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"Doulas shouldn't be considered visitors, we should be considered a part of [the] team": doula care in Georgia, USA during the COVID-19 pandemic

Daria Turner,[a] Alyssa Lindsey,[b] Priya Shah,[c] Ayeesha Sayyad,[d,e] Amber Mack,[f] Whitney S. Rice,[g] Elizabeth A. Mosley [h,i]

a Master of Public Health Student, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

b Master of Public Health Student and Graduate Research Assistant, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

c Master of Public Health Student, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

d Master of Public Health Student, Georgia State University School of Public Health, Atlanta, GA, USA

e Graduate Research Assistant, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

f Research and Policy Analyst, Healthy Mothers, Healthy Babies Coalition of Georgia, Atlanta, GA, USA

g Assistant Professor, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

h Affiliate Faculty Member, Center for Reproductive Health Research in the Southeast (RISE), Emory University Rollins School of Public Health, Atlanta, GA, USA

i Assistant Professor, Center for Innovative Research on Gender Health Equity (CONVERGE), University of Pittsburgh, Pittsburgh, PA, USA. *Correspondence:* eamosle@emory.edu, eam241@pitt.edu

Abstract: *Doula support improves maternal-child health outcomes. However, during the COVID-19 pandemic, hospitals restricted the number of support people allowed during childbirth. An academic-community research team conducted 17 in-depth interviews and structured surveys with doulas in metro-Atlanta, Georgia, USA from November 2020 to January 2021. Surveys were analysed for descriptive statistics in Stata v. 14, and interviews were analysed in Dedoose using a codebook and memo-ing for thematic analysis. All 17 doulas reported COVID-19 changed their practices: most were unable to accompany clients to delivery (14), started using personal protective equipment (13), used virtual services (12), and had to limit the number of in-person prenatal/postpartum visits (11). Several attended more home births (6) because birthing people were afraid to have their babies in the hospital. Some stopped seeing clients altogether due to safety concerns (2). Many lost clientele who could no longer afford doula services, and some offered* pro bono *services. Most doulas pointed to restrictive hospital policies that excluded doulas and disallowed virtual support as they felt doulas should be considered a part of the team and clients should not be forced to decide between having their doula or their partner in the room. COVID-19 has severely impacted access to and provision of doula care, mostly due to economic hardship for clients and restrictive hospital policies. At the same time, doulas and their clients have been resourceful – using virtual technology, innovative payment models, and home births.* DOI: 10.1080/26410397.2022.2133351

Keywords: doula, pregnancy, childbirth, COVID-19, pandemic

Introduction and objectives

Doulas are non-medical, trained professionals that provide continuous support (informational, emotional, physical) during pregnancy, labour and childbirth, and postpartum.[1–5] Doula support is associated with improved maternal-child health outcomes including better birthing experiences, less likelihood of induction or augmentation with synthetic oxytocin, shorter length of labour, higher rates of vaginal births, lower rates of Cesarean delivery, lower use of pain medication, higher Apgar scores, reduced postpartum depression, and increased breastfeeding.[1–4,6–12] For all pregnant people – but especially those who have experienced trauma or are living with post-traumatic stress symptoms – trauma-informed doula care can also reduce the risk of birth trauma or re-traumatisation during birth.[10,13,14]

Doulas can also "disrupt" the social determinants of health that predispose low-income women and women of colour to worse pregnancy-related outcomes.[15] They do this by providing health education at appropriate literacy levels, offering social support and connection to resources, respecting the client, upholding their autonomy and agency, enhancing communication between clients and medical providers,[11,16] and resisting racism (including provider implicit bias) in the healthcare system.[15,17] Doula support is particularly important in settings like Georgia, USA, with high rates of and wide racial/ethnic and economic disparities within maternal and infant mortality and morbidity.[18–20] In Georgia, Black women are three times as likely to die from pregnancy-related causes as White women, and Black infants are twice as likely to die in their first year as White infants.[19,20] Researchers have further demonstrated that higher levels of income inequality exacerbate racial/ethnic disparities by worsening pregnancy-related outcomes among Black women.[21] Georgia's high levels of income inequality,[22] therefore, suggest additional need for doula services, particularly for Black and low-income people.

Despite overwhelming evidence about the benefits of doula support, doulas have been barred from many hospitals during the COVID-19 pandemic.[5,17,23–27] Early on during COVID-19, hospitals implemented policies limiting the number of visitors birthing patients were allowed to have in the labour and delivery room.[5,17,23–27] Nearly all hospitals counted doulas as visitors rather than as part of the healthcare team.[5,17,23–27] Emergent research has examined doula care during the COVID-19 pandemic,[5,17,23–27] yet many questions remain. The current study builds on this existing literature and explores: changes in doula care during the COVID-19 pandemic, challenges faced, and solutions for improving doula care access during the pandemic and beyond.

Methods

This study was conceptualised, implemented, and overseen by the Georgia Doula Access Working Group led by the Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA) with representation from doulas, hospital administrators, clinicians, insurance payers, and policymakers. Such an approach ensured doula and relevant stakeholder engagement during the generation of research questions, study instruments, and conclusions from the results.

Study design, setting, and participants

To achieve our study objectives, we conducted a cross-sectional, observational study using concurrent mixed methods (qualitative and quantitative) to survey and conduct in-depth interviews with doulas ($n = 17$) in metro-Atlanta, Georgia. All study procedures were reviewed and approved by the Emory Institutional Review Board (IRB) with exempt status on July 10, 2020 because the human subjects' identities are not easily ascertained and any disclosures would not place the subjects at risk of damages [see rule 45 CFR 46.104(d)(2i((2ii))]. Our research team included two Faculty Researchers (one is a White full spectrum doula, the other is a Black mother), a Lead Graduate Student Researcher (who is a Black woman) three Graduate Student Research Assistants (one is a South Asian-American woman, one is a Black woman, and one is a Latinx-Asian/Pacific Islander woman), and a Community Partner (who is a Black woman) from the community-based organisation, HMHBGA. Collectively, the team represents diverse perspectives from Black women and mothers, doulas, and community organisations serving families in Georgia, each with our own positionality. Research team members received training in qualitative data collection, qualitative analysis, reflexivity, community-engaged research, and reproductive justice. After each interview and in group meetings, the

researchers were prompted to reflect on how their own identities (of marginalisation or privilege) affect their approach to this work, the data collected, and their interpretations of the data.

Doulas were recruited to the study between November 2020 and January 2021 through emails to the Georgia Doula Access Working Group, a statewide steering committee consisting of doulas, doula-trainers, community-based maternal and child health organisations, reproductive justice organisations, policy advocates, researchers, healthcare administrators, insurance payors, and clinicians. Doula members of the working group were encouraged to participate, and all members were encouraged to share the study opportunity with doulas in their network. Eligibility criteria included self-identification as a doula, experience practising as a doula in Georgia for at least 6 months, English speaking, and over 18 years of age. Study participants were also asked to share study information with other doulas within their networks. Participants were compensated with a US$20 gift card. Our original planned sample size was 20 participants. We concluded interviews and surveys after we reached thematic saturation of our qualitative data at 17 participants.

Data collection

We enrolled the 17 doulas who expressed interest in the study, after they were deemed eligible by the screening tool and verbal consent. From October 2020 to February 2021, the survey data collection was conducted using Qualtrics and took less than 30 minutes to complete (see Appendix A for the full list of survey items). The link was emailed to participants prior to their in-depth interview. The survey included sections on: doula demographics, personal experiences with pregnancy and doula care, doula training, client demographics, payment and costing, scope of doula work, building doula businesses, and beliefs about doula services. No identifying information was collected, and all names were replaced by anonymous participant ID numbers.

Survey measures

The survey first measured demographics. Participants were asked about their gender, age, economic status, highest level of education, current employment, sexual orientation, and immigration status. Immigration status was then categorised into not an immigrant (self, parents, and grandparents born in the US), first-generation immigrant (born in U.S. but not parents or grandparents), or second-generation immigrant (self and one/more parents born in the U.S. but not grandparents). The survey also measured changes in doula practices during COVID-19. D Doulas were asked if they provided virtual doula services ever and if they provided doula services during COVID-19. We also asked "How do you connect with your clients virtually?" Finally, we asked "What platforms do you use for video calls?" Notably, we protected confidentiality by not reporting categories with a single, identifiable respondent.

In-depth interview domains

After the survey, participants were scheduled for a one-hour, in-depth interview over Zoom with the Lead Graduate Student Researcher. The interview guide included sections on: doula training, clientele, payment methods, building doula businesses, barriers and challenges to providing care, experiences as doulas, and ways to improve doula care (See Appendix B for Interview Guide). All interviews were audio recorded and transcribed by Zoom with quality assurance from the Lead Graduate Study Researcher and the two Graduate Student Research Assistants. All identifying names were redacted and/or replaced with a pseudonym.

Data analysis

Data analysis occurred from February 2021 to April 2021. The surveys were analysed using descriptive statistics in Microsoft Excel and Stata v. 14.[12] Frequencies and proportions were calculated as all variables were categorical. The in-depth interviews were thematically analysed using Dedoose.[13] Transcripts were carefully reviewed, then the researchers wrote an interview memo for each summarising the main content and why the interview is important for the study and 10 emerging topics of interest. The comprehensive list of emerging topics was used to create a comprehensive codebook. This included deductive and inductive codes about training, doula scope of work, increasing awareness about doulas, building doula businesses, underserved populations, payment, challenges, client stories, benefits of doula care, medical outcomes, ways to improve doula care, and COVID-19. In Dedoose, the Lead Graduate Student Researcher and two Graduate Research Assistants then horizontally coded all 17 transcripts using the codebook. Two coders were assigned to individually code each

transcript; the two coders then came together to discuss and reconcile their coding to ensure consistency across transcripts and full use of the codebook. The group then developed analytic memos for each code in order to develop themes within and across codes. This process was supported by additional analyses within Dedoose including code co-occurrence and coverage across transcripts. The Lead Graduate Student Researcher and Graduate Student Researchers met biweekly with one of the Research Mentors for training in qualitative analysis, quality assurance of coding, and ongoing discussion about emerging themes.

Results

We interviewed and surveyed a diverse sample of 17 female doulas (see Table 1). About half were White (53%) and 42% were Black. Over half of participants (59%) never experienced economic difficulty, and 41% experienced difficulty in the past or currently. About half of the doulas graduated from college (47%), with about one-quarter (24%) having an advanced degree and 29% having less than a college degree. Most of the doulas were heterosexual (88%) and 12% identified as lesbian or bisexual. Similarly, most did not identify as immigrants (88%) and 12% were first-generation immigrants.

There was a wide range of experience among the doulas (see Table 2) with 12% practicing less than one year and 35% practicing more than nine years. There was also a wide range in the types of doulas: most practice birth doula services (82%), about half practice postpartum care (53%), and another 41% practice prenatal care. Some doulas also offer less traditional services including preconception doula care (29%), abortion (24%) or full spectrum (29%) care, and death support (12%). Some doulas self-identified as radical justice doulas, which Imani – a Black full spectrum and radical doula – described as:

"*To me a radical justice doula is basically an advocate … Me being a black doula … I am specific to making sure that I am advocating and I'm you know staying up to date on legislation and politics and how that all effects access to having a doula and the level of concern that your elected officials have for the fact that mothers, especially Black mothers are dying or Black people are dying when they're giving birth … the advocacy is a part of being a doula and the justice part of it.*"

Table 1. Demographics of the doula sample ($n = 17$) in Georgia.

Variable	Frequency	Percent
Female[a]	17	100
Race/Ethnicity[a]		
White	9	53
Black	7	41
Hispanic/Latinx	1	6
Age		
25–35	7	41
36–45	6	35
46+	4	24
Economic status[a]		
Prefer not to say/Currently experiencing economic difficulty	2	12
Experienced economic difficulty in the past/temporarily in the past/historically	5	29
Never experienced economic difficulty	10	59
Education[a]		
Technical degree/non-clinical professional degree	2	12
Some college	3	18
Graduated college	8	47
Clinical professional degree	2	12
Graduate degree	2	12
Employment[a]		
Yes, full-time	10	49
Yes, part-time	3	18
No, not looking for employment	3	18
No, looking for employment	1	6
Sexuality[a]		
Straight/heterosexual	15	88
Bisexual/Lesbian	2	12
Immigration status		
Not an immigrant	15	88
First generation immigrant	2	12

[a]Response categories were "check all that apply".

Our qualitative data about doula care during COVID-19 revealed five major themes, which we detail below: (1) loss of clientele during COVID-19, (2) restrictive hospital policies, (3) increasing home births during COVID-19, (4) prenatal and postpartum doula innovations, and (5) the challenges of virtual labour and delivery support.

Loss of clientele during COVID-19

Doulas reported that due to the pandemic changes in potential clients' financial situations (e.g. job loss), they either lost clients or were unable to recruit new clients. Financial hardships caused by the pandemic greatly limited doulas' client base, which in turn negatively impacted doulas' financial stability. Some doulas, including Imani, shared how they would provide *pro bono* services for clients who couldn't afford services:

"*And then the other issue is just people not being able, like I had about three contracts that had to cancel because they, you know, we're now on unemployment and they couldn't justify you know the cost … So of course offering I'm not going to leave you hanging out there, as we've already started. So let's just finish it, and we'll do [it] for free.*"

Another major contributing factor to doulas' loss of clientele was hospital policies that limited the number of support people allowed in the delivery room. Potential clients did not see the value in hiring a doula if their doula could not be in the delivery room with them. Jasmine, a Black full spectrum doula explained,

"*A lot of people like, What's the point if I can't have you with me. They only see doulas as one way and that way has been taken away. We don't have that way anymore. And so they are starting to feel like, what's the point? What's the point if you can't be in a hospital with me? What's the point if you, if I can't do this, that, and the third?*"

Restrictive hospital policies

Overall, doulas reported that restrictive hospital protocols were one of the biggest barriers to providing care, and the restrictive hospital policies further drove a wedge between doulas and the medical community. Two of the most common policies were (1) limitations on the number of people allowed in the delivery room and (2) requiring proof of doula certification. Clients delivering at hospitals that restricted the number of support people had to make tough decisions about whether they would have their doula or their partner with them during their birth. Susan, a White full spectrum doula, and Andrea, a Black birth and postpartum doula, shared similar "sad" and "heartbreaking" stories:

"*I had one client who chose to, because they have two-year-old and they wanted to have somebody advocate, they chose to have me instead of her husband at her delivery, which was really sad.*" (Susan)

"*Parents having to decide on if it's going to be their doula or their partner in the room because a lot of the hospitals are saying, you know, you can have either or. You can't have both. You have to have either or. So, that's been a challenge within itself because, you know, it breaks a lot of parent's hearts, because of course they want their partner to be there. So, that's kind of discouraging.*" (Andrea)

According to our participants, these policies add an extra layer of stress on the birthing process. Doulas explained that the policies ignore differences in the types of support provided by a doula versus a lay support person during labour and delivery. Multiple participants pointed out that a typical lay support person does not have expertise about supporting people during labour and delivery.

In response to these restrictive hospital policies some birthing people chose to switch to providers who work at hospitals or birthing centres that allow multiple support people. Mira, a White prenatal, birth, abortion, and death doula said, "*I've had a lot of people just leave their practices and go to a hospital or practice that is allowing in-doula support or opting for home birth.*" If families wanted a hospital birth and their doula present, they had limited options.

Prenatal and postpartum doula innovations

While COVID-19 hospital restrictions limited in-person doula services, some doulas were able to expand their businesses through virtual services and/or extending prenatal and postpartum services. Twelve (71%) doulas in the study offered virtual services during the pandemic (see Table 2). The two most popular virtual platforms were Zoom and Facetime. The prenatal educational and birth planning components of doulas services were relatively easy to adapt to the virtual world. Andrea explained how she adapted to virtual care,

Table 2. Doula characteristics and practice changes during COVID-19.

Variable	Frequency	Percent
Time as Doula		
Less than 1 year	2	12
1–3 years	6	35
More than 3 and up to 9 years	3	18
More than 9 years	6	35
Type of Doula[a]		
Preconception/Fertility	5	29
Prenatal	7	41
Birth	14	82
Postpartum	9	53
Abortion	4	24
Full Spectrum	5	29
Radical/Justice	1	6
Death	2	12
Demographics of Clientele		
Average % of clients who are Black	–	42
Average % of clients who are White	–	45
Average % of clients who are Latinx	–	3
Average % of clients who are Mixed	–	5
Average % of clients who are low to low-middle income	–	27
Average % of clients who are middle income	–	41
Average % of clients who are upper-middle to upper income	–	28
COVID Changed Practice[a]	17	100
Stopped Seeing Clients	2	12
Unable to Accompany to Delivery	14	82
Limited Number of Prenatal/Postpartum Visits	11	65
Increase in Home Births	6	35
Used Personal Protective Equipment	13	76
Provided Virtual Services Ever	12	71
Virtual Services During COVID[a]	12	71
Zoom	9	82
Facetime	8	73
Google	3	27
Messenger	1	9
Skype	1	9

[a]Response categories were “check all that apply”.

"*Basically, I offer the same services that I would for in-person. So, instead of two prenatal visits, I would actually do one prenatal visit and I try to get it done with the partner as well … I do like weekly check ins with them. So, it's either via FaceTime or Zoom or Skype. I'm just checking in to see how they're doing, or I'll even text them just to kind of see like, you know, 'have you had your water for the day, or for the week, or how are you feeling, you know, just dropping into check on you.' Once the baby has actually arrived, a week later I'll hold another session either Skype or Zoom or FaceTime, just to kind of see how things are going and if additional resources are needed for the parents since they're at home now.*"

Physical touch is a key component of comfort measures during labour and delivery, so doulas had to find creative ways to train their client's support person on providing physical support such as massage, squeezing hips, and heat/ice. Some doulas, like Mary (a White birth and postpartum doula), started to offer virtual classes for support people who would be at the hospital with their client. She shared,

"*Learn, you know how to do virtual meetings, how to also provide more training virtually for what is essentially a hands-on job to the birthing partner. I have been training birthing partners essentially to do some of the services I provide as a doula so I've had to figure out how do I train birthing partners and provide information to them so they can be not only the birthing partner, but also the doula you know in these hospitals that aren't allowing another support person.*"

Of course, there were limitations in how well the virtual trainings translated to actual birth support. Imani explained:

"*I don't know how comfortable their support person really is with doing it. I can't see if they're really doing it right and hitting the right point.*"

Doulas like Andrea also mentioned that due to the unpredictable and stressful nature of birth, those trainings may not be enough:

"*And a lot of the parents, you know, they don't know what to expect or what to do because it's like we go through all of this training, but when the laboring starts, all of that kind of goes out of the window*." (Andrea)

Because they were losing clientele and not allowed in most hospitals during the pandemic, some doulas began offering postpartum services. They emphasised that their support was needed even more during COVID-19, when family members weren't able to assist their clients. Mary described how she started postpartum care, filling in for family members who could not be there:

"*2020 is when I began offering postpartum doula services … supporting a family once a baby is home and so that could look like so many different things. I'm cooking for the family, cleaning the home, I'm helping with bathing the baby, feeding the baby … while the mother takes a nap. I could help with the older children. I could come in and do their laundry, run errands for them. Basically like the best grandmother, aunt, doula, friend wrapped into one. As far as those you know sometimes you can have a really great mother or grandmother, but maybe they don't have some of the knowledge or training, you know, as far as like breastfeeding goes … these days of families being very spread apart, not being able to be together, international families, my three of my four postpartum families, they were not born in the United States. And so, they were not able to have their immediate family travel to the United States because of COVID so I was able to come in and you know assist them in ways that maybe their mother or grandmother would have been able to come in and do that kind of care for them.*"

The challenges of virtual labour and delivery support

Given the importance of evidence-based doula care and the limitations of training alternative support people, some doulas also began offering virtual labour and delivery support. When a client arrives at the hospital, the doula connects with the client and their support person virtually via phone or video. However, many hospitals were resistant to having doulas on the phone during labour and delivery. Imani recounted this story, where she was not allowed to provide virtual care to her client:

"*I had an issue where my client, they told her to turn off the phone on her support person … They would not allow me to support her through the pushing phase and they said, we can't video record. They're like, oh, we're not recording this is our doula via FaceTime. They were like no, you have to shut off the phone off sir, please turn off the phone. And I'm like, wait what, so I'm like, go ahead and*

turn it off, it's fine. I don't want you to just miss anything that's not but just, you know, call me when it's over. He called me when it was over and they still asked them to turn off the phone. No, no real reason or logic behind it, or policy that I could find, but they just wouldn't allow me to support my client during this most trying sometimes part of the labor process."

Doulas described how this situation and restrictive hospital policies demonstrate the divide between healthcare providers and doulas. Participants explained that providers' and administrators' misconceptions and lack of awareness about doulas leads them to believe that doulas are neither essential, nor part of the care team. Susan asserted,

"*The hardest part has been a lot of hospitals shutting down and even though I guess it's the AWHONN [Association of Women's Health, Obstetric and Neonatal Nurses] had written that letter stating that … doulas shouldn't be considered visitors, we should be considered part of the care team.*"

Increasing home births during COVID-19

Due to hospital restrictions and fears about being in the hospital during a pandemic, birthing people are opting more for home births. Six doulas (35%) reported an increase in the number of home births they supported during the pandemic (Table 2). One doula, Denise (a Black prenatal and birth doula) mentioned that the midwives she normally refers clients to for home births were fully booked,

"*Um, I have been referring couples to more home birth midwives. And a few of the home birth midwives that I know have never been full for a whole year. Like I had a home birth midwife in April, she was book for the whole year and that's never happened before.*"

Doulas explained that while home births are an option to avoid hospitals during the pandemic, they may not be accessible to some birthing people because they are expensive and not normally covered by insurance in Georgia. One doula, Jasmine, described some concerning methods families were using to avoid the high financial costs associated with home births including unassisted births:

"*And so what I have actually been noticing is a lot of women are choosing unassisted home birth. So they don't they can't afford a midwife, so they opt out of having a midwife to have a doula there and of course we don't work in the capacity as a midwife.*"

These scenarios put doulas (and birthing people) in compromising and high-risk positions. With such clients, Jasmine always makes it clear that she is not a medical professional and that she is not able to deliver their baby. She also educates these families about the importance of having medical assistance during birth, but she is scared and frustrated that this is their only option:

"*I know the reasons they're choosing to do it, they're choosing to do because they're afraid to have to be they're afraid to have their babies in the hospital and they're afraid to be in the hospital with no one there to advocate for them, but they cannot afford a midwife. They can't afford $3000 $4,000 to have someone come to their home. So they're choosing the less costly option for them. And that scares me because that shouldn't be why, you shouldn't choose to have this birth because you just can't afford to do it any other way. You should be choosing it because that's what you vision for your birth.*"

Discussion

The current study discusses one aspect of a community-engaged, mixed methods investigation of doula care in Georgia during the COVID-19 pandemic. The research team, including a community partner from HMHBGA and a doula from the Georgia Doula Access Working Group, surveyed and interviewed 17 doulas from metro-Atlanta, Georgia about the scope of doula work, barriers and challenges of building doula business, benefits of doula care, and COVID-19. Notably, the findings and implications of this study must be considered in the context of its limitations. This study reflects the experiences of a relatively small purposive sample of doulas in metro-Atlanta, which means the results are not meant to be generally representative (e.g. to the entire country, to rural areas, to the perspectives of doula clients) nor do they prove causation.

COVID-19 dramatically changed the landscape of doula care and forced doulas and their clients to innovate in new ways. During the pandemic, doulas have experienced a significant loss of clientele – either because of their own fears about COVID-19, clients' financial hardships, or restrictive hospital policies that force birthing people to choose only one labour support person.[17,23,28–31] In response, doulas in our sample and from other studies have

innovated with virtual prenatal services, virtual labour support (where possible), training the client's support person in basic birthing techniques, shifting to home births, and expanding to postpartum services. Through this adaptive support, doulas are working to mitigate the harmful effects of COVID-19 on pregnancy, birth, and early parenting, particularly for their clients of colour and low-income clients most affected by COVID-19 and its economic consequences.

Yet our study and several others[17,23,28–31] have also documented restrictive hospital policies and protocols during COVID-19 that limit the number of birthing support people to the exclusion of doulas and detriment of patients. At the beginning of the pandemic, some areas – most notably New York City – forbade any support person to enter the labour and delivery room during childbirth, leaving birthing patients isolated and scared.[28] Luckily these prohibitive policies were relaxed over the course of the pandemic, and most hospitals began allowing one support person to attend a birth. Of course, this forced birthing patients to choose between their support person (e.g. partner, mother) and their doula. Such policies ignore the vast health benefits of doulas,[8,32] which have been identified as the "essential ingredient"[33] for significantly improved birth outcomes above and beyond the psychological benefits of having a lay support companion such as a male partner – and the particular importance of doula care during a pandemic.

Further, these policies delineate doulas as outside of the maternity care team, despite widespread evidence and calls to integrate doulas as essential maternity care team members from the American College of Obstetrics and Gynecology (ACOG) and others.[34] Similar exclusion of doulas from the maternity care team has been extensively documented in the literature, even prior to COVID-19.[11,16,35–37] Restrictive policies during COVID-19 seem to exacerbate pre-existing tensions between doulas and clinical care team members (e.g. doctors, nurses), who already misunderstand the role and value of doulas.[4,35,38] Researchers have previously explained how doulas approach pregnancy and childbirth in a holistic way that can conflict with the medical model of birth, particularly in hospitals.[36–40] In fact, our finding that hospitals were requiring doulas to have certification in order to attend births during COVID is part of a larger trend toward the professionalisation (and opponents would argue medicalisation) of doulas. While doula certifying bodies seek to standardise doula training and the scope of work, critics note that mainstream certification trainings and procedures are not culturally sensitive. Traditional, holistic doulas serving low-income communities of colour are less likely to access certification and therefore more likely to be excluded by hospital policies requiring certification. Regardless of certification status, doulas are lower in the social hierarchy within medical settings, meaning they have less power than clinicians and must, therefore, carefully navigate their interprofessional relationships so as to be allowed to remain in the birthing space.[36] This doula exclusion is particularly troubling for Black, Latinx, and other birthing people of colour who experience racism, obstetric violence,[41] poor birth outcomes, and maternal mortality at higher rates than White women, and who stand to benefit more from doula support.[15,17,29] Moving forward, hospital policies need to identify doulas as essential maternity care team members, who are allowed full access to their clients while at the hospital.[29] Reparative work will be needed to establish healthy working relationships between doulas and clinical care providers, in order to provide patient-centred, integrative and high-quality care.

The observed shift in doula work to virtual services during the pandemic echoes previous findings from studies here in the U.S and globally.[23,28–30] In Rivera's[23] study on Black and Latinx community-based doulas in Central New York, she found that doulas began offering Zoom virtual childbirth classes, and some still provided virtual labour and delivery support. Other studies have documented doulas' attempts (and challenges) providing postpartum support such as lactation counselling.[30] Yet there are major barriers to providing adequate virtual doula support including hospital policies against the use of video equipment, inequitable doula and client access to technology, and the need for additional doula training in virtual care provision.[23,29] Ogunwole and colleagues[29] explain that while hospital-based and institutionally-funded doula programs have the infrastructure and resources to provide virtual doula services, community-based doulas and organisations (who are more likely to serve low-income and pregnant people of colour) struggled to transition to virtual services. This study and others observed that even when doulas had the capacity to provide virtual services, medical staff created barriers to them holding space

with their clients by physically shutting down computers or preventing the use of other devices during labour.[5,26] Moreover, doulas themselves have emphasised their discomfort switching to virtual services because "*touch is so important*" and integral to doula care.[30(p.5)]

Increasing demand for home births during COVID-19 has contributed to and possibly accelerated the shift in birth location away from hospitals and toward birth centres and home birth. Since 2004, the percentage of planned midwife-assisted home births in the U.S. has steadily increased by 85% from 0.9% in 2004 to 1.61% in 2017,[42] and maternity care leaders – including the American College of Obstetrics and Gynecology – have acknowledged that midwife-attended home birth is a safe option for low-risk pregnancies.[43] Granted, those organisations firmly maintain that hospitals are the safest location for birth during the COVID-19 pandemic.[43] However, like the current study, other birth research during the COVID-19 pandemic documented similar increases in the demand for and use of home birth. Searcy and Castañeda found that, globally, doulas saw an increase in requests for home birth support since the beginning of COVID-19.[26] Davis-Floyd and colleagues[28] documented an increased interest in home birth during COVID-19 using their rapid-assessment in the U.S. from March-April 2020. Reyes[31] also noted a surge in homebirths during her study of birth workers in Puerto Rico during quarantine, as did Oparah and colleagues[30] in their virtual community-based study of Black birth workers during COVID-19. Rivera[23] similarly noted greater use of home births in New York during COVID-19, but emphasised barriers to skilled birth attendance, including a dearth of midwives who attend home births. In our study, we heard from one doula about community-based doulas who are being expected by their clients to attend births alone without a midwife – so-called "freebirth."[28] This is because clients are afraid to birth at the hospital, because of COVID and/or being alone without an advocate, yet they cannot afford at-home midwifery care. Other researchers have similarly reported an increase in freebirths during COVID due to financial constraints and fears of birthing in the hospital, as reported by doulas, midwives, and obstetricians. Prior to the pandemic, some people chose freebirth intentionally, but now COVID and economic insecurity appear to be driving people to this decision.[28]

COVID-19 lays bare the fragmented and often racist maternity care system here in the U.S., and the exclusion of doulas from hospital-based maternal health care teams is only one example of systemic care fragmentation and racism.[17,28–30] Other research has already indicated the concern doulas feel about hospital policies regarding doulas as visitors extending beyond the pandemic, and what it means for the maternal outcomes, particularly of marginalised mothers.[24,26,27] Overwhelming evidence shows how Black, Latinx, and Indigenous women experience obstetric racism during hospitalised births,[41,44,45] and doula care is one of few practices shown to mitigate that racism and violence.[15,17,29] As Davis describes it, obstetric racism "lies at the intersection of obstetric violence and medical racism".[46,47(p. 561)] It is systemic violence by physicians, nurses, and other medical professionals (through policies, within institutions, and interpersonally) against people of colour with regard to their reproductive capacities. For example, Black women are finding their concerns about pregnancy complications are not being taken seriously and are then being blamed for resulting negative birth outcomes.[47] Obstetric racism is rooted in gendered, racialised ideologies such as stratified reproduction (valuing the reproduction of White and affluent communities over non-White and non-affluent communities),[48] stereotypes of Black patients (e.g. non-compliant), and dehumanisation of Black bodies (e.g. beliefs they are less sensitive to pain).[46,47] Given their role as patient advocates – tasked to support pregnant, birthing, and postpartum patients' autonomy – doulas are well-poised to disrupt and prevent obstetric racism.[15,47] In their research with low-income women of colour, Kozhimannil and colleagues[15] have previously described how doulas interrupt negative social determinants of health by supporting agency, personal security, respect, knowledge, and connectedness. In turn, the exclusion of doulas from hospitals may enable obstetric racism and maintain or exacerbate current racial/ethnic inequities in maternal and child health outcomes.

Implications

Used to being adaptive and resourceful, many doulas can offer prenatal and postpartum services virtually, but for some doulas and clients this is not ideal. Working virtually prevents doulas from attending prenatal visits as they often do otherwise, which eliminates opportunities for the doula and maternity care team to become familiar, establish roles, and work together as an

integrative care team. If virtual services continue to be desired by clients, doulas will need to be trained and supported on various technology platforms. As Rivera reported, Syracuse-based reproductive justice organisation Village Birth International is providing trainings to community-based doulas on virtual technology for doula care,[23] and other organisations could follow suit.

The policy implications of this study are multifold. They include (1) state-level reimbursement for doula care among low-income women; (2) hospital-level policies that recognise doulas as essential members of the maternity care team; and (3) organisational support for doulas. State-level reimbursement for doula care, either through Medicaid or community health worker programs, would ensure the most vulnerable and economically disadvantaged women have access to this life-saving service.[49,50] At the hospital level, administrators and clinicians should be educated and mobilised on the importance and value of doula care so they can enact policies that integrate and respect doulas. And professional organisations such as the American College of Obstetricians and Gynecologists as well as the American College of Nurse-Midwives should make clear position statements that support integration of doulas as essential members of the maternity care team, particularly during the COVID-19 pandemic.

Moreover, doulas need to be supported to continue their "advocacy" and "justice" doula work, even during COVID-19. In order to address racism in maternity care and racial disparities in maternal and infant outcomes, some doulas – particularly community-based doulas; Black, Latinx, and Indigenous doulas; LGBTQ doulas; and self-identified "radical doulas" – ground their work in the birth justice movement, which aims to "dismantle inequalities of race, class, gender, and sexuality that lead to negative birth experiences,"[30(p. 2),45] and the larger reproductive justice movement.[17,23,29,30,51–54] During the COVID-19 pandemic and post-pandemic aftermath, birth and reproductive justice doulas from marginalised communities are more needed than ever before, particularly given the evidence that doula advocates often drive policy change.[55]

The current study highlights important lessons and potential opportunities for future research. In the realm of maternal and child health during COVID-19, research needs to be community-engaged, where those most affected have an equal voice from beginning (conceptualisation) to end (dissemination). Future studies need to develop and demonstrate effective integration of doulas into maternity care teams, moving beyond documentation of challenges and barriers, which have been established. Finally, researchers need to focus on racial equity including racial differences in the access to and experience of doula care during COVID-19.

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ORCID

Elizabeth A. Mosley http://orcid.org/0000-0001-9534-2457

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Résumé
Le soutien des doulas est bénéfique pour la santé maternelle et infantile. Néanmoins, pendant la pandémie de COVID-19, les hôpitaux ont limité le nombre d'accompagnants autorisés pendant l'accouchement. De novembre 2000 à janvier 2021, une équipe de recherche universitaire et communautaire a mené 17 entretiens approfondis et des enquêtes structurées avec des doulas dans la région métropolitaine d'Atlanta, Géorgie, États-Unis d'Amérique. Les enquêtes ont été analysées pour en tirer des statistiques descriptives dans Stata v.14 et les entretiens ont été analysés avec Dedoose à l'aide d'un manuel de codage et la préparation de notes pour l'analyse thématique. Les 17 doulas ont indiqué que la COVID-19 avait changé leurs pratiques : la plupart n'ont pu accompagner leurs clientes jusqu'à l'accouchement (14), ont commencé à utiliser un équipement de protection individuelle (13), ont eu recours à des services virtuels (12) et ont dû limiter le nombre de visites prénatales/postnatales en personne (11). Plusieurs d'entre elles ont accompagné davantage de naissances à domicile (6) car les mères avaient peur d'accoucher à l'hôpital. Certaines ont complétement arrêté de voir leurs clientes car elles craignaient pour leur sécurité (2). Beaucoup ont perdu des clientes qui ne pouvaient plus se permettre de payer les services d'une doula et certaines d'entre elles ont assuré des services gratuitement. La plupart des doulas mis en évidence les politiques hospitalières restrictives qui excluaient les doulas et empêchaient le soutien virtuel ; à leur sens, les doulas auraient dû être considérées comme faisant partie de l'équipe et les clientes n'auraient pas dû être obligées de choisir entre la présence de leur doula ou de leur partenaire en salle d'accouchement. La COVID-19 a eu de graves répercussions sur l'accès aux soins prodigués par les doulas, principalement en raison des difficultés économiques des clientes et des politiques hospitalières restrictives. Dans le même temps, les doulas et leurs clientes ont fait preuve d'ingéniosité en ayant recours à la technologie virtuelle, à des modèles de rémunération novateurs et aux naissances à la maison.

Resumen
El apoyo de doulas mejora los resultados de salud materno-infantil. Sin embargo, durante la pandemia de COVID-19, los hospitales restringieron el número de personas de apoyo permitidas durante el parto. Un equipo de investigación académica-comunitaria realizó 17 entrevistas a profundidad y encuestas estructuradas con doulas en metro-Atlanta, Georgia, EE. UU., entre noviembre de 2020 y enero de 2021. Las encuestas fueron analizadas para extraer estadísticas descriptivas en Stata v. 14 y las entrevistas fueron analizadas en Dedoose utilizando un libro de códigos y la elaboración de memorandos para análisis temático. Las 17 doulas informaron que COVID-19 cambió sus prácticas: la mayoría de ellas no pudieron acompañar a sus clientas durante el parto (14), empezaron a usar equipo de protección personal (13), utilizaron servicios virtuales (12) y tuvieron que limitar el número de consultas de atención prenatal/posparto presenciales (11). Varias atendieron más partos domiciliarios (6) porque las clientas temían tener su bebé en el hospital. Algunas dejaron de atender a clientas por preocupaciones de seguridad (2). Muchas perdieron clientela que ya no podía pagar por los servicios de una doula y algunas ofrecieron servicios gratuitos. La mayoría de las doulas señalaron políticas hospitalarias restrictivas que excluían a las doulas y no permitían el apoyo virtual, dado que ellas creían que deberían ser consideradas como parte del equipo y que las clientas no deberían verse obligadas a decidir entre estar acompañadas en el cuarto por su doula o por su pareja. COVID-19 ha afectado marcadamente la accesibilidad y la provisión de atención por doulas, en gran parte debido a las dificultades económicas de las clientas y a políticas hospitalarias restrictivas. Al mismo tiempo, las doulas y sus clientas han sido ingeniosas, utilizando tecnología virtual, modelos de pago innovadores y partos domiciliarios.

Appendix A. Survey Instrument

Study ID: _____

Demographics

1. With which of the following races/ethnicities do you identify? Check all that apply:

☐ Black or African American
☐ Hispanic or Latinx
☐ Asian or Pacific Islander
☐ American Indian, Alaskan Native, or Native Hawaiian
☐ Biracial or Multiracial
☐ White
☐ Other (specify) _____
☐ Prefer not to answer

2. How old are you in years?

☐ Under 25
☐ 25-35
☐ 36-45
☐ 46-55
☐ Over 55

3. Have you had difficulty affording necessities such as education costs, food, clothing, transportation, housing, and medical care? Check all that apply

☐ Yes, currently
☐ Yes, in the recent past (within 3 years)
☐ Yes, in the past for a limited period of time (for example, while I was a student)
☐ Yes, historically throughout my life
☐ No
☐ Prefer not to answer

4. Are you currently employed? Check all that apply

☐ Yes, full-time
☐ Yes, part-time
☐ No, not looking for employment
☐ No, looking for employment

5. What is the highest level of education you have completed?

☐ High School
☐ Some college
☐ Graduated college
☐ Graduate degree (e.g., MPH, PhD)
☐ Clinical professional degree (e.g., RN, LPN, MD, PA)
☐ Non-clinical professional degree (e.g., GED)
☐ Other (specify) _____

6. **With which of the following genders do you identify?** Check all that apply:

☐ Female/woman
☐ Male/man
☐ Transgender
☐ Genderqueer
☐ Nonbinary
☐ Self-identify (please specify): _____
☐ Prefer not to answer

7. What is your sexual orientation? Check all that apply:
☐ Lesbian
☐ Gay
☐ Bisexual
☐ Queer
☐ Straight or heterosexual
☐ Don't know/questioning
☐ Prefer to self-describe_____
☐ Prefer not to answer

8. What language do you primarily speak at home? Check all that apply:
☐ Arabic
☐ Chinese (Cantonese, Mandarin, others)
☐ English
☐ French or French Creole
☐ German
☐ Hindi
☐ Korean
☐ Spanish
☐ Tagalog
☐ Vietnamese
☐ Other (Specify): _____

9. What is your immigration generation status? Check all that apply
☐ My parents and grandparents were born in the United States
☐ One or more of my grandparents were born in the United States
☐ One or more of my parents were born in the United States
☐ I was born in the United States
☐ Prefer not to answer

10. In which Georgia county do you reside?_____

Pregnancy Information

11. Have you ever been pregnant?
☐ No → Go to introduction to doula work and training
☐ Yes→ Go to 11.1

11.1. **How many times have you been pregnant?**
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 or more

11.2 **How many live children do you have**? _____

11.3 **For any of the pregnancies you mentioned above, did you have a doula?**
☐ No→ Go to introduction to doula work and training
☐ Yes → Go to personal experiences with doulas section

Personal Experience with Doulas

For these questions, consider the last time you had a doula:

12. **What type of doula services did you receive?** Check all that apply

☐ Birth doula
☐ Postpartum doula
☐ Prenatal doula
☐ Abortion doula
☐ Full Spectrum doula
☐ Radical/Justice doula
☐ Death/Grief/Loss/Bereavement doula
☐ Prison doula

13. **How satisfied were you with those doula services?**

☐ Very unsatisfied
☐ Unsatisfied
☐ Neutral
☐ Satisfied
☐ Very satisfied
☐ Mixed feelings (Explain: _____)

14. **How valuable were their services?**

☐ Not valuable at all
☐ Mostly not valuable
☐ Neutral
☐ Somewhat valuable
☐ Very valuable

15. **How did the doula affect your anxiety about the pregnancy?**

☐ Negatively affected, increased anxiety
☐ No effect
☐ Positively affected, decreased anxiety

16. **How did the doula affect your pain during childbirth?**

☐ Negatively affected, increased pain
☐ No effect
☐ Positively affected, decreased pain

17. **How did the doula affect your empowerment during the pregnancy?**

☐ Negatively affected, decreased empowerment
☐ No effect
☐ Positively affected, increased empowerment

18. **Did you have any negative experiences with your doula?**

☐ No
☐ Yes: Please explain_____

19. **Would you want a doula again?**

☐ No
☐ Yes

Introduction to Doula Work and Training

20.**How long have you been a doula?**_____ Years _____Months

21. **What kind of doula do you identify as?** Check all that apply
☐ Birth doula
☐ Postpartum doula
☐ Prenatal doula
☐ Abortion doula
☐ Full Spectrum doula
☐ Radical/Justice doula
☐ Death/Grief/Loss/Bereavement doula
☐ Prison doula
☐ Other (Specify): _____

22. **What, if any, doula training have you completed?**
☐ Doulas of North America (DONA) International
☐ CAPPA Childbirth and Postpartum Professional Association
☐ ALACE – Association of Labor Assistants and Childbirth Educators
☐ BirthWorks International
☐ Childbirth International
☐ HypnoBirthing
☐ N/A
☐ Other (Specify): _____

23. **What, if any, doula certificationhaveyou completed?**
☐ Doulas of North America (DONA) International
☐ CAPPA Childbirth and Postpartum Professional Association
☐ ALACE – Association of Labor Assistants and Childbirth Educators
☐ BirthWorks International
☐ Childbirth International
☐ HypnoBirthing
☐ N/A
☐ Other (Specify): _____

24. **How would you describe your yearly load?**
☐ Fewer than preferred
☐ Actual number preferred
☐ More than preferred
☐ Don't know

25. **How many clients (of each kind) have you been a doula for?**
☐ Birth doula clients_____
☐ Postpartum doula clients_____
☐ Prenatal doula clients_____
☐ Abortion doula clients_____
☐ Full Spectrum doula clients_____
☐ Radical/Justice doula clients_____
☐ Death/Grief/Loss/Bereavement doula clients_____
☐ Prison doula clients_____

Client Demographics: For the answers to each of these questions please estimate a percent for each demographic group (scroll over for 100% option)

26. **Estimate the racial/ethnic breakdown (in percentage) of your clients (total in column should add up to 100)**

	10	20	30	40	50	60	70	80	90	100
Black or African American										
Hispanic or Latinx										
Asian or Pacific Islander										
American Indian, Alaskan Native, or Native Hawaiian										
Biracial or Multiracial										
White										
Other										

27. **Estimate the age breakdown (in percentage) of your clients (total in column should add up to 100)**

	10	20	30	40	50	60	70	80	90	100
Under 25										
25-35										
36-45										
Over 45										

28. **Estimate the socioeconomic status breakdown (in percentage) of your clients (total in column should add up to 100)**

	10	20	30	40	50	60	70	80	90	100
Upper										
Upper Middle										
Middle										
Lower Middle										
Lower										

29. **Estimate the highest level of education breakdown (in percentage) of your clients (total in column should add up to 100)**

	10	20	30	40	50	60	70	80	90	100
High School										
Some college										
Graduated college										
Graduate degree (e.g., MPH, PhD)										
Clinical professional degree (e.g., RN, LPN, MD, PA)										
Non-clinical professional degree (e.g., GED)										
Other										

30. **Estimate the number of pregnancies breakdown (in percentage) of your clients (total in column should add up to 100)**

	10	20	30	40	50	60	70	80	90	100
1										
2										
3										
4										
5										
Over 5										

Clients, Cost, and Other Logistics

31. **How do you primarily find your doula clients? Check all that apply:**

☐ Personal website
☐ Professional doula organization website/registry
☐ Word-of-mouth
☐ Other online forums
☐ Telephone
☐ Health care providers and institutions
☐ Community-based programs

32. **What type of doula practice are you a part of? (check all that apply)**

☐ Solo practice
☐ Group practice with 2-4 doulas
☐ Group practice with 5+ doulas
☐ Hospital-based practice
☐ Clinic-based practice

33. **How much do you currently charge ($USD)per:**
a) Prenatal visits_____
b) Birth visits_____
c) Postnatal visits_____
d) Bereavement visits_____
e) Abortion visits_____

34. **How much do you think you should be paid (ideally, in order to reach standard of living) per:**
a) Prenatal visits_____
b) Birth visits_____
c) Postnatal visits_____
d) Bereavement visits_____
e) Abortion visits_____

35. **How willing are you to do pro-bono or volunteer doula services?**
☐ Not willing at all
☐ Mostly unwilling
☐ Neutral
☐ Somewhat willing
☐ Very willing
☐ Mixed feelings (Explain): _____

35.1 **Open answer to explain your choice above:**_____

Beliefs about Doula Services

36. **For each of the following, mark the answer that you most closely agree with.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I believe current pricing of doula services helps me to provide doula services.					
I believe current pricing of doula services helps my clients access doula services.					
I believe current insurance coverage of doula services helps me to provide doula services.					
I believe current insurance coverage of doula services helps my clients access doula services.					
I believe current doula training helps me to provide doula services.					
I believe current doula training helps my clients access doula services.					
I believe current doula certification requirements help me to provide doula services.					

I believe current doula certification requirements help my clients access doula services					
I face challenges in starting my doula business.					
I face challenges in building my client base for my doula business.					
I face challenges in making enough profit to continue my doula business.					

Possible Changes for Doula Service Reimbursement

37. **How interested would you be in Medicaid reimbursement for your doula services?**

☐ Not interested at all
☐ Mostly uninterested
☐ Neutral
☐ Somewhat interested
☐ Very interested
☐ Mixed feelings (Explain: _____)

38. **How interested would you be in Georgia doulas being classified as Community Health Workers who are reimbursed through Department of Public Health?**

☐ Not interested at all
☐ Mostly uninterested
☐ Neutral
☐ Somewhat interested
☐ Very interested
☐ Mixed feelings (Explain: _____)

Doula Services during COVID-19

39. In what ways have you and your work been affected by COVID-19? (Check all that apply)

☐ Stopped taking on clients
☐ Unable to accompany clients in the delivery room
☐ Limited prenatal and postpartum visits
☐ Increase in client home births
☐ Use of protective equipment (i.e. masks, gloves) when working with clients
☐ My work has not changed as a result of COVID-19

40. Are you interested in providing doula services virtually (i.e. video and phone calls)?

☐ Yes
☐ No

41. Have you provided virtual doula services?

☐ Yes
☐ No

42. Have you provided doula services virtually during the COVID-19 pandemic?

☐ Yes
☐ No

43. How many clients have you served virtually since the onset of the pandemic? _____

44. Do any of your clients have difficulties accessing the internet?
☐ Yes
☐ No
☐ Unknown

45. How do you connect with your clients virtually? (check all that apply)
☐ Video calls (Zoom, Microsoft Teams, Facetime)
☐ Phone
☐ Other: Specify _____

46. What platform do you use for video calls?
☐ Zoom
☐ Skype
☐ Teams
☐ Other: Specify _____