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The Birth Doula Workforce in the U.S.
Rapid Response Brief

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KEY FINDINGS

The focus of this rapid response brief is on the birth doula workforce, which is the dominant type of doula discussed in the literature (other types of doulas not covered in this brief serve their clients through abortion or infant loss, death, and adoption among many others). Based on literature from January 2021, we found that:

- The literature that has been published from January 2021-August 2022 on the birth doula workforce is limited, with many more studies focused on the association between doula services and perinatal outcomes.
- The literature focused on the doula workforce identifies challenges that individual doulas face as part of their work, particularly doulas who identify as Black, Indigenous, and other People of Color (BIPOC)and/or Lesbian, Gay, Bisexual, Transgender, Queer, Intersex or Asexual (LGBTQIA). Until recently, a majority of those served by birth doulas, and doulas themselves, identified as White and cis-gendered. A growing number of doulas identifying as community-based doulas – who identify with and are often from the communities they serve – are working to expand access to services for underserved communities and are increasing racial and ethnic diversity within the doula field.
- Challenges experienced by the doula workforce include witnessing and/or experiencing discrimination while working with their clients in a variety of healthcare settings, struggling with ineffective or inadequate payment models, meeting resistance when collaborating with other perinatal providers, feeling alienated from mainstream doula groups, and experiencing burnout.

Impact of the COVID-19 pandemic:

- Doulas experienced additional barriers to providing services during the COVID-19 pandemic as new hospital rules and policies around visitors created by hospitals often resulted in doulas being deemed “non-essential” personnel, reinforcing existing strains between doulas and hospitals and medical providers.

Data availability:

- There is no comprehensive public or private database available on the doula workforce in the U.S. that could be used to describe the size, distribution, and characteristics of the doula workforce. Opportunities exist to improve collection and availability of data on the doula workforce in the U.S.

Recent policies and programs to expand the use of doulas:

- Three states are actively reimbursing for doula services under state Medicaid plans, and many more have proposed or are currently working towards that aim. These policies range regarding requirements for reimbursement (training and certification), the total reimbursement amount, and the number of reimbursable visits, and many doulas and doula organizations think these policies do not go far enough.
- Concerns with policies include a lack of focus on racial equity, prohibitive training and certification requirements, as well as a potential emphasis on hospital care which could move attention away from local, community-based perinatal services.

Research gaps and opportunities:

- Research is needed which provides comprehensive information on the doula workforce, including workforce characteristics, and workforce outcomes such as retention, job satisfaction, turnover, stressors, and burnout. In addition, research is needed which further explores core competencies and skills as well as effective strategies for addressing wellbeing among this workforce.
- While diversity within the doula field is growing, more work is needed to increase diversity and facilitate access to needed training, employment, and ongoing professional development.
- Increased doula representation and involvement in policymaking is needed given that research demonstrates the expertise community-based doulas and community-based organizations have regarding what is needed to address perinatal inequities in their communities.

INTRODUCTION

Pregnant individuals of color in the U.S. have had unequal access to high quality care compared to other communities in the U.S. that has contributed to poor birth outcomes. Pregnant people of color, particularly Black and Indigenous peoples, experience higher maternal mortality rates than that of their White peers. Black and American Indian/Alaska Native individuals have been two to three times more likely to die from pregnancy-related causes and twice as likely to experience serious perinatal complications based on available data.[1] Prior research has focused on individual risk factors to explain these differences in outcomes, however, such explanations are limited and do not facilitate solutions which address the systemic inequities underlying such differences.

Research has shown the physical and emotional benefits of birth doula care, including decreased maternal stress, lower rates of cesarean sections and medical procedures during birth, lower odds of postpartum depression or anxiety, and improved trust with the birthing process.[2–4] Insurance coverage for doula services is limited and has largely been paid for out-of-pocket, resulting in doulas historically serving predominately White, cis-gendered, higher-income individuals.[5] Given the landscape of perinatal health disparities and inequities, there is a wide gap between those who would benefit most from doula care and those who can afford doula care. Over the past couple of years, there has been an increased focus in both research and policy on the role of birth doulas as an intervention to address structural inequities in the U.S. health care system and reduce health care disparities. In response to this interest in doula services, there have been multiple state bills to expand Medicaid coverage to pay for doula services.

This rapid response brief provides an overview of research on the birth doula workforce that has been published since January 2021, including workforce challenges and the effect of the COVID-19 pandemic on doulas. We begin with a brief overview of the doula workforce for which literature has been emerging and describe the available data to study the doula workforce. We also highlight opportunities and research needs to support the doula workforce in the U.S.

MEASURING THE BIRTH DOULA WORKFORCE

What is a birth doula?

Birth doulas are non-medical paraprofessionals who provide continuous physical, emotional, and informational support to individuals prenatally, during labor, and postpartum. This includes providing childbirth and nutrition education, facilitating clients' self-advocacy and communication with providers, coaching during labor, lactation and other support postpartum, and referring clients to other needed resources. Community-based doulas are a specific subset of birth doulas who identify with and are members of the communities they serve, often communities which are underserved and experience systemic inequities, including Black, Indigenous, and other People of Color (BIPOC) communities; community-based doulas note that this provides them with a unique ability to connect with their clients and provide culturally relevant support.[6–9] Recent research from the University of Washington's Center for Health Workforce Studies (UW CHWS) also found that doulas identify aspects of their

work which can address perinatal inequities, including supporting their client's self-advocacy and decision-making skills and ensuring continuity of perinatal health care.[9] This aligns with findings from other studies, where doulas state that part of how they may impact perinatal health outcomes is through identifying and filling, where appropriate, critical gaps in health services.[4,9–11]

How doulas are trained

There are no formal requirements to become a doula. As of 2022, certification is not mandated for doulas to provide services, but it is required under some Medicaid and private insurance reimbursements.[12] Certification often requires additional training, including: the completion of reflection essays; physiology exams; reflections on attended births; evaluations from medical personnel or other birth attendants for those births; additional fees for training; and service hours or job shadowing.[11] Certification can take from three months to a year and cost thousands of dollars if a doula receives a mentor or shadows a professional doula on the job. The time doulas invest for certification is often unpaid. Some training/certification organizations oversee the certification, offering mentorship and support; however, most of the time the doula navigates the process independently.

Doula training organizations are crucial components in shaping doula care as they develop curricula, set national standards and certification criteria, aid in expanding reimbursement policies, and recruit doulas to work in underserved communities. Without national standards or accreditation for birth doulas, the topics covered in doula training and the length of that training vary widely. A recent study on doula organizations from UW CHWS found that doula training organizations fell into two main categories: commercial or mainstream and community based.[11] Commercial training organizations often focus on training doulas to work in hospital settings, emphasizing inter-professional communication and collaboration with hospital delivery teams. Training components covered everything from communication, pregnancy, and birth physiology, to how to be a birth doula and entrepreneurship and business skills. Training time commitments could range from weekend courses to more than three months, with options for certification.

Community-based organizations focus more on training doulas to address community needs, rather than preferencing location of training or certification. In some cases, community-based organizations provide specialized training to the doulas they hire or hire doulas who have completed other community-based training programs. Community-based organizations that train doulas, in addition to covering topics of childbirth, breastfeeding, and childbirth education, emphasize holistic approaches to birth and perinatal health , trauma-informed and culturally responsive care, and approaches to reducing gaps in health equity through doula services. Training from these organizations typically involves a larger time commitment and a more expansive curriculum to introduce future doulas to the added complexities of working with underserved communities. Experts have highlighted the role of doulas in advancing health equity in perinatal care and the importance of this expanded curriculum for all birth doulas.[4]

How doulas are employed and paid

Doulas in the U.S. have typically been private, independent paraprofessionals who work with individual clients who can afford to pay for their services out of pocket. Health insurance coverage has been limited, although several states are working to address this. Focusing on the wide range of mechanisms by which doulas can be employed and paid, UW CHWS' recent study found that some of these differences are due to whether the employer is a commercial or community-based organization.[11] Many employer organizations are hospital-based and employ their doulas through unpaid volunteer agreements or as independent contractors. Often among these organizations, there is a preference for hiring commercially trained and certified doulas for employment. Community-based doula employers place less of an emphasis on certification as a hiring qualification. Community-based organizations emphasize the importance of paying their doulas a living wage and often employ doulas through salaried or independent contract work. Achieving the goal of a livable wage can be a challenge, as

discussed below, given that many community-based doulas and community-based organizations serving these communities provide services on a sliding scale or free of charge to increase access, relying on grants or donations to fund their programs and services.[8] Doulas not employed by these organizations tend to be independently hired by clients.

DATA SOURCES PROVIDING INFORMATION ON THE DOULA WORKFORCE

There is no comprehensive public or private database available on the doula workforce in the US. Training and certification organizations may have available registries on segments of the doula workforce, but these are likely not representative samples, nor do they provide additional demographic or workforce information beyond name, location, and certification status. The doula workforce is not identifiable in common federal data sources used to estimate workforce size and describe the health workforce broadly such as the Census, American Community Survey[34], and Occupation Employment and Wage Statistics. These data sources use a Standard Occupation Code (SOC) to estimate those currently working as doulas. In the Bureau of Labor Statistics, doulas fall under the category of *39-9099. Personal Care and Service Workers, All Other* occupational code with butlers, house sitters, shoe shiners, and magnetic healers.[35] It is not possible to determine the number of doulas that fall under this SOC compared to the other occupations in this category. Doulas that work within community-based organizations may also fall under *21-1094.00 Community Health Workers*, but it is not possible to distinguish between doulas and other occupations that may fall under this category.[36]

There are no specific Classification of Instructional Programs (CIP) codes to estimate the number of those training to become doulas in the Integrated Post-Secondary Education Data System (IPEDS)[37], a mandatory reporting system for educational programs receiving federal funding for student financial aid programs. But even if available, doula training programs are not often associated with academic institutions that would report in IPEDS. There are no formal requirements that available doula training programs report the number of program completions to the Department of Education or other federal agencies.

WORKFORCE CHALLENGES INCLUDING THE EFFECT OF COVID-19

Much of the research on doulas focuses on the use of doulas as a type of health equity intervention and the influence of doula care on the health outcomes of their clients. We focused our literature review on the workforce challenges that individual doulas face as part of their work, finding that doulas often witness and/or experience discrimination while working with their clients in a variety of healthcare settings, meet resistance when working to collaborate with other health care providers, struggle with ineffective or inadequate payment models, and experience burnout.[9,13,14]

Lack of diversity in the field

While there are significant benefits to birth doula care during the perinatal period, studies have found that the rise of doula care has taken place primarily in White and middle-class communities, leading to a predominance of White doulas that reflect the communities that they serve.[5] Research has shown that there is growing attention towards increasing racial and ethnic diversity, particularly among Black and Latinx doulas.[5,7]

Stress and burnout

Recent research has found that community-based doulas often reported feeling stress and burnout from their work. A recent UW CHWS study found that doulas working with historically excluded and underserved populations often witness discrimination against their clients or experience discrimination themselves as a part of their work.[5,9] Another study found that doulas of color often feel alienated both from the healthcare system and from the mainstream birth doula community, further contributing to stress and burnout.[7]

Financial instability

Doulas have expressed frustration with wanting to provide services to everyone in their community that wants doula care, but being forced by financial constraints to make difficult service allocation decisions to earn a living wage.[9] Doulas also noted that they are often requested to provide their services *pro bono*. A UW CHWS study of doula organizations found that across organization types, doulas reported struggling to raise sufficient funds to run their programs, recruit and hire new doulas, and invest in already-employed doulas through wage increases, reimbursement for services, and professional development.[11] The organizations in the study relied on multiple, smaller, and irregular grants and local agreements with managed care organizations or took on private-pay clients to subsidize low-income clients. The patchwork of funding sources added an additional barrier to many organizations interviewed that sought to expand access to and utilization of birth doula services.[8] Other research highlights the issues with contractual arrangements, stating that a one-time flat fee often fails to appropriately compensate doulas and does not account for training and the additional support often provided due to gaps in the system, nor does it provide for health care benefits.[15]

Stresses from the COVID-19 pandemic

Recent research coming out from the COVID pandemic on doula care continues to center on how doulas have adapted to meet the needs of their clients, rather than the strains the doulas have faced as a result of the pandemic or how they are mitigating additional stressors.[16–19] One recent study highlights the difficulties in establishing trust with clients in a virtual environment as a result of the pandemic.[16] The findings from this study and another study by UW CHWS found that doulas experienced additional stressors from changing hospital policies, provider attitudes, and communication barriers and challenges with hospital providers during the pandemic.[9,16,20] Doulas encountered further challenges in providing services to their clients as many hospitals deemed them "non-essential" personnel during the pandemic and prohibited them from attending births in person.[21] The switch to virtual meetings and doula services also came with some opportunities that many doulas hope will continue, including: growing and sustaining interest in doula telehealth services, expanding access to doula training and education on topics related to health equity, and increasing diversity in the profession and client population.[16]

Despite these challenges, recent research has highlighted that doulas feel a calling to their work.[9] Methods individual doulas employ to overcome these challenges include developing partnerships, working to set boundaries, finding support and community among their peers.

POLICIES AND PROGRAMS TO EXPAND THE DOULA WORKFORCE IN THE U.S.

Policies to expand the doula workforce in the U.S. are generally emerging at the state level. There are several pieces of legislation proposed at the federal level to fund or incentivize doula services through Medicaid, as well as a number of federal grant programs that provide funding for training, employing, and compensating doulas to reduce perinatal health inequities.

Federal Insurance programs

Five bills were introduced at the federal level from 2019 and 2022 that include recommendations or requirements for state Medicaid program to cover doula services, including the Healthy MOMMIES Act[22] (introduced in May 2019), the Maternal CARE Act[23] (introduced April 2021), the MOMMIES Act[24] (introduced May 2021), the Helping MOMS Act[25] (introduced May 2021), and the Mamas First Act[26] (introduced April 2022).[27] The MOMMIES Act even includes a provision designating doula care as a mandatory health benefit. No further action has been taken on these bills by the U.S. House or Senate. In addition, TRICARE, a federally run insurance program of the Department of Defense, is rolling out a five-year pilot program to provide doulas and lactation support to those who use TRICARE at civilian facilities. The Department of Defense will cover up to six prenatal and postpartum doula visits

at $46 each visit in addition to support for labor and delivery, which is reimbursed at a rate of $690 and will be adjusted annually. The benefit may become permanent if there is sustained demand.[28]

Federal funding programs

In 2021, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) announced an initial $3 million in grant funding under the Healthy Start Initiative, with the aim of improving perinatal health outcomes and reducing racial and ethnic disparities in infant deaths and perinatal health outcomes by increasing access to community-based doula services.[29] In April 2022, HRSA announced the availability of an additional, supplemental $4.5 million through HRSA's Healthy Start Initiative for hiring, training, certifying, and compensating community-based doulas in areas with high rates of adverse maternal and infant health outcomes.[30] The supplemental funding aims to double the number of Healthy Start doula programs from 25 to 50 across the country.

State-level Medicaid and private insurance programs

To expand coverage for doula services, some organizations and policymakers have turned to public funding through Medicaid. The Doula Medicaid Project of the National Health Law Program is one of the only organizations that compiles active and proposed state and federal legislation on expanding access to doula services through Medicaid.[28] As of August 2022, six states are actively reimbursing doulas for their services under Medicaid: Florida, Maryland, Minnesota, New Jersey, Oregon, and Rhode Island.[12,28] Several other states have passed bills to reimburse doulas under Medicaid: California, Illinois, Indiana, Michigan, Nevada, Ohio, Virginia, and the District of Columbia. Even more states have proposed or passed legislation to do more research or scope potential options and reimbursement mechanisms relating to doula care, including Arizona, Connecticut, Georgia, Iowa, Louisiana, and Washington.

States that are actively reimbursing doula services under Medicaid are going about this in different ways. While Minnesota and Oregon have been covering doula services through Medicaid for the longest and tend to serve as the inspiration for legislation in other states, Oregon requires doulas to register as traditional health workers and Minnesota does not.[11,12] Minnesota currently covers up to six prenatal and postpartum visits at a rate of $47 per visit and a total rate of $488 for labor and delivery. Oregon currently reimburses doulas for two prenatal visits, two postpartum visits, and labor and delivery for a total rate of $350. New Jersey, on the other hand, reimburses for more visits (a total of 8) and a higher labor and delivery rate, which is more than Minnesota and Oregon combined (a total of $900 per birth). Florida does not have a state plan amendment in place, instead adding doulas as an extended benefit under Medicaid Managed Care. Doula reimbursement is negotiated with each plan ranging from a total of $800-$1,100 and credentialing is also determined by each plan. Often credentialing is delegated to the National Doula Network.[128] As of June 2022, Maryland has a state plan amendment in place. Doulas must be certified and have liability insurance to be reimbursed through Medicaid at a total reimbursement of $930, including the flat rate of $350 for labor and delivery, four prenatal visits, and four postpartum visits. In June 2022, Rhode Island also had a state plan amendment approved for their state Medicaid plan which reimburses trained and certified doulas for a total of $1,500 per client at three prenatal visits, three postpartum visits, and labor and delivery at $900.

Several states have implemented task forces and working groups to ensure that reimbursement rates and visit numbers adequately cover the needs of the Medicaid populations and doulas. California, Washington, DC, and

[1] The National Doula Network is an independent organization that works to credential doulas in six states (Florida, Iowa, Michigan, Nebraska, New Jersey, and New Mexico). The National Doula Network either contracts directly with Medicaid plans or assists states in pilot programs for doulas. Credentialing may require doula certifications, practice information, service area information, background screening, CPR and first aid certification, liability insurance, HIPAA training, and reference letters.[31]

Illinois are in discussions with stakeholders to implement services. California's benefits are set to begin in the summer of 2022 and DC's in the fall of 2022; Illinois does not yet have a set date. California, DC, and Illinois all plan to submit state plan amendments for approval as required by the Centers for Medicare & Medicaid Services (CMS). Rhode Island plans to require coverage of doula services through both Medicaid and private insurance, with the state plans covering three prenatal visits, three postpartum visits, and labor and delivery for a total reimbursement amount of $1,500.[12]

Medicaid policy and practice implications for doula reimbursement

A recent study found a fivefold increase in the number and variation of proposed state-level legislation related to doula care from 2015 to 2020.[32] Medicaid reimbursement can provide doulas with steady income and improve the affordability of doula care for low-income populations. Expanding Medicaid benefits to include doula services can help pregnant persons utilize otherwise unaffordable services while reducing costs on state and national levels. However, while an average of 43% of pregnancies in the U.S. are covered by Medicaid, with communities of color being disproportionately served by Medicaid, this study found that none of the policies had a clear focus on improving racial equity.[22] In addition, none guaranteed a living wage for doulas.[32]

As discussed above, states may apply for a Delivery System Reform Incentive Payment of Medicaid's Section 1115 waiver program, also known as a state plan amendment, to expand Medicaid benefits to cover doula care.[27] However, there are several limitations to consider. First, doulas may be limited on the number of visits they can bill to Medicaid and may receive a lower amount for the birth than they might receive from private-paying clients. Interviewees from studies exploring doula perspectives on Medicaid reimbursement as a solution explained that low reimbursements rates may lead independent doulas to turn down Medicaid clients, which is a fundamental concern for organizations and doulas who want to serve underserved populations that would benefit most from doula support.[8,11] Second, our recent UW CHWS study found that many community-based doulas and the organizations that employ them are wary of a reliance on Medicaid reimbursement as it could emphasize hospital care, moving attention, expertise, and funding away from perinatal services in local communities.[8] Third, this study, as well as another conducted by UW CHWS , found that seeking Medicaid reimbursement may trigger additional barriers, such as licensing or credentialing requirements as well as requirements that doulas complete commercial training.[8,11] In Oregon, for example, doulas must take a community health worker training that may cost as much as $800. Finally, some state Medicaid policies may require that doulas being paid by Medicaid either be licensed or provide care under the supervision of another licensed health care professional, which could be cost prohibitive in requiring doulas to undertake additional training or certification, or unappealing for doulas that want to remain on the periphery of the medical system.[12,27,28]

Suggestions for addressing some of these limitations include having state Medicaid programs enable the CMS Preventive Services Rule to allow for state coverage of non-licensed care providers, which would permit doulas to provide their services independently of medical providers.[27] In addition, there are opportunities for state and federal agencies to support awareness campaigns about the benefits of doula care, while promoting access to doula training in historically excluded and medically underserved communities. A 2013 study found that only 6% of birthing people in the U.S. received support from a doula during labor, while 27% indicated they would have liked to have one.[33] Finally, to ensure equitable policies for supporting and reimbursing doula services, policymakers should engage doulas in the policy development process.[8,13]

RESEARCH GAPS AND OPPORTUNITIES

- Improve data collection on characteristics of the doula workforce. Many doula workforce characteristics are unknown, including their number, distribution, demographics, information on training, wages, employment types, job satisfaction and turnover, and workforce well-being. A regular national survey

focused on the doula workforce is one approach to identifying ways to monitor the size, distribution, and diversity of the doula workforce and equitably supporting continued growth of this field.

- Research approaches to support and strengthen the doula workforce. Research could further explore doula perspectives on what is needed to expand services and provide equitable access to all communities, including areas such as ongoing professional development, identified skills and competencies, and strategies to address worker well-being. This research could inform approaches to addressing concerns such as stress and burnout and supporting workforce development. In addition, research is needed which examines associations between doula workforce outcomes, quality of services, and health outcomes.
- Identify opportunities for doula collaboration and coalition-building. Current research notes the stresses that doulas experience are partially due to experiencing isolation in the field.[7,9] Strategies are needed that facilitate collaboration and connections across the field to reduce this isolation. Supporting coalition-building can also offer opportunities for doulas to create a shared platform for advocacy.
- Research programs to diversify the doula workforce. As policies are developed to increase access to services, parallel attention needs to be given to ensuring there is equitable expansion of the doula workforce, with greater representation from BIPOC doulas as well as doulas who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex or Asexual (LGBTQIA).
- Encourage doula participation in all policymaking processes affecting the doula workforce. Some states have deliberately engaged with a diverse stakeholder group of doulas and doula organizations as they have drafted policies, including Washington, California, and Rhode Island, to improve Medicaid reimbursement rates and address racial health disparities.[13,38,39] Engaging doulas regularly in state-level policymaking processes, highlighting the evidence on the strengths of the community-based doula model, and incorporating perspectives of community-based doulas and organizations may strengthen state-level policies aiming to improve racial health equity.[32]

CONCLUSION

Recent literature focused on the doula workforce has been limited. The literature which does exist highlights the challenges that doulas face in their work, such as financial instability and discrimination, as well as emphasizes their commitment to the job. In many cases, these challenges were exacerbated by the COVID-19 pandemic and shifting policies in birthing facilities that made it more difficult for doulas to provide services in person. Data adequate to describe the size, distribution, and characteristics of the doula workforce in the U.S. is not currently available. Federal- and state-level legislation has been and continues to be developed which focuses on providing funding and support for expanding the doula workforce as well as reimbursing doula services mainly through state Medicaid plans. Research is needed which seeks to better understand doula workforce characteristics and workforce outcomes, as well as what strategies are effective in supporting this critical part of the perinatal workforce to ensure their continued growth and ability to provide services.

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