aware. You need to be thoroughly aware of how to properly serve people from a different culture or a different background before you get into that space, because you don't want to ever run the risk of affecting their dignity while they're within that space.</td>
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<tr>
<td>Licensed provider vignettes:</td>
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	So I do think that it's really important to ensure that we have representation across the field – all fields in the medical industry, but that we're also culturally humble when caring for the patient and really sensitive to the fact that we're not able to speak for everyone, or assume culture and expectations, and all of those things for every person. So I do think that when it comes to black and brown women, or women specifically, who aren't white, they [may] come to the table with post-traumatic experiences dealing with bias in health care. *We're getting a larger population of Hispanics and Creole, especially in the Lower Sussex County, especially with the chicken plants being here. I think it would be wonderful if we could help some of these patients, and if we were able to have some bilingual translators/doulas that would definitely make a difference. I think we have to look at it in the equity piece and access to care because sometimes they've not had any prenatal care at all. They've just arrived here a couple of days ago and come in and deliver not really knowing anything. So I think that if we had those doulas present that that would take away a lot of angst for those patients. It's got to be pretty scary coming into a new country, a hospital, and not speaking the same language and our translation services that we have that are by phone, that a lot of them really don't speak Creole. So that communication piece is not really happening, and it can be kind of scary, especially if they need a stat C section, and you're not able to communicate … It pulls your heartstrings.* *With all the inequities that are still going on today, especially with black birthing people…I think it is another layer of support and care for them, particularly. I know there is a huge push nationwide because, really a lot of the doulas are within their community. These doulas look like them, and they can form relationships prior to coming into the hospital, especially if there were any complications going on, especially with the patients. They're there, they have the full understanding and can really provide a lot of education and resources for these moms prior to coming into the hospital, during labor, and even post-delivery. I think that's a real added benefit to for a lot of these moms.* *I think the real value in doulas in low-income populations are support. I mean, women are scared to give birth. And because of what they read and what they hear, and statistics, and so they are scared to give birth, and I think, knowing that they have that support and have a Doula is really important. And in my view, that's probably the most important thing right is just peace of mind. I think it's the most important thing.*
Category 1: Training, credentials, and competencies Theme 2: Perspectives on	**Doula vignettes:** *I know after the first training I didn't feel prepared really to serve the clients. It was only a two-day training and then we did some continuing education online. I really, honestly, I didn't feel prepared afterward. I didn't feel confident enough to go out and serve these clients. I didn't feel like I knew enough. But as I started to practice, I did learn by doing.*

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credentialing and certification policy	*So, training-wise, it's important to not limit people to specific organizations just because they have bigger names. That's actually dangerous for a doula, and for the people that they support as well.* *We don't want just anybody subscribing to and saying, Yeah, I'm a doula. No, there absolutely does need to be some kind of certification.*
	Licensed provider vignettes: *In that training has to be basic knowledge of pregnancy. I'm not talking, you know they don't have to be at the level of a nurse, midwife, or anything like that, but a basic understanding of pregnancy, and a basic understanding of the process of labor, the options that patients have for different things in the labor process that can help them through the labor process. When is it time to say we're done.* *I think that doulas need to demonstrate a level of competency by having a certification from an organization such as DONA. And so they want to present themselves with the best credentials that they can, so that they can feel like they're part of the team and so that they can be accepted as part of the team.* *I ask them (other nurses), what are the things that you would want, and what are things that you don't want, and all of them have said minimum standards. And so they either want a certification from something like DONA, or some kind of minimal qualifications.* *If everyone has ... at least the same certification ... you know they've met a certain level of competency. And you can feel safe that they are doing what they should be doing for the patient.* *It cannot just be all OJT [on the job training]. There has to be a level of content in a classroom setting, whether it's an online or whether it's an in-person classroom setting where they can learn about childbirth. If they're going to establish the level of trust, they have to understand the complications of childbirth…There needs to be information on, not heavy physiology and anatomy, but understanding the birth process.*
Category 2: Logistical considerations for policy & practice change Theme 1: Financial considerations	**Doula vignettes:** *I think I think financial support is one of the biggest [challenges], because a lot of the black and brown women that I plan to support are from communities that are underserved. And so the doulas that are in those communities also may have a financial burden if they have to pay for [training], you know, extensive classes for doing what they just naturally do. So, I think that needs to be considered, because there's some people that really cannot afford a doula, but they want a doula, and to be denied support like that because of finances, it's just to me, that's a travesty. And again, there are plenty of doulas who live in underserved communities, and financially may not have the money… one thousand five hundred dollars to take training…This is ridiculous.*

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We need to be able to sustain our own households because a lot of times as a doula, we can't show up for our clients when we're mentally drained and burnt out ourselves because we can't even pay our own bills.

I have a lot of Black young women who would love a doula. A nineteen-year-old right now, and I looked at her, and I was like, 'Listen, this is something that you need. This is not a luxury. This is a necessity. Let me show you. Here's a resource so that you can be able to get this for free.' So, if we have more money being funneled into programs like this on top of having those who do have access to Medicaid, this is not an extra expense, but this is something that is a part of the package.

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Licensed provider vignettes:

Many of them are not businesspeople, right? This may be their first time having to go through a process like this, so I'd like it to be as simple as possible, and really be able to have a return on investment for the doulas in this community, because we are really trying to address disparities right? And likewise I think that they need to have an equitable income for these services. I think that we've learned some lessons in other states that have really looked at reimbursing doulas and we've seen that they've had some low salaries there, so that's a concern for me as well.

A labor can last a really long time 48, 56 hours. That doula may need to hand off to another doula. Does that mean that she misses out on reimbursement because she's needed to do that hand off? You know. Sometimes we may not be contacted by a pregnant person until later in their pregnancy, and so we may only be able to see them once or twice before they even go into labor. Or maybe they're having a premature labor right? And so would that impact their reimbursement in a negative way?… And also, what does the postpartum coverage look like? We do have opportunities for postpartum care and when we're thinking about maternal mental health and families that may not have a lot of resources. For example, maybe they don't have a primary support person in their home. Maybe they have to go back to work early. Maybe they have a baby who's had a NICU stay – on and on. What does that look like from a postpartum perspective? Can we engage doulas to become postpartum doulas, and potentially help specifically like our first-time families, or those with the lower socioeconomic status? Or, again, just those without resources. I think that that would be an amazing thing to be able to explore.

I think what we've heard from the doulas that the certification is expensive. Some of them have said they haven't gotten the certification because it's expensive. If that's the case, then the State could support that. I think if there are – with accepting Medicaid again, I think there's gonna be a lot of responsibility on documentation, record keeping, billing, to ensure that there is not any fraud. And so I think the doulas are going to need support with that. Yeah, how to how to document how to make sure that they have great a good accounting for the money trail there.

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Category 2: Logistical considerations for policy & practice change Theme 2: Administrative and legal concerns and assistance	**Doula vignettes:** *Historically, it's been very challenging for people of color to get ahead when it comes to certain things…if for Medicaid billing [we] have to jump through hoops and file this paperwork that it's ridiculous, and it's just kind of another form of discrimination. And some people may say that it's not, but it really is. It keeps us from achieving the goals that we really are set out to achieve. So, it would be nice if there were certain forms that need to be filled out… It needs to be minimum, and it needs to be very well compensated for all that we do.* *That's [administrative support] very important, and I will say that I think it's important to make sure that it doesn't create a barrier, because I can see creating a barrier with it being too extensive or too much or not having adequate support to complete whatever needs to be completed…So, when it's time, we can get out there and get it done. But yeah, definitely, having support for billing and adequate support, not just saying there's support, but actual…like maybe aids showing like 'click here.' Do that, like actual things that walk people through the steps, and then having that support that's available to teach as well. I think that's extremely important.*
	Licensed provider vignettes: *A way to resolve like grievances, you know, like some sort of a responsible party within the State that can address any kind of concerns that are coming up, and you know, some way for that to be addressed if there is unsafe practices or something that's happening.* *And there's a lot of medical legal stuff going on there. So if you have a lay doula in the community, what's the medical legal responsibility when they walk into the hospital because now the hospital takes responsibility to some degree. Unless by legislation you remove hospital responsibility, that's a problem.*
Category 3: The whole care team: Relationship between doulas and medical partners Theme 1: Building cooperative and collaborative relationships	**Doula vignettes:** *We are all here literally to do the same job. Get this baby first, and make sure that the birthing person is safe. Period. Period.* *To be honest, we are all a team, the mother, the father, or whoever our support person is, the doctor, the nurse, the doula. We are all there for one particular thing, that is to make sure the baby comes out healthy. So, we are all together in this one hundred and fifty percent.* *I don't want to call them 'meet & greets,' but something where providers are introduced to the role of doulas as well as meet doulas ... You actually sit down and talk to us. We can have an open back and forth discussion so everything can get laid out ... making sure that we come together, and having that open dialogue, I believe would be helpful.* *I think it should be required for medical providers to have some type of continuing education regarding what doulas do. Also, maternal and infant mortality - I think that they should be aware of that, and what's actually going*

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	on, especially in their state. And I think that they should be aware that doulas are a part of the birth team.
	Licensed provider vignettes: *[Doulas] can serve as a liaison between the clinical provider and you know those who kind of spit out a lot of medical jargon and help to ensure that the birth parent understands what that jargon means, so that they can make an informed decision.* *A doula is very valuable because they're interacting with the patient; they're in many ways a 'go between' between the patient and the medical team.* *Start with educating the team and having that general understanding of ... the service that [doulas] provide, and fully understanding the benefits to it, and how we can partner together…. And once you understand it, then that's how you would be able to form a partnership to be able to provide this service for the patients.* *I think provider and care team education [is important] because there is definitely going to be a huge differing of opinions about doulas. And you know another thing in medicine that we view as the end all be all is evidence-based. So I know there's evidence that doulas improve birth outcomes ... I think the medical community is always more likely to embrace things that [are] evidence-based so I think that really educating… would be really important.*
Category 3: The whole care team: Relationship between doulas and medical partners Theme 2: The role of a doula	**Doula vignettes** *I'm not here to cut your pockets. I'm not here to undermine your authority. I'm not here to change, or even question your knowledge…you know your expertise. I'm just here to also offer extra because this is what the client is asking for.* *I would never argue with anybody else on the birth team, because then that's causing more stress for my client, you know. So, I do it very respectively. If I do have to speak up about something, I ask questions, you know, and that's just how I show up in the birth space in the hospital setting.*
	Licensed provider vignettes *Doulas provide a consistent presence of someone who is supportive, and who they trust and that the family trusts, which reduces the patient's anxiety, reduces the patient's fear, and it makes just for a calmer birthing experience.* *If [doulas] develop a bond with a patient who's scared… with the comfort of a doula that they know and says, "Okay, just remember, these were the things we talked about from pain control perspective. We talked about breathing, we talked about nitrous, we talked about IV medication, and we talked about the epidural," in the moment when a nurse is saying, "Okay, your pain's a 7 all of a sudden, are you thinking you want an epidural?" If you don't have someone to kind of bring them back to what their full options are, they might take that as a suggestion instead [of a question].*

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	I like to think of [the role of the doula] as social capital. Somebody to listen to what a provider may be saying, and a second ear at times, or to run things by, or to give primary advice to a mom. I think that works well in the labor process. It's an extra level of support and comfort for that patient ... to help guide that mom if she needs to get to an obstetrician or if she doesn't need to get to an obstetrician, or to run something by about the normalcy of certain findings.

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