Doula Stakeholder Engagement: Focus Group Study Report

July 2023

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Family Health Systems

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Executive Summary

Infant and maternal mortality rates in the United States 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] (Delaware Health Statistics Center, 2023). 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 (Delaware Health Statistics Center, 2023). Racial disparities in maternal mortality are also well documented (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2023). Between 2018 and 2022, there were 11 maternal deaths in Delaware, the majority of which were women of color (Delaware Maternal Mortality Review, 2022). There is much more work needed to close the gaps between Black and White infant and maternal health outcomes.

Delaware is among several states considering policy options related to doulas to improve birth outcomes. Doulas are professionals who provide physical, emotional, and informational support to mothers before, during, and after childbirth (Simkin, 2012). They also act as advocates (Knocke et al., 2022) and promote self-advocacy for birthing people (Guenther et al., 2022), and may help mediate the negative impacts of social determinants of health, including implicit bias in health care (Kozhimannil et al., 2016). In addition to improved outcomes, research shows that doula care has the potential to reduce unnecessary medical interventions and can reduce costs (Bohren et al., 2017; Kozhimannil e. al., 2013).

As the State of Delaware explores strategies to improve access to doula care for women at risk of poor birth outcomes, many outstanding issues must be resolved, including questions related to qualifications and training requirements for doulas and other administrative supports. Our purpose was to engage doulas themselves and gather their insights on these issues to inform policy development and implementation. The specific research questions were:

- How do doulas perceive training and certification requirements for their practice?
- Assuming certification is required for Medicaid reimbursement, what core competencies do doulas believe should be included in approved training programs to meet the needs of low-income women and women of color?
- What supports do doulas believe are needed to better serve the Medicaid population in Delaware?

To address these questions, all eligible doulas in Delaware were invited to participate in a series of virtual focus group discussions. Three focus groups, including 11 doulas representing the three counties, were conducted via Zoom (online video conferencing) between September and November 2022. Transcripts were analyzed using a combination of inductive and deductive methods. Detailed findings

[1] The use of five-year averages is due to the relatively small number of events in a single year, making annual rates particularly susceptible to the effects of random variations.

presented in this report are organized according to four major categories: Training Components and Core Competencies; Certification Requirements; Relationships with other Care Providers; and Other Supports Needed. Within each category, themes are expressed using direct quotes from participating doulas to promote authenticity and elevate their voices.

Findings from the focus groups led to the following six recommendations, many of which are consistent with recommendations based upon similar research in California (Chen & Robles-Fradet, 2020) and Oregon (Everson et al., 2018), though some are unique to the Delaware context:

1. **Training and Core Competencies –** 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. Further, cultural competence training should be considered as an essential component of approved training programs. Need-based financial assistance for training should be provided, particularly for those serving communities with the highest need, to expand access to doula care.

2. **Certification –** The state should provide flexibility in training requirements, including allowing different training programs and/or sponsoring organizations. In addition, certification that includes a pathway for experienced doulas to waive training requirements may be considered.

3. **Education of Health Care Providers –** Positive working relationships between licensed providers (nurses, midwives, and physicians) and doulas are critical for the delivery of high quality, integrated care. Identifying and investing in strategies to raise awareness about doulas' scope of service and the value to birthing people, along with promoting opportunities to build professional rapport across team members, will improve access to doula care and promote better birth outcomes.

4. **Doula Representation –** Regardless of the approaches taken by the State of Delaware to improve access to doula services, representation of doulas in policymaking — from planning through implementation — is essential. Policymakers should seek direct input from doulas through various ongoing methods (e.g., surveys, town halls, etc.) and include doula representatives on advisory boards or other decision-making bodies. Given the racial inequities in birth outcomes across the state (Delaware Health Statistics Center, 2023) and the persistence of structural racism in the U.S. health care system (Beck et al., 2020; Hill et al., 2022), concerted efforts should be made to ensure doulas of color are included.

5. **Professional Development and Networking/Mentorship Opportunities –** Given the range of important topics that may be covered in doula training, the State and/or health care organizations should identify ways to encourage and support professional development of doulas. Topics of interest may be identified through input from doulas, particularly those serving birthing people with the highest level of need. Further, opportunities for networking and mentorship among doulas should be developed and supported.

6. **Support for Navigating the Medicaid Reimbursement Process –** If Medicaid reimbursement for doula services is approved, the State and/or health care organizations should develop training and

support systems for navigating the reimbursement process. Adequate ongoing technical assistance should be made available, and ease of processes should be prioritized. This is particularly important to ensure access to culturally competent care and promote reimbursement for doulas of color, both of which are critical to addressing health inequities.

This study revealed important implications for the 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, meaning 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. Further, while the findings highlighted concerns among doulas regarding relationships with other licensed providers and assumptions about how those providers perceive them, future research is needed (and planned) to gain a more complete understanding of provider awareness and attitudes towards doulas.

Despite these limitations, this research provides critical insights about a range of issues related to improving access to high quality care from the perspective of community-based doulas. The authors recognize, respect, and value the knowledge, beliefs, and perspectives that doulas have gained by serving birthing people in Delaware. The recommendations offer a starting point for policymakers and health care organizations to ensure the delivery of the most accessible, high quality, and culturally competent care for birthing people and to decrease negative health outcomes.

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Background and Purpose

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 (Delaware Health Statistics Center, 2023). 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 (Delaware Health Statistics Center, 2023). It is noteworthy that the Delaware White infant mortality rate is already lower than the national White infant mortality rate of 4.7 but the Delaware Black infant mortality rate remains higher than the national Black infant mortality rate of 10.8 death per 1,000 live births (Delaware Health Statistics Center, 2023).

Despite being largely preventable, maternal morbidity and mortality are also on the rise in Delaware and Black women are particularly at risk (Trost et al., 2022). Between 2018 and 2022, there were 11 maternal deaths in Delaware, seven of which were women of color and nine of which were determined to be potentially preventable, according to the Delaware Maternal Mortality Review (2022). While the numbers of maternal deaths each year are relatively small, it is well established that persons of color have the highest rate of maternal death compared to their White counterparts (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2023). Reasons for these inequities are complex and related to myriad social and economic factors, including structural racism (Beck et al., 2020; Hill et al., 2022; Knight et al., 2019; Office of Health Equity, CDC, 2022).[2]

There is growing evidence that doulas contribute to improved outcomes, particularly among women most at risk (Bohren, et al., 2017; Falconi et al., 2022; Kozhimannil et al., 2013; McComish & Visger, 2009). Doulas are professionals who provide physical, emotional, and informational support to mothers before, during, and after childbirth (Simkin, 2012). They also act as advocates (Knocke et al., 2022), promote self-advocacy for birthing people (Guenther et al., 2022), and may help mediate the negative impacts of social determinants of health, including implicit bias in health care (Kozhimannil et al., 2016).

In addition to improved outcomes, research shows that doula care has the potential to reduce unnecessary medical interventions and can reduce costs (Bohren et al., 2017; Kozhimannil e. al., 2013). 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 survey of women across the U.S. found only 6% engaged with a doula during labor (Declercq et al., 2014) and women of color and low-income women face several barriers to accessing doula care. Support for policy changes to expand doula care is growing, including an increasing number of states that reimburse providers for doula services through their Medicaid programs (National Health Law Program, 2022). Recognizing that birthing people of color may particularly benefit from doula services, the federal government is also engaging in efforts to expand access to doula care, including providing guidance on ways to reimburse doulas through Medicaid (Knocke et al., 2022).

[2] For more information on Delaware's infant and maternal morbidity and mortality, see the website for the Delaware Healthy Mother & Infant Consortium (DHMIC) (https://dethrives.com/dhmic). DHMIC provides statewide leadership and coordination of efforts to prevent infant and maternal mortality and improve the health of women of childbearing age and infants throughout Delaware.

Given the potential of doulas to improve outcomes for women and babies at highest risk, the State of Delaware is considering ways to improve access to doula care for this population, including possible Medicaid reimbursement. As the State explores policy change, many outstanding issues must be resolved, including the type and scope of billable services, qualifications, and training requirements for doulas; referrals and supervisory relationships; and other necessary administrative supports. The Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA) engaged the services of Mercer to assess the landscape, including strategies employed by other states, and to make recommendations related to Medicaid reimbursement. The research presented in this report complements the efforts of DMMA and Mercer by providing an in-depth and systematic analysis of doula perspectives on many of these issues, especially those related to training, certification, and other potential gaps or opportunities related to infrastructure.

While doulas are expected to understand the physiological processes associated with pregnancy, birth, and postpartum health, they are not medically trained and do not provide medical care. Further, doulas' expertise is often grounded in generational, ancestral, and experiential knowledge shared among lay birth workers, and many often resist certification as it resides within what is often considered an over-medicalized approach to childbirth (Parkhideh, 2021). 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. National Medicaid policy provides states with broad flexibility to determine coverage and reimbursement rates, as well as requirements for training and certification. Delaware policy makers and stakeholders of the Delaware Healthy Mother and Infant Consortium (DHMIC) are assessing different options for training and certification and developing recommendations. Considering the perspectives and expertise of community-based doulas will contribute to standards that ensure the delivery of high quality and culturally competent care, while not discouraging access.

Given this context, the research purpose was to engage doulas across the state and gather their insight on training and certification issues to inform the development of a statewide infrastructure to increase access to high quality doula care for women most at risk of poor birth outcomes. The team aimed to gain an in-depth understanding of community-based doulas' knowledge, attitudes, feelings, beliefs, and experiences regarding training and certification and other perceived needs. The research questions included the following:

- How do doulas perceive training and certification requirements for their practice?
- Assuming certification is required for Medicaid reimbursement, what core competencies do doulas believe should be included in approved training programs to meet the needs of low-income women and women of color?
- What supports do doulas believe are needed to better serve the Medicaid population in Delaware?

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. Further, the researchers recognize, respect, and value the knowledge, beliefs, and perspectives that doulas have gained through their experience serving birthing people in Delaware. Finally, this study is part of a larger project in which the research team also engaged with licensed maternity care providers (physicians, midwives, and nurses) across the state to explore similar issues from their perspective. See the companion report (forthcoming) for more information about licensed providers' views on doula care, training and certification, relationships with the care team, and other considerations for policy and practice.

Study Methods

Approach

Researchers used a cross-sectional research design employing focus groups to address the research questions. Similar to qualitative interviews, focus groups allow for an in-depth understanding of participants' attitudes, feelings, beliefs, and experiences. However, the group interaction that occurs through focus group discussions can often elicit additional information and understanding that might not be revealed through individual interviews. Further, the interactions among participants can lead to individuals reconsidering their responses or re-evaluating their feelings; as such, group interaction can be an avenue for learning as well as sharing.

Focus groups were limited to no more than eight individuals and were relatively homogenous groups (according to demographic profiles such as race, ethnicity, and geography) to encourage participation but also allow for diverse opinions. Research subjects received a $50 electronic gift card for their participation. The study was approved by the West Chester University Institutional Review Board #2022-337.

Sample

Based on a review of websites and provider directories, approximately 40 eligible doulas were identified in the state at the time of recruitment. All were invited to participate in the study.

Recruitment occurred through established networks and doula organizations. Flyers were distributed through the DHMIC email list service; social media posts were shared through the DE Thrives Facebook page; and various affiliated groups (e.g., Black Mothers in Power, Parent Information Center (PIC) of Delaware, etc.) shared information with their members and partners. Research participants were encouraged to share information with their colleagues, and the sample grew through a snowball sampling technique. The final sample consisted of 11 doulas.

Research participants met the following inclusion criteria determined through a REDCap screening survey:

a. Any "doula" currently practicing in the State of Delaware was eligible to participate. 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 to participate.

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

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).

Of the 11 focus group participants, 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 International, or from one of the community-based organizations in Delaware that received funding to train doulas through a mini-grant from DPH and the DHMIC. Most are 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.

Data Collection and Analysis

Three focus groups were conducted via Zoom (online video conferencing) between September and November 2022. Each participant attended only one focus group based upon their availability, with five participants in one session and three in each of the remaining sessions. Each session was facilitated by the lead researcher, who is a PhD-trained social scientist with extensive experience conducting qualitative research, including focus groups, and expertise in maternal and reproductive health. All focus group meetings were recorded after securing informed consent from each research subject (via an electronic REDCap survey). Participants were encouraged but not required to turn on their video cameras.

Focus groups lasted approximately one hour and were facilitated using an interview guide developed to address the major research questions (Appendix). The questions within the guide included the high-level topics that were asked in all focus group meetings (in bold), as well as prompts that varied depending on the nature of the focus group conversation. This semi-structured approach allowed for flexibility and ensured that the key topics were covered in every focus group session.

Zoom recordings were automatically transcribed and data were manually cleaned for analysis. Transcripts were then analyzed using a combination of inductive and deductive approaches (Patton, 2015). First, all transcripts and post-focus group reflection notes were reviewed to develop an understanding of the big ideas or themes that emerged from focus group conversations (Patton 2002). Subsequently, data were 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 focus group 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. Transcripts were cleaned by a graduate research assistant and all analysis was conducted by the lead researcher.

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 a qualitative method whereby interpretations and conclusions are tested with study participants who have an opportunity to confirm, deny, or add to the interpretations, and it is important for establishing credibility in qualitative research (Lincoln & Guba, 1985). In addition to addressing potential limitations related to the number of respondents, member checking provided an opportunity for doulas 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.

Specifically, the team shared a draft report of its preliminary findings with all participants and asked them to respond to the following questions (Birt et al., 2016) 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?
(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 presented in this report. No new information was offered.

Findings

Findings are organized below according to four major categories: Training Components and Core Competencies, Certification Requirements, Relationships with other Care Providers, and Other Supports Needed. Within each category, themes and unique ideas are expressed relying heavily on direct quotes from doulas to promote authenticity and elevate their voices.

Training Components and Core Competencies

Focus group participants had experience with many different types of training programs, which covered a range of topics including prenatal nutrition, comfort measures during labor and delivery, and lactation and breastfeeding. Some participants had taken classes that included business practices, as well as training on specialized services such as placenta encapsulation. Training format, length, and sponsoring organizations varied quite a bit. Across all focus groups, two themes stood out in relation to critical training components or core competencies needed for doulas serving communities at risk of poor birth outcomes: (1) cultural competence should be mandatory; and (2) doula training should be comprehensive and cover the full spectrum of perinatal care (prenatal through postpartum). Finally, focus group participants generally agreed that ongoing professional development or continuous education is important for their practice, and several specific topics for such ongoing training were identified.

Theme: Cultural competence should be mandatory

Most focus group participants identified as women of color, who primarily serve birthing people of color, in a predominantly "White" health care system. Therefore, it was not surprising to find that cultural competence was identified as a critical training element for delivering quality care. Consistent with the literature (Govere & Govere, 2016), doula participants recognized that cultural competence training is essential for serving minority communities. As one doula explained, "In relation to the cultural competence piece…it needs to be mandatory because the only way that people are really going to lean into that is if they are made aware." This sentiment was echoed by another doula, who specifically mentioned the Medicaid population, and argued:

> *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.

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 offered. Again, this is consistent with the literature in terms of the potential value of cultural competence training for health care providers by improving their cultural sensitivity (Renzaho et. al., 2013). One doula explained:

We have a Caucasian woman who is [in our training] and I've seen her cry... when we watched the movie 'Aftershock,' and just to see how touched she is by being aware of what's actually happened to, what's happening to Black women right now in America. And I know for a fact that that's going to stay with her, and 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. And 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 alarming rate for things that could have been prevented.

In speaking about the importance and context of this type of training, one doula stated, "Cultural competence can't be taught by people who are not of color… Whoever is in charge of facilitating diversity, inclusion, and whatnot, they need to be people of color." Further, some doulas agreed that cultural competence rises to the level of needing to be assessed as part of a training or certification program, particularly as they believe there is still so much misinformation and misunderstanding related to treating patients of color. One doula described:

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.

Finally, 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. Along

those lines, one doula recognized her need for more training before being prepared to serve a transgender person. She explained:

> *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.*

Theme: Comprehensive/Full Spectrum Perinatal Training

Focus group discussions highlighted the idea that doula 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 really 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.*

The importance of training on the full continuum of care may have emerged because the majority of the doulas who participated in the focus groups provided support during the prenatal period, during labor and delivery, and the postpartum period. However, the discussion seemed to indicate a recognition that this comprehensive understanding would be important even for doulas who provide more limited services, such as only during labor and delivery. There was a clear sense that the focus group participants understood the nuances and complexities of maternity care such that they valued a more complete understanding of the continuum to be better caregivers at each phase.

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. This theme is consistent with other research that found doulas' perceptions that competence is developed through experience (Young, 2021). This is exemplified in the comment by one participant who explained:

> *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.*

Further, many participants recognized that the potential list of topics that could be included in training programs is relatively long, and that learning is an ongoing process whereby opportunities for regular professional development are warranted. One focus group participant recognized, "It's all about continuous education and training, and you know, growth." Highlighting many of the topics that could be included, another doula explained:

> *Education about the whole birthing process, your entire body, and honestly every aspect…C-section, is necessary; birth-centered care is necessary; at home, necessary; in the hospital, necessary, whether that's assisted with the medication or not… All of these, because you can have babies in all of these ways. And we didn't even talk about foster care. We can talk about surrogacy. We didn't talk about adoption because they need doulas as well. We didn't even talk about miscarriages. They need doulas as well. You know I've taken a bereavement one. So…there are different trainings. It's a never-ending learning process.*

Based on our focus group discussions, it would be difficult to develop a comprehensive list of core competencies; however, several participants agreed that doula training should include nutrition, lactation, and breastfeeding. Other more unique topics were highlighted, including, trauma-informed care, and intimate partner violence. Given the disproportionate rates of infant mortality among communities of color, one doula emphasized the need to give more attention to "how to support people dealing with loss...that's a huge one, because it's not heavily spoken on in the training. It's kind of like breezed by." Finally, many doulas talked about the importance of advocacy skills, both in terms of learning how to be advocates themselves, and how to help their clients be better advocates. Acknowledging that her previous training was insufficient in this regard, one participant argued:

> *I learned from my DONA training that we're not supposed to advocate for birthing people when actually like as a birth worker, you definitely should be not only advocating for them, but you should teach them how to advocate for themselves as well.*

Beyond cultural competence as a critical element of doula training, more research is needed to reach consensus on a list of core competencies from the perspective of doulas themselves.

Certification Requirements

While focus group 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, similar to many other states' policies (National Health Law Program, 2022).

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. This is consistent with the literature (Young, 2021), in that doulas may feel some ambivalence about certification; on one hand it helps to legitimize their role, but on the other, the work of a doula does not require such legitimation. As one doula explained,

> *You know it sounds kind of crazy, but women have been supporting women for centuries, and its only kind of in this modern viewpoint that we've started saying, 'Oh, you have to be trained to be able to support women'. It's intuition and just having personal experience.*

Building on this sentiment that professionalization of the doula role may be counter to the culture of birth work, one doula expressed, "Being a doula is very sacred and spiritual, so it's something that I believe you need to be called to." This idea is consistent with other research findings, particularly

among doulas of color, and suggests that retention of experienced doulas may promote culturally competent care and improved birth outcomes (Hardeman & Kozhimannil, 2016). As a way to potentially bridge this conflict, focus group participants seemed to agree that a certain level of experience could serve as a substitute for formal training to meet any state certification requirements.

Theme: Do not limit training to specific sponsoring organizations

As described earlier, focus group participants had a range of experiences with training, and several doulas had participated in more than one training program with different sponsoring organizations. While some doulas were critical of DONA International — often considered the most widely recognized doula training organization — most found value in all training opportunities in which they had participated. As one doula stated, "I'm up into about three different doula trainings, and each of them offered something different." Another doula agreed, adding, "It is interesting how I feel like every doula training is different."

Specifically in reference to DONA International, concerns were raised that training requirements for certification should not be limited DONA, simply because it is the most widely recognized. One focus group participant said, "I haven't experienced this, but I've heard from several different doulas that if you weren't trained with DONA, you weren't recognized as much as other doulas. And I don't think that's really right." This idea was expressed by others, including one participant who argued, "DONA, for example, is a very expensive organization to be part of and it's honestly not the best." Another doula expressed additional concerns:

> *My first training was with DONA, and coming from a nursing background, I didn't know any better and I was looking for like the big organization that you know, had long history, but I will say, from my training I did not feel prepared afterwards. I didn't feel like it prepared me enough personally to get out in the world of birth work.*

While this comment may speak to the need for practice and experience to build competence, as described earlier, it was also specific to the limitations of DONA training. This participant sought out additional training after her experience with DONA and went on to explain:

> *[One] was phenomenal… just knowing the history of certain things like in relation to breastfeeding and slavery, like there are so many different things that were touched on that were just super valuable. 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.*

Along these lines, doulas seemed to agree that other doula training programs with a specific interest in promoting culturally competent care for communities of color should be supported and endorsed. This aligns with the theme discussed earlier that cultural competence should be a mandatory element of any doula training, and a concern that some training programs do not include adequate attention to this topic. This is also consistent with a recent research that found that mainstream organizations are often slower to adapt and incorporate content that addresses the impacts of structural racism on birth outcomes; whereas community-based doula training programs are historically attentive to these issues and are often tailored to meet the needs of communities they serve (Guenther et al., 2022; Van Eijk et al., 2022). Again, in referencing concerns about the more widely recognized training programs, one participant acknowledged:

What I have learned since training is that certain hospitals, certain persons or certain places, do look down upon people who are not trained by certain organizations, and the downside to that… is that just because they may be the standard of training for doula work does not mean that they include everything that that we need to know about being a birth worker of color and assisting primarily people of color.

Further, the opportunity to promote diversity of training programs was described in concert with the need to promote more diversity in care. As one doula offered:

I think that my fear is knowing that there's not enough diversity in the Doula world, and especially being allowed to enter into certain spaces, there's not enough diversity. And so, in order to order for certain people, in order for some clients to be properly served, they may not be able to have access to a doula that understands them, or looks like them, or is trained to properly serve them, because the certifying organization that that space allows is not on the list.

Many focus group participants specifically referenced the Commonsense Doula training program as one that offered particular value in this regard and should be included in any list of potential training programs for certification.

Theme: Recognize experience and informal training as a substitute for formal training

Focus group participants generally believed it was important for certification requirements to include a pathway based upon years of experience as a substitute for formal training. One participant explained:

I think one of the things that [other states with training requirements] are missing out on is this kind of community doula piece, which is a large portion of our community, and I think if Delaware could come up with some type of attestation form, or something where, say I've served for x number of years, here's my three different professional references and one character reference, and just process to recognize training pathways that are not very formal, you know.

The perception that experience is a valid substitute for formal training was grounded in an understanding of the nature of birth work, as described earlier, and reflected by one doula, who commented, "It's just passed down by tradition. That's kind of the root of the care work that we're involved in. So, it's important to have that recognized." It was also described in practical terms and seemed to reflect a sense of respect for doulas who have been practicing for a long time. One participant succinctly explained, "Doulas that go that route that have been practicing for years should still be able to be reimbursed even without meeting those training requirements."

This belief was also grounded in an appreciation for the value that experience provides, also discussed earlier, and a concern that there already exists access barriers for birthing people to find culturally competent doula care. One focus group participant explained:

We don't really want to exclude people from practicing as a doula because that's the opposite of what we're trying to do, because I mean, I really don't think doulas need to be legitimized. Even though it is important for hospitals and for insurance companies to see that we're legitimate, that's kind of the opposite of what we're trying to do.

Relationships with Other Care Providers

Discussions about working with other care providers emerged in every focus group. Participants had a variety of experiences practicing alongside other licensed providers (i.e., nurses, midwives, and physicians) in Delaware. While some doulas recounted positive interactions, many described challenging relationships with other providers and felt there was a general lack of respect for the work that they do. One doula clearly stated, "Some people don't respect the role of the doula," and another reflected, "I definitely have felt very unwelcome sometimes." This tension was typically perceived by doulas as being grounded in a lack of awareness and understanding of the role they play. While clearly bothered by the ways in which they were often treated by other care providers, focus group participants were genuinely interested in building positive working relationships, thereby improving quality of care and providing a better patient experience.

Theme: Lack of awareness/appreciation for the role of doulas

Focus group participants were clear in describing their roles in supporting birthing people, including the scope of their practice, and frequently acknowledged what was beyond the scope. Despite this, they believed that many other providers may not understand this scope of practice and feel threatened by doulas' presence. As one doula explained, "When we come into the hospital sometimes, we are not welcome in the birth space, because it seems as though we're trying to step on medical toes." Another doula echoed this sentiment:

> *I feel like the understanding of the relationship between what we do and understanding that 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.*

One doula acknowledged that the concern that doulas may practice beyond their scope could be a valid concern among medical providers based on past experience working with doulas who did overstep, commenting:

> *It's important to know what you do and what you don't do, because some of us go out, and we want to support and do all of these things when some things are just not in our scope as a doula. We shouldn't even be answering certain questions because that's medical.*

While we have not yet interviewed medical providers in Delaware, a recent study in Rhode Island found that "negative interactions between doulas and other providers reflected the perception or experience of doulas' interference with clinical decision-making" (Neel et al., 2019, p357). All focus group participants in the study seemed to be clear about the parameters of their role and what was beyond the scope of their responsibilities; this may be related to the formal training that they had received. In this way, certification with formal training requirements may offer additional benefits in relation to clearly defining a scope of practice that is accepted and recognized by doulas, other providers with whom they work, and even administrators. As one participant explained:

> *The other thing about being a doula is that we don't do clinical tasks. So, there's a lot less risk involved as far as from a financial standpoint. And I think at least that's one of the things that DONA does right, is having a really strong scope of practice and code of ethics.*

Tensions between doulas and other providers may appear to be related to misunderstandings about doulas' scope of practice but may also be grounded in the role that doulas play as advocates. Recent research confirms that doulas fill a critical need with respect to patient advocacy (Attanasio et al., 2021), yet one doula acknowledged that some providers might feel threatened by this role:

> *I understand we never take the place of the medical provider, and we say that all the time. 'I'm only here to ask questions and to assist them in making an informed decision.' And so, by asking those questions, you shouldn't feel threatened because you're assisting them as well. And so, I think that's where a lot of those barriers come from is when we are assisting the clients in making informed decisions, and that comes across as a challenge.*

Beyond issues related to scope of practice and potential challenges related to advocacy and clinical decision-making, focus group participants described many experiences in which they felt they had been viewed as inferior. As one doula explained:

> *There's a hierarchy that comes into play… doctors, nurses, and doulas are the bottom of the barrel. We're really like the low man on the totem pole, and we are experienced. We are trained, we are certified, and I understand that we didn't go to school for 10 or 15 years to become a doctor, but we're still knowledgeable about what we do.*

Another doula relayed her experience observing doulas in practice and raised concerns about the ways in which Black doulas, in particular, may be treated poorly or viewed differently based upon the color of their skin. She described:

> *I've [observed] White clients that have had White doulas, you know. No complications or no questions, or you know, they're allowed to move freely. But then I [observed] one Black client who had a Black doula, and there was problem after problem where she was being questioned and it was like she could not do her job. And I know this woman. She's been a doula for over fifteen years. So, it was like why be that way? Why be treated differently?*

This is consistent with research by Kathawa and colleagues (2021), who found that many doulas of color, in particular, "feel alienated by the medical system" (p32).

There also seemed to be variation in relationships between doulas and other providers that was dependent on specific factors, such as type of provider, setting, or previous experience. This is highlighted in the comment by one focus group participant:

> *I was in a birthing center, and when I walked in, the midwife was like, 'Oh, my God! I'm so happy to see you.' It was like I had known her, and we were a great team, and I just feel like if I can meet up with other midwives before the mother even goes into labor, then it would be a more welcoming experience, and then they can see what I do, and I can contribute to that, and you know it all works out better for the birthing mother…But some people just look at me when I walk into a space, and they've never seen me before. They're kind of like, 'Okay, what are you supposed to be here for, or what are you doing, or am I in the way?' You know, I don't want that to happen, so I feel like the more we collaborate on a regular basis, that's a step in the right direction.*

Finally, some focus group participants acknowledged that tension with other providers may be more practical. For instance, doulas may support birthing people in ways that require changes in the way that care is provided or may disrupt the usual workflow. As one doula explained:

> *A lot of the work of the doula does directly conflict with some ideas of certain providers. If we're in the business of creating a comforting environment, that doesn't go with bright lights and people coming in and out of the room, you know. The nurses say no. We don't want her taking a shower right now or you know we need the bright light… It's just a conflict. I think part of it is just how a hospital environment works.*

Again, while we have yet to examine attitudes about doulas from the perspective of Delaware providers, these findings are consistent with other research that has found that culture, environment, and previous experience working with doulas is associated with positive perceptions of the value that doulas provide (Neel at al., 2019). In this way, relationship-building (as discussed below) can be an avenue for improving access and quality of care.

Theme: Building Positive Relationships and Opportunities to for better care

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 participant 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.*

However, focus group participants did not feel as if other providers shared this perspective about their place on the team and viewed this as a critical missed opportunity for improving the quality of care for birthing people. One doula elaborated:

> *A lot of us [doulas] want to work with the entire birth team. But we're closed out. It's been times I've walked in a hospital, and they love me. They embrace me, they're like, 'Come back, [doula name] please. You've been a great help.' But there were also times I walked in the hospital, and I was told 'Oh, she's all right…You know, like really standoffish, as if I don't have a space there in the birth area when his mom deserves that comfort. She deserves that support.*

Focus group participants highlighted the importance of including doulas representing communities of color on the care team, particularly for birthing people of color. Speaking about her own experience with the health care system in Delaware, one participant reflected:

> *Sometimes it's just a representation. Another sister sees another sister in the bathroom, and she feels comfortable because a lot of times we walk into these doctors' offices, we walk into these hospitals, and we see a bunch of White women on the posters. We don't see any of us, and that takes a toll on your mental health, even if it's just small. I didn't know what to expect, but I was at a point where it was like I got to go to this hospital because I don't know what's going on with me. And I walked in, and it was a Black woman, and she was a doctor. We're still friends to this day, because the connection that we had…and she spoke to my spirit that doctor there, and it*

was just seeing her. I've had encounters with doctors who were Black, and they weren't so good. But it was just seeing that it gave me a sense of calmness and that's so important.

Further, in connecting this to her experience as a doula working with a Black mother, she elaborated:

I've seen a sister where she was giving birth, and her nerves were just so tense, and that was keeping her away from progressing. She was going to need a c-section. [But] she was able to calm down. She had that baby the next hour. All she had to do was to come down. So, I believe representation matters.

While more research is needed in this area, there is an underrepresentation of Black primary care physicians in Delaware (Mitchell et. al., 2020) and a decreasing proportion of Black OB/GYN residents nationally (López et al.,2021). Given these trends and the importance of racial concordance between providers and patients in addressing the Black-White gap in infant mortality (Greenwood et al., 2020; Kathawa et al., 2021), it is important to give more attention to the integration of Black doulas, in particular, on care teams to improve birth outcomes for communities of color (Kathawa et al., 2021; Safon et al., 2021).

According to focus group participants, providing training for other licensed providers, and opportunities to get to know doulas, were ways that could 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. Reflecting a common theme across focus groups, one doula argued:

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 on, especially in their state. And I think that they should be aware that doulas are a part of the birth team.

Focus group participants also highlighted the need for education for other licensed providers. According to doulas, provider education should include building an understanding of the doulas' role as advocate for their client, particularly when working with communities who may feel marginalized in the health care system. Focus group conversations reflected an understanding of the need for such advocacy when supporting women of color, who often experience a lack of power in relationships with their providers and a diminished ability to make decisions for themselves (Altman et al., 2019). Doulas can help address this power dynamic through their role as advocates, as described by one focus group participant when referring to training of other providers:

Medical providers need to be aware, and it's not going to change everybody, because you got to think about it. We're coming in. We're advocating. You know we're going to speak up…and for me personally, I do it respectfully. I'm not here to argue with you. 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 respectfully. 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.

Focus group participants were generally optimistic about how both training and other relationship-building activities could support a more collaborative environment. Several participants suggested the

benefit of strategies to get to know one another better, outside the labor and delivery room. 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. I think getting to know people, you know, networking as opposed to just hearing... You actually sit down and talk to us. We can have an open back and forth discussion so everything can get laid out on the line, because when there is that tension… it's due to ignorance, it's due to lack of knowledge and not necessarily understanding the role of the doula, but I think they feel threatened. So, when that energy is in someone's face it can disrupt things. So, making sure that we come together, and having that open dialogue, I believe would be helpful.*

Finally, doulas emphasized opportunities for more integrated care by normalizing the role of doulas. They believe that once medical providers understood and valued doula care, they would be more apt to recommend it to their patients. As one doula explained:

> *I think it would be beneficial if, when getting your prenatal care, the option of a doula is offered... Just letting a patient know like, hey, this is an option. There are doulas here in Delaware. Here are some ways to find them if you want one…showing that it just opens someone's eyes to that option.*

Although there was some personal frustration expressed by focus group participants in terms of their relationships with other providers, these conversations were largely focused on the risks and benefits to birthing people. There was a sense that stronger working relationships could benefit the system and ultimately promote more integrated care and better outcomes. This idea is supported by research that suggests improved relationships and incorporation of doulas on care teams could help to address health disparities (Falconi et al., 2022; Neel et al., 2018; Safon et al., 2021). Further, while the research team has yet to explore these issues with licensed providers in Delaware, the optimism expressed among doulas about opportunities for building better working relationships through education is consistent with Neel and colleagues (2018), who found that "strained relationships could be improved through mutual respect between doulas and hospital staff, education about doulas' training, and role clarification…Nurses and physicians emphasized the importance of learning more about how a doula is trained to improve their trust in doulas" (p359).

Other Supports Needed

While the primary focus of our research was on training and certification, our focus group interview guide prompted participants to consider what other kinds of supports may be needed to improve access doula care in Delaware. Discussions centered around financial and administrative support for doula training, serving clients with limited resources, and Medicaid billing.

Other more specific recommendations included the development of a resource directory of support services and community-based resources for doulas to share with their clients, as well as a directory of doulas to share with medical providers for referral purposes. Further, some doulas discussed the value of building relationships with other doulas, and the fellowship and support that would provide, particularly among those who are newly practicing. Along these lines, some suggested that the State could support a formal organization that might coordinate training, professional development, networking, fellowship, and mentoring. Notably, one focus group member suggested that "it would be

important to keep in mind the different counties across Delaware" when establishing such an organization.

Finally, focus group participants expressed gratitude for the opportunity to share their perspectives on these issues, and an interest in continuing to be involved in planning and decision-making at the state level.

Theme: Financial and Administrative Support for training, services, and billing

As referenced earlier, focus group participants often described their work as a calling or a mission to serve. This often translated into doulas providing care to clients with limited means, resulting in limited income for doulas themselves. One participant explained:

> *Doulas need the money too. Me being a doula all this time, I've had an eviction notice a few times. There's been times where I was like right at that mark before my electric got turned off. It's been times where my daughter was walking around shoes that don't fit and ripping, and I couldn't afford to get her a new pair because the inconsistency sometimes in the work that I do. But I love this work, and this is my passion, and it would just, you know, burn me not to do this work. I believe that Medicaid reimbursement would be beneficial for both doula and clients of course.*

Another focus group participant echoed this sentiment:

> *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.*

Several focus group participants discussed 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." Another participant explained:

> *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.*

Existing grant-funded programs were highlighted, and doulas described the benefits to themselves as well as their clients. One explained, "It [grant funding] is now affording me to be able to turn around and give to someone else." Another focus group participant described the value of grant funding and the potential for Medicaid reimbursement this way:

> *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.

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 doula care. One doula explained:

> *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.*

One focus group participant 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.*

This argument is consistent with findings from Van Eijk and colleagues (2022), who raised concerns that Medicaid reimbursement could potentially perpetuate systemic racism in the health care system if securing such reimbursement discouraged doulas of color from participating. Findings regarding financial instability and stress among doulas are also consistent with research from Guenther and colleagues (2022), who concluded that such challenges can lead to burnout. Research funded by the U.S. Department of Health and Human Services argued for better compensation of doulas to strengthen the workforce (Kett et al., 2022)

Theme: Doula Representation in Planning and Decision-Making

Doulas expressed immense gratitude for the opportunity to share their perspectives and an interest in continuing the conversation as efforts to expand access to doula care at the state level evolve. Some shared frustration that decisions are being made without their input and encouraged policymakers to invite doula representation on planning committees and other decision-making bodies. One focus group participant expressed:

> *On the committees, we need to make sure that we have representation. I have noticed in the past couple of years, there's a lot of people that are making decisions, but they're not doulas. So, I don't understand how you can speak on something that you're not [expert in]… I think making sure that you get input from doulas is extremely important.*

Another doula echoed this feeling, arguing "One other thing I'd say is for policymakers, lawmakers, those who are in politics, to be receptive to speaking with us as well. That's been a barrier."

Another focus group participant specifically recommended establishing "an advisory group of community-based doulas…but also providing opportunities for doulas to attend meetings and advocate for necessary changes with the State of Delaware." These perspectives are consistent with research by Van Eikj and colleagues (2022), who found that more community input and participation in policy making is needed, especially regarding potential Medicaid reimbursement. Further, Guenther and colleagues (2022) argue that increased representation of doulas in policymaking is needed given the expertise that they have regarding addressing perinatal inequities among the communities they serve.

Discussion and Recommendations

Focus groups elicited critical insights about what is needed to support increased access to quality doula care from the perspective of community-based doulas. While it is difficult to distill the richness of the focus group discussions into a few key recommendations, this is useful to inform decision making at the state level in the short term. Many of the following proposed recommendations are consistent with recommendations based upon similar research in California (Chen & Robles-Fradet, 2020) and Oregon (Everson et al., 2018), though some are unique to the Delaware context:

1. **Recommendation on Training and Core Competencies –** While more research is needed to identify 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. Further, cultural competence training should be considered as an essential component of any approved training programs. Need-based financial assistance for training should be provided, particularly for those serving communities with the highest need, to expand access to doula care.

2. **Recommendation on Certification –** The state should provide flexibility in training requirements, including allowing different training programs and/or sponsoring organizations. In addition, certification that includes a pathway for experienced doulas to waive training requirements may be considered.

3. **Recommendation on Educating Health Care Providers –** Positive working relationships between licensed providers (nurses, midwives, and physicians) and doulas are critical for high quality, integrated care. Identifying and investing in strategies to raise awareness about doulas' scope of services and the value they offer to birthing people, along with promoting opportunities to build professional rapport across maternity care team members, will improve access to doula care and promote better birth outcomes.

4. **Recommendation on Doula Representation –** Regardless of approaches taken by the State of Delaware to improve access to doula services, it is essential for doulas to be represented in policymaking from planning through implementation. Policymakers should seek direct input from doulas through various ongoing methods (e.g., surveys, town halls, etc.) and include doula representatives on advisory boards or other decision-making bodies. Given the racial inequities in birth outcomes across our state and the persistence of structural racism in the health care system across the U.S., concerted efforts should be made to ensure doulas of color are included.

5. **Recommendation on Professional Development and Networking/Mentorship Opportunities –** Given the range of important topics that may be covered in doula training, the State and/or health care organizations should identify ways to encourage and support professional development of doulas. Topics of interest may be identified through input from doulas, particularly those serving birthing people with the highest level of need. Further, opportunities for networking and mentorship among doulas should be developed and supported.

6. **Recommendation on Navigating the Medicaid Reimbursement Process –** If Medicaid reimbursement for doula services is approved, the State or health care organizations should develop training and support systems for navigating the reimbursement process. Adequate ongoing technical assistance should be made available, and ease of processes should be prioritized. This is particularly 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 in the state.

Study Limitations

The researchers believe this study generated valuable knowledge to inform the 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. As discussed earlier, due to the relatively small number of focus groups, the research team was not able to reach saturation with many of findings (Glaser & Strauss, 1967). Said differently, the research team was unable to determine whether some seemingly unique ideas would rise to the level of a "theme" without additional data collection. The approach with member checking addresses this limitation, as research participants could review the draft findings, share additional information and/or suggest revisions. However, more research with a larger and potentially more diverse sample could offer additional insights. Finally, the findings highlighted concerns among doulas regarding their relationships with other licensed providers and doulas' assumptions about how those providers perceive them. While participants' feelings in this regard are valid, future research is needed (and planned) to gain a more complete understanding of provider awareness and attitudes regarding doulas.

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 to increase access to doula care. As the State of Delaware explores Medicaid reimbursement for doulas, and other infrastructure changes to better support doulas and the communities they serve, this report provides important insights about these issues from the perspective of community-based doulas. The recommendations offer a starting point for policymakers and health care organizations to move forward to ensure the delivery of the most accessible, high quality, and culturally competent care for birthing people in Delaware.

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Appendix: Doula focus group interview guide

1. **Introductions,** including: How long have you been practicing as a doula and what kind of care you provide (prenatal, support during labor/delivery and/or postpartum)? What are the characteristics of your clients, and whether you work alone or as part of a group/collective?

2. **Describe your training to become a doula. Potential prompts:**
    a. Did you receive formal training to become a doula? If so, describe.
    b. If not, how/where did you learn to provide doula care?
    c. In what ways was your training adequate (or not) for your current practice? When or how did you know when you were ready to be a doula?
    d. How well did your training prepare you to serve the women of color and/or women from low resource communities in Delaware?
    e. What training topics, if any, were missing that you believe to be important?

3. **What would you include in a list of core competencies for doulas who are seeking to effectively serve women of color and/or women from low resource communities in Delaware?** Potential prompts: How important are the following: trauma informed care, cultural humility, implicit bias, working with interpreters, breastfeeding, etc.

4. **What do you see as the difference between training and certification?** Potential prompts:
    a. In what ways do you think certification has value apart from training?
    b. How important do you feel it is for the State to require some kind of certification for doulas who are seeking Medicaid reimbursement for doula care?
    c. How important do you feel it is for hospitals to require some kind of certification for doulas who are seeking to provide care in their facility?

5. **If you were to design a system for certification of doulas at the state level, what would it look like?** Potential prompts:
    a. What kind of training requirements are needed for certification?
    b. What about years of experience or other ways to support certification? (e.g., letters of recommendation from clients, other providers, etc.)
    c. Other cost or administrative considerations?

6. **What role can community-based doula groups play in helping to prepare doulas to serve the Medicaid population (or women of color and/or women from low resource communities)?** Potential prompts:
    a. What kind of infrastructure would be helpful (e.g., a doula network)?
    b. Who should be involved? What role should the state play?

7. **What recommendations do you have for policymakers (and/or health care leaders) who are interested in creating a system that promotes doula care in our state that is equitable, sustainable, and inclusive?**
    a. What, if anything, is needed to help facilitate good working relationships among maternity care providers and doulas?
    b. What other recommendations do you have for integrating doulas into hospital-based care?

8. **Is there anything else you would like us to know about your thoughts and/or experiences as a doula?**