Doula Stakeholder Engagement: Report on Interviews with Licensed Providers of Maternal Health Care

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

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July 2023

Prepared by

Erin K. Knight, PhD
Assistant Professor
Department of Health
West Chester University
610-436-2113
eknight@wcupa.edu

Rebecca Rich, PhD
Assistant Professor
Department of Health
West Chester University
610-436-2138
rrich@wcupa.edu

Prepared for

Delaware Department of Health and Social Services
Division of Public Health

For more information, contact:

Leah Jones Woodall, MPA
Section Chief, Family Health Systems
Delaware Department of Health and Social Services
Division of Public Health
1351 W. North Street, Suite 103
Dover, DE 19904
302-608-5754
https://dhss.delaware.gov/dph/chca/fhsmhome.html

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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 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). Of the 11 maternal deaths that occurred in Delaware between 2018 and 2022, the majority were women of color (Delaware Maternal Mortality Review, 2022). Much more work is 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 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, ideally with input from relevant stakeholders. Researchers engaged maternal health care providers (i.e., physicians, midwives and nurses) across the state to gather their insight on the role of doulas; necessary training and certification; and relationships across the maternity care team. Researchers also sought insight on developing a statewide infrastructure to increase access to high quality doula care for women at risk of poor birth outcomes. The team aimed to gain an in-depth understanding of licensed providers' knowledge, attitudes, feelings, beliefs, and experiences related to the role and potential value of doulas as members of the care team. The research questions included the following:

- How knowledgeable are licensed providers with respect to doula care?
- What are the perceptions of licensed providers in regard to doulas?
- What is needed to facilitate positive working relationships between doulas and other maternity care providers?

The research team conducted key informant interviews with 12 licensed providers: six nurses, four physicians, and two certified nurse midwives. Interviews were conducted via Zoom (online video conferencing) between March and April 2023. Transcripts were analyzed using a combination of inductive and deductive methods. Detailed findings presented in this report are organized according to four major categories: role of a doula; credentials and competencies of doulas; logistical considerations

[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.

for policy and practice change; and challenges regarding doula presence in hospitals. To promote authenticity and credibility, each category's themes are expressed using direct quotes from participating providers. Findings from the interviews led to the following recommendations, which align with similar research conducted with providers in other places:

1. **Recommendation on Integrating Doulas onto the Care Team –** It is important to integrate personnel on the care team, and for doulas to become better oriented to the systems within which they would be working. Opportunities for doulas to get to know the institutions, doctors, and nurses – and vice versa – should be supported and promoted for cooperative working relationships to flourish. Further, all members of the maternity care team need more education about respective roles and expectations. Education and relationship-building should be an ongoing process as new doulas are trained and certified and/or new providers are established within the local health care system. There are many potential benefits of "meet-and-greets" and institutional orientations to help doulas and other licensed providers get to know each other. While hospital-based education and orientation sessions may be useful, state agencies and professional associations may have a role to play to educate their respective members about the role and value of doulas as members of the care team.

2. **Recommendation on Necessary Competencies, Training, and Certification –** Key competencies and skills, attained through structured training programs and validated through mandatory certification, are needed to improve access to high quality doula care and integrate doulas into care teams. Certification is an important avenue for promoting high quality care. Certification would ensure that doulas are knowledgeable in the necessary areas of pregnancy, childbirth, and postpartum care. In addition, certification would help to assure that doulas' scope of practice is well-defined and well understood, including articulating boundaries between doula care and medical practice. In this way, certification would promote high quality care by building trust and respect across the care team. Financial support for doula training and certification should be considered, particularly as the State aims to improve outcomes for vulnerable populations.

3. **Recommendation on Preparing for Challenges –** Specific challenges are likely to arise and should be prepared for in advance (to the extent possible). For example, this study's interviewees identified potential boundary conflicts between doulas, birthing people, and licensed providers. Such conflicts can be prevented (or lessened) by having improved lines of communication between all parties prior to birth. Any barriers to cooperation between doulas and care teams that result from cultural differences or practical constraints can be mitigated by relationship- and trust-building activities. Challenges associated with referral and reimbursement systems should also be anticipated; advance planning can support a smooth transition to Medicaid-supported doula care as state policy is enacted. These and other challenges can be minimized through the efforts described in Recommendation 1 and facilitated by a neutral party and/or by leadership at the state level, such as the Delaware Healthy Mother and Infant Consortium (DHMIC).

These recommendations are relatively general and speak more to approaches than specific strategies. This is due in part to the identification of many concerns and outstanding questions raised by study participants. For instance, providers were clear that certification should be required, but had few specific ideas about how such certification should look or how it should be implemented. Similarly,

some providers raised questions related to liability, handling of grievances, and other legal considerations.

Based on these and other observations, the research team has two additional recommendations for policy maker consideration:

a. **Recommendation to establish an independent statewide advisory board –** Outstanding questions and issues will invariably arise, and these can be discussed by independent statewide advisory board or other organizational mechanism to convene licensed providers and doulas. Membership should include all relevant provider types and doulas representing all three counties, as hospital systems and cultural characteristics vary by community. Given the existing power differential between doulas and other members of the care team, a neutral party should facilitate the group, and representatives from relevant state agencies should also be included (i.e., the Division of Public Health (DPH) and the Division of Medicaid and Medical Assistance (DMMA)) to contribute expertise and listen to stakeholder concerns.

b. **Recommendation for the State to support a comprehensive evaluation of pending policy changes –** As discussed earlier, there is growing evidence that speaks to the value and benefits of doulas in terms of improved patient outcomes, patient satisfaction, and lower health care costs. However, more research, grounded in the Delaware context, is needed to ensure doulas are integrated effectively and that increased access to doula care, does in fact, contribute to improved outcomes. An evaluation of current and future efforts can offer useful information about needed adjustments or refinements and can support ongoing policy and practice changes. Further, evaluation data may help to allay ongoing concerns among providers and others who may be skeptical about proposed changes to the health care system.

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 sample was purposive; it was important to interview licensed providers to obtain relevant and useful information (Suzuki et al., 2007). However, the findings may not represent all varied perspectives of licensed providers in the state. Further, the number and demographic characteristics of participating providers limited any conclusions that could be drawn based upon their characteristics. While purposive sampling was necessary and this limitation does not void the findings, it did not allow for in-depth analysis of the experiences of providers who are of the same race/ethnicity and/or socioeconomic background of the patients who were the focus of conversations in this study. The analytical approach also did not allow researchers to draw conclusions based upon factors such as the type and gender of providers, location of service, length of time practicing, and other demographic information that may influence providers' perceptions of doulas.

Despite these limitations, this research provides valuable insight from licensed providers in Delaware to improve access to high quality doula care. The companion report, *Doula Stakeholder Engagement: Doula Focus Group Study Report,* shares perspectives of community-based doulas practicing in the state. The authors recognize, respect, and value the knowledge, beliefs, and perspectives that doulas and licensed providers have gained by serving birthing people in Delaware. Combined, the recommendations from both reports offer a starting point for policy makers and health care organizations to move forward to ensure the delivery of the most accessible, high quality, and culturally competent care.

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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[2] (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 non-Hispanic White infant mortality rate is lower than the national non-Hispanic White infant mortality rate of 4.7 but the Delaware non-Hispanic Black infant mortality rate is higher than the national non-Hispanic Black infant mortality rate of 10.8 death per 1,000 live births (Delaware Health Statistics Center, 2023).

Like U.S. trends, maternal morbidity and mortality are on the rise in Delaware and Black women are particularly at risk (Trost et al., 2022). Between 2018 and 2022 in Delaware, 11 maternal deaths occurred, seven among women of color and nine of which were determined to be potentially preventable, according to the Delaware Maternal Mortality Review (2022). While the numbers of maternal deaths each year are relatively small, it has been 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 a myriad of 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).[3]

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 that only 6% engaged with a doula during labor (Declercq et al., 2014) and that women of color and low-income women face several barriers to accessing doula care. Other research suggests that licensed maternity care providers may be unaware of the benefits of doulas and/or may even resist the integration of doulas as part of the care team (Bohren et al., 2019).

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[2] 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.

[3] For more information on Delaware's infant and maternal morbidity and mortality, see the website for the Delaware Healthy Mother and 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 benefits of doulas and the importance of policy change to help address gaps in practice (Bohren et al., 2019), several states have started to reimburse providers for doula services through their Medicaid programs (National Health Law Program, 2022). Support for policy changes to expand doula care is also growing at the federal level, as the U.S. Department of Health and Human Services is engaging in several efforts to expand access to doula care, including providing guidance on ways to reimburse doulas through Medicaid (Knocke et al., 2022).

Recognizing 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: 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 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 the perspectives of licensed providers who work in Delaware about working with doulas.

Specifically, the research purpose was to engage licensed providers (i.e., physicians, midwives and nurses) across the state and gather their insight on a number of questions related to the role of doulas, necessary training and certification, relationships across the maternity care team, and other issues related to developing 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 licensed providers' knowledge, attitudes, feelings, beliefs, and experiences related to the role and potential value of doulas as members of the care team. The research questions included the following:

- How knowledgeable are licensed providers with respect to doula care?
- What are the perceptions of licensed providers in regard to doulas?
- What is needed to facilitate positive working relationships between doulas and other maternity care providers?

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 providers have gained through their experience serving birthing people in Delaware. The team believes it is critical to listen to, and learn from, a variety of stakeholders to inform policy development and ensure the delivery of the most accessible, high quality, and culturally competent care for birthing people.

Finally, this study is part of a larger project in which the research team also engaged with community-based doulas across the state to explore similar issues from their perspective. See the *Doula Stakeholder Engagement: Focus Group Study Report* for more information about doulas' views on 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 key informant interviews to address the research questions. Key informant interviews provide in-depth information on a given topic from the perspective of individuals who have relevant, first-hand knowledge, experience and/or expertise (Patton, 2002). As such, key informants can provide insight into the nature of problems and important contextual factors, as well as offer recommendations for solutions.

The study was approved by the West Chester University Institutional Review Board #2023-47.

Sample

The research team used a purposeful sampling technique to recruit key informants. The team aimed to interview different types of licensed maternity care providers (i.e., physicians, midwives, and nurses) representing the range of maternity care hospitals and health centers across the state.

Research partners at the Delaware Division of Public Health (DPH) and DMMA reached out to their colleagues at hospitals in Delaware that provide maternity care services and asked for their assistance in recruitment. Similarly, the team contacted existing maternity care provider networks, including the Delaware Healthy Mother and Infant Consortium (DHMIC), the Healthy Women, Healthy Babies Network, the Delaware section of The American College of Obstetricians and Gynecologists (ACOG), and the Delaware Health Care Association for their assistance. Leaders and contacts within these organizations were asked to personally invite potential participants whom they identified as having relevant experience. Potential research participants were required to contact the lead researcher, who determined eligibility and shared information including an informed consent document. Finally, research participants were encouraged to share information with their colleagues, and the sample grew through a snowball sampling technique. Maternity care providers not currently licensed in Delaware and/or not currently affiliated with a maternity care hospital or birth center in the state were excluded.

The final sample consisted of 12 licensed providers: six nurses, four physicians, and two certified nurse midwives. All three Delaware counties (New Castle, Kent, and Sussex) were represented in the sample, with six hospitals and/or health care systems represented. Four key informants held positions that allowed them to participate in policy or practice at the state level (e.g., on a statewide committee or board), and three key informants were formally trained as a doula, though were not currently practicing as a doula.

Data Collection and Analysis

Semi-structured interviews were conducted via Zoom (online video conferencing) between March and April 2023. All interviews were conducted by the lead researcher, who is a PhD-trained social scientist with extensive experience conducting qualitative research, including in-depth interviews, and expertise in maternal and reproductive health. All interviews 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.

Interviews lasted approximately 30 to 60 minutes and were facilitated using an interview guide developed to address the major research questions (Appendix). As a "guide," the list of

questions included the high-level topics that were asked in all interviews (in bold), as well as prompts that varied depending on the nature of the conversation. This semi-structured approach allowed for flexibility and ensured that the key topics were covered in every interview (Bryman, 2004).

Zoom recordings were automatically transcribed and data were manually cleaned for analysis. During this process, the lead researcher and co-investigator (also PhD trained with expertise in qualitative methods and women's health) created memos to note their ideas and facilitate reflection throughout the analysis process. Transcripts were analyzed using a combination of inductive and deductive approaches (Marshall & Rossman, 2006). First, all transcripts and post-interview reflection notes were reviewed to develop an understanding of the big ideas or patterns that emerged from interview conversations (Patton 2002). Subsequently, data were organized into categories which served as structured codes from which we were able to explore deeper meaning. A review of relevant literature and the interview guide informed this initial deductive analysis. The patterns identified through the initial review of transcripts were then refined, resulting in themes that were evident across interviews. The lead researcher and the co-investigator conducted the analysis, working together to discuss initial patterns, test alternate explanations, and refine the resulting themes. The themes are "supported by evidence from the data set in the form of excerpts from interviews that link the researchers' assertions to what was said by speakers in interview contexts" (Roulston, 2010, p151). This connection between researcher interpretation and the data increases the trustworthiness of the findings. Working together in the categorization and thematic analysis process, the lead researcher and co-investigator creatively organized the data while maintaining rigor by reading and re-examining interview data, memos, and categories into assertions supported by data excerpts (Roulston, 2010, p153).

Findings

Findings are organized below according to four major categories: role of a doula; credentials and competencies of doulas; logistical considerations for policy and practice change; and challenges regarding doula presence in hospitals. Within each category, themes are expressed relying heavily on direct quotes from research participants to promote authenticity. Where appropriate, previous research or supporting evidence is highlighted.

Category 1: Role of a doula

Participating providers had varying experiences working with doulas. Many had relatively limited direct experience working with doulas, though expressed a willingness to do so. The nature of their experiences also varied depending on the circumstance. Across the interviews, four themes were identified regarding the providers' perspectives on the role of a doula: (1) support for birthing people; (2) patient advocacy; (3) connection between birthing person and their care; and (4) non-medical partners with the care team. Participating providers were generally very positive about the role and value of doulas but made clear that these should be the general parameters of a doula's role.

Theme 1: Support for birthing people

Doulas provide various means of support for the birthing person in labor and delivery. Support for the birth parents was discussed in depth in the interviews, and providers described in detail the value and the varying nature of that support. Most often, the support that providers believed doulas should provide involved emotional and practical support as well as education. This emphasis on the supportive

role of doulas is consistent with existing scholarship regarding providers' expectations of doulas (Neel et al., 2019).

Providers expressed that emotional and practical support should be provided by doulas to birthing people before, during, and after birth. As seen in the following vignettes, this can be in the form of building a strong, healthy relationship between doula and birthing person, a sounding board for the parents' concerns, or someone to help the birthing person feel empowered in their decisions regarding their birth plan. As one provider stressed, the first step is for the doula to get to know the birthing person:

> *I really see the doula as the person who can support Mom. First of all, she has to know Mom. She has to learn what this mom wants. With a birth doula she has to participate in her prenatal care. The doula has to make herself known to the provider and the birthing woman also has to make known the fact that she wants a doula known to the provider and the doula and the provider have to figure out how they're going to work together.*

Providers see a particular value in this relationship-building process between the birthing person and the doula, as this generates trust which helps to reduce fear and anxiety. One participant explained that doulas provide a "consistent presence of someone who is supportive, and who they trust and that the family trusts. Which reduces the patient's anxiety, reduces the patient's fear, and it makes just for a calmer birthing experience." Another provider shared this sentiment by explaining how that trust between a doula and birthing person can also translate into more thoughtful decision-making:

> *I think with doulas, if they develop a bond with a patient who's scared… scared people don't do nitrous, scared people get epidurals, even if they don't know if they wanted that or not. But when they're scared, they're like, "oh, okay, anesthesia's available now, I'll get one." Whereas I think, with the comfort of a doula that they know and says, "okay, just remember, these were the things we talked about from pain control perspective. We talked about breathing, we talked about nitrous, we talked about IV medication, and we talked about the epidural." Just the kind of in the moment when a nurse is saying, "Okay, your pain's a 7 all of a sudden… Are you thinking you want an epidural?" If you don't have someone to kind of bring them back to what their full options are, they might take that as a suggestion instead [of a question].*

Importantly, this support was not described as a replacement for other providers or in conflict with the role of other providers, but rather as an "additional layer of support" and a complement to other members of the care team that could benefit the birthing person:

> *Yeah, I mean, I think it's support for a mom or pregnant person. I like to think of it as social capital. So you know somebody to listen to what a provider may be saying, and a second ear at times, or to run things by, or to give primary advice to a mom. I think that works well in the labor process. It's an extra level of support and comfort for that patient, and, you know, postpartum again, an additional layer of support to help guide that mom if she needs to get to an obstetrician or if she doesn't need to get to an obstetrician, or to run something by about the normalcy of certain findings. So I think I think it's an extra layer of support throughout the pregnancy process.*

One provider, who also had experience as a doula herself, explained that clarity on the birthing person's birth plan is an important part of the doula role that contributes to the support that they can provide:

A lot of non-medical pain management and really seeking to understand what that birth parent's birth plan is and exploring ways with them, and partnering with them on how we can best achieve that, as well as preparing them for if things don't go as exactly as planned, "here's how I can support you emotionally, so that you still feel whole, even if you don't exactly have the birth experience that you're aiming for."

Another shared this sentiment in describing the doula's role "helping a patient to process her hopes, dreams, and expectations for her birthing process."

As is evident in these quotes, providers understand the doula's support role begins during pregnancy and ideally continues through postpartum. This can involve things such as prenatal counseling, pain management, and emotional support and education in the initial breastfeeding process.

[Doula] service can help mitigate pain and decrease the rates of epidurals. Additionally, because of the education that's provided, and the support and that constant focus on that birth parent, we can also see a decrease in the likelihood of C-section, and we can also see an increase of breastfeeding rates right, because that person is there with them immediately after birth and helping them with really getting the baby time for skin to skin and latching on.

Some providers emphasized the support role of the doula as extending to partners and how such support could lead to a "calmer birth experience" for the entire family, particularly as the doula often becomes someone that the family trusts. For example, support for partners in relation to pain management was identified as an important role for doulas:

Partner management is a big deal because the partners very often feel powerless. Nobody likes to see your significant other, or if the mom is the support person, you don't like to see your daughter in pain. It's really hard to kind of say, "okay, they're going to break her water, and so what you might see is…you know, she could go from a pain level of 3 with these contractions; she might go immediately to a 6 or a 7, and that's not for sure. But you just don't need to be alarmed. What we can do is help her with a little hip pressure or counter pressure for her lower back, because that can be a thing that partners can give them." Or if they get really, really worked up to say, "Would you like to go to the cafeteria? And I can be here with her?" That way she's not alone, because partners will not leave their partner alone.

Another provider also emphasized that pain management and emotional support often include the other support people in the birthing person's life:

I think that, especially with like comfort, coping with pain and coping with anxiety, I think if you have a really well-educated doula, who is working with someone prenatally, and can help talk them through some of the medical procedures that may happen, help them to think through what their opinions are about those things, how they can make informed choices in the moment. I think they also help with being able to like integrate Dad into the picture a little bit more, so help him to understand a more supportive role that he can play by giving him suggestions of what to do, because I think, without really good – especially now with Covid, where you don't have like in-person childbirth classes and things like that or you've got really young parents – I mean Dad doesn't know what to do.

Later in the interview, this provider explained that the root of a doula's role is ultimately unbiased emotional and practical support.

> *But you know your job is not to control the outcome for that woman. Your job is to show up and support her for what she's choosing. You may be a doula who's really into unmedicated birth support. And you know you have a woman who wants an epidural, and that's what serves her in that moment. And so you want to, really, you want to be unbiased, because, in order to support the family you have to allow them to make choices that aren't choices that you would make as well. So you have to remove your own bias from that.*

Another interviewee shared this sentiment, along with a concern that some doulas they have worked with in the past have let their priorities interfere with those of the birthing person.

> *A doula should be a support person, essentially. In an ideal world, educated in the process of pregnancy and labor. A support person for the patient, having had lengthy discussions with the patient about the patient's desires, as well as understanding that people's desires may not always be medically achievable and sometimes you have to deviate from your desires… knowing that the patient can always change their mind. And it's about the patient; it's not about the doula.*

As these quotes reveal, providers generally viewed doula support as having value, but that support should be grounded in the unique desires, values, needs and circumstances of individual patients. This is consistent with the Standards of Practice and Code of Ethics for doulas promoted by DONA International, the widely recognized international leader on doula care. As explained in a DONA position paper, "Doulas do not make decisions for their clients; they do not project their own values and goals onto the laboring woman" (Simkin, 2012).

Along with providing emotional and practical support as described above, providers believed that doulas can best support birthing people by educating them on various aspects of pregnancy, labor, delivery, and post-partum life. Postpartum education and support was highlighted as a valuable role for doulas. One provider explained, "I feel that the doulas are important because they're also there postnatally, and to be able to ensure that these patients are understanding their discharge instructions, and how to care for themselves after delivery." Another explained in more detail how education is a critical part of postpartum support for birthing people.

> *I worked with them in a postpartum perspective, and that's where I found them to be really helpful and that would be just, you know, coordinating the follow-up care….There tends to be a big drop-off in the perceived level of support, and transitioning people from the information that we told you here in the hospital, in the acute care setting, and like, how does that apply here in the outpatient setting or 48 or 72 hours later. You know, what we said today at discharge might look really different than what is the case three days later. So the care is very fragmented because you have a mom who has a medical team and a baby who has a medical team at that point. And the patients, especially ones who are not medically inclined, really struggle with health literacy, and understanding the context of some of the education that they're provided.*

Providers also described supportive education as an empowering component of the doula's role with birth parents because information allows for better decision-making.

They're there to provide unbiased education ... So they're there to educate the couple before the birth happens about options and possibilities, comfort measures, ways that they can support one another. And really they should be like facilitating conversations ... within the couple, of you know, well, "I deal with pain best when there's low lights, and it's really quiet, and I don't like to be touched." A good doula will help those conversations happen organically between the parents. So that it's really their experience, you know, and they're more of like a facilitator, and then also giving them accurate evidence-based up to date education that empowers them to make choices within the actual event.

Theme 2: Patient Advocacy

Providers emphasized that patient advocacy is an important role for doulas, as they help birthing people to find their voice during labor and delivery. One provider described the role of a doula as:

Being an advocate and helping the mom find her voice… sometimes the voice that the mom has makes it hard for the staff to hear it. And a doula, I think, could play a wonderful role in helping a woman who's in labor, a woman who's coming in for delivery to bring that voice to a place that it can be heard there … Making sure that her needs are heard.

Other providers shared this sentiment and explained ways in which the doula's support could promote self-advocacy of the birthing person in a way that is most effective and meaningful. This was often described as the way in which doulas can simply help ensure the birthing person understands information that providers are sharing and empowering them to ask questions when they do not understand. For instance, one provider explained, the doula "can really help them if they're having trouble expressing what they're feeling or maybe not understanding things. They are there to say, 'Hey, you didn't ask these questions, like, are you truly understanding this?' " Another shared a positive experience that exemplifies this role:

I have this one doula that I love and what she does, she has a notebook with her. And she writes down the patient's questions, and she does not ask them to the doctor, but when the physician or the nurse, or somebody walks in the room, she says, you know I'm just going to use a name, "Hey, Darlene remember that you wanted to ask the question about blah blah blah blah blah." So she's empowering the patient to ask the question and she's not you know, saying, hey, how come we're not doing this, you know. She's reminding the patient of the questions that she had said earlier, or maybe something happened, and she said to the patient, "Oh, that's a good idea. We should ask." But she doesn't hit the call light every 4 min to say, oh, the patient has a question, the patient has a question… she writes them all down, so that when the health care provider comes in the room, then she's empowering the patient. And I love that because she's you know kind of giving permission to the patient to ask any and everything, which a lot of patients are afraid to do.

Providers emphasized the role of doulas in helping to advocate for populations that are particularly vulnerable or may have been marginalized in the past.

They truly are an advocate for the patients, especially patients that might not have had gone through an experience like birth before or maybe they had past experiences when they weren't treated well, or they had people in their lives, families, or friends that went through experiences where they weren't treated right.

Theme 3: Connection between birthing person and their care

A specific type of support that doulas provide is helping to connect the birthing person with appropriate care and/or helping them navigate the health care system. One provider explained, "A doula is very valuable because they're interacting with the patient; they're in many ways a 'go between' between the patient and the medical team." This idea was often expressed by providers with terms like "liaison" or "bridge":

> *I think they're a wonderful bridge. They're a qualified, educated bridge between the patient's values and the care that we offer. And they really can help to merge those two together. If I was talking specifically to my postpartum nurses, I would say," [doulas are] like an interpreter for your patient. They already have a relationship. They know them, but they also know the work that you have to get done, and so they help us to interpret the patient, and translate the needs of the patient, and help in return, help to explain your needs as a nurse, and the clinical things you have to get done in a way that the patient can understand and trust."*

> *We've tried hard to bridge the gap between medical care and the home, but it still feels like there's a big disconnect, and it's hard to get to our patients outside of the four walls of our exam room. So the impression that I have for doulas is that connection between the patient and the health care system which can be hard to get there all the time.*

> *I think that the doulas are making that connection with the mom, and you know, being able to help them navigate the system. A lot of patients really don't know how to navigate the system, as you know. Sometimes they see being pregnant as being healthy, and that they're not really compliant; whereas, you know, if they had a doula there, you know that they could explain the importance of getting care and making sure you know they're getting their glucose levels checked, getting our prenatal labs done, getting their ultrasounds done, going in for blood pressure checks. So I feel like, if we were able to provide doulas for those patients that there would be better outcomes and better outcomes for mom and baby.*

Other providers emphasized the importance of the role of the doula as helping to connect patients to care by acting as a sort of interpreter or translator; someone who can promote better health literacy, and in doing so ensure the birthing person understands the information that providers are trying to communicate. One provider acknowledges that the doula can "serve as a liaison between the clinical provider and you know those who kind of spit out a lot of medical jargon and help to ensure that the birth parent understands what that jargon means, so that they can make an informed decision." Other providers shared similar thoughts:

> *[Doulas] are kind of like a second set of eyes and ears for the patient, so if they miss something or didn't hear a provider or nurse correctly, they could share that with them again, or share it with them and their spouse, and to be that support, person and kind of like help guide them with like the next steps. You know, "Okay, the doctor is probably going to come in and check you again one more time, and if you're not dilating, then they may suggest Pitocin, or something to be able to be able to start your labor process" – so kind of being like those eyes and ears, and just mainly being there for the patient and giving them these next steps.*

I think there's a ton of times when I have seen patients here… And the nurse will come in and say something, and the patient's like, "okay, okay," and I look at them, and I'm like you don't get it, like I just know you don't get it, and I think that that's another role for a doula to really say, "Is this what you're saying?"

Theme 4: Non-medical partners with the care team

The notion of doulas as a part of the care team for birthing people during labor and delivery was discussed in-depth in each interview. Providers described the benefits thereof and considered how to better integrate doulas into hospital care teams. Providers were clear that doulas had specific roles and responsibilities (as described previously), and that there should be clear boundaries. As one provider explained, "doulas are the supportive role, to support and encourage and educate and empower women… And so nothing medical, right. They don't have the education to make it medical." Another provider echoed this idea, "they need to be the person's emotional support, mental support, and physical support. But they are not the medical support." These quotes highlight the reality of the situation expressed by many providers: doulas working with the care team can provide ample benefits to all involved, but the "how" of integrating them onto the team must be carefully considered.

In terms of benefits, providers often recognized the limitations of current maternity care practice, particularly with staffing shortages and the nature of hospital-based maternity care where nursing-patient ratios do not often allow for continuous patient support, and the ways in which doulas can help address those limitations. While many would like to be able to provide more support to birthing people, several acknowledged the value of doulas as an "extra layer of support." For example, doulas may alleviate some of the workload of nurses, as described by providers in the following vignettes:

I think, in these days, where hospitals are so strapped for staff, it can be very helpful, you know that if the hospital allows the doula to go into the kitchen to get ice or juice, or whatever that the doula can do that kind of stuff, and that's really helpful. A lot of labor delivery units don't have nursing systems to do things like that.

Another thing is that we're just like in a staffing crisis in medicine. So you know, if this can take the burden off a little bit... to help physicians and nurses and NPs like our whole care team provide the care, you know. That's great because we have still not enough staff to do the job.

Providers [should] understand that having a doula there at the bedside, only makes their jobs easier right? Because we're taking away a lot of need for running back and forth and trying to solve pain management issues and things like that, because having somebody right at the bedside solely focused on the parent can significantly help that.

I don't have to feel guilty not being there because the hospital… they can't support them. [Our hospital] is so short on nurses right now. There's no support, they can't, they don't… Even if they wanted to, they can't, so it fits a need right. So if you're so busy and say, somebody's in early labor, your priority isn't to make sure that they're well hydrated or those different things. But that's where the doula comes in… those comfort measures, and that support of constant, constancy is important.

Some providers also acknowledged the specialized expertise that doulas possess that enhances the care that the entire team can provide, particularly when working in partnership with one another:

Sometimes when I walk in [the doula] will say something about... "Can you think of another way that we can help her. She's having back pain right here," and she'll have the patient roll on her side, and she'll show me and that's fabulous, because yes, I can do that I can, you know, when she has pain right there. It means this. And so if I say it means that the baby's shoulder is going right by the hip. She's like, "Oh, that's my territory. I know how to do that, and she'll help spin the patient in such a way that [helps]… so that partnership is very valuable. I mean it. It's very valuable, because you know that's not something that a husband or a mother, or a mother-in-law… They can't do that because they have not been trained as a doula, that specific doula training, in partnership with the medical team is what we want.

Recognizing that challenges exist with respect to integration, providers offered specific suggestions about ways that doulas and the hospital care team can become more cooperative and better able to function together. As one provider saw it, "If a doula is coming into the hospital, they should have some idea of the hospital system." Others acknowledged that as doulas need to learn more about licensed providers and the way that the system currently functions, providers and hospital systems need to learn more about doulas. One provider explained, "You have to get together and be part of the community that's caring for the patient." Suggestions for how to do this included things like meet-and-greets and other relationship-building opportunities:

From the management perspective of a unit … if there was a doula company coming to work at the hospital that I was managing the labor and delivery unit, I'd want to bring them in to meet with them and have them invited to staff meetings from time to time… and people can ask questions and share.

I think you have to do things like meet-and-greets, and you know, like lunch-and-learns. And you know you have to get people talking to each other. So you need to increase your communication in order to increase the trust.

We all agree that there should be an orientation time for doulas to meet the providers and the nurses, and nurses to meet the doulas, to develop a better understanding.

Suggestions of having more opportunities for doulas and providers to meet one another and learn more about each other's systems and functions were also identified by Neel and colleagues (2019), who interviewed providers in Rhode Island. Their study highlighted the value of getting to know one another ahead of time, particularly as this might be a way to address concerns outside of the stress of labor and delivery. This was confirmed by one provider, who explained:

We can have some kind of "meet the doulas," almost like a town hall where we are inviting the doulas in a as a third party, meaning that you know there's another group that's facilitating these meetings. It's not like the doulas are forcing themselves in the front door…You know we can have muffins or something. Just meeting them when there's not, when we're not trying to work together. That's also going to help cross bridges, right? Because we've met them on the outside. And there may be physicians that may say "these are the things that drive me crazy about doulas," and the doula might say, "You know, because of our training we don't do that, so that concern off the table."

As expressed in this quote, meeting one another outside of the labor and delivery room allows for more productive conversations about roles and responsibility. This was also expressed by providers interviewed by Neel and colleagues (2019) who believe that more communication among team members was needed to ensure that roles are clearly defined and understood by all team members. Neel and colleagues (2019) found that this was particularly important when there was the potential for overlapping roles, such as with nurses and doulas. The providers who were interviewed seemed to be more concerned with doulas "overstepping" into the clinical realm and interfering with clinical decision-making (see more under Category 4: Challenges regarding doula presence in hospitals).

Importantly, many providers recognized that relationship-building, and especially trust-building, takes time. Several acknowledged that they found it difficult to build relationships with doulas when they only worked with them occasionally. This suggests that meet-and-greets, while an important first step, may have limited value until practice becomes more common.

> *At [our hospital], we have so many delivering families, there's a great opportunity here. We just have to learn from one another how we maximize each other's roles, and I don't think that with the any kind of infrequency of seeing the same people we won't be able to develop the rapport and make the process improvements.*
>
> *I feel like if there was more integration that took place, and like a stronger working relationship where you know, you have doulas that are working within the same hospital systems over and over again. And then the nursing staff get to know those people, and they start to understand what this person's role is… then that creates trust. And then also that doula now knows these nurses and these physicians, and now she's developed – he or she has developed a relationship with them that creates trust … between both sides of the coin within the community.*

This is consistent with research from Roth and colleagues (2016) who found that nurses who worked with doulas more often had more favorable views of doulas. The providers in our study emphasized the need for nurses to be included in the integration process, but they also stressed the importance of forming strong, trusting, respectful relationships among all types of providers. Further, while many providers identified opportunities within their own institutions for education and getting to know one another, some suggested that support and leadership from external groups could help to promote better relationships.

> *I think having the support from the Division of Public Health maybe or DHMIC, or the Perinatal Quality Collaborative, or other entity such as that to really promote the support of a doula would be helpful, because that's where a lot of our providers take [the] lead from.*

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

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

I think provider and care team education [is important] because there is definitely going to be a huge differing of opinions about doulas. And you know another thing in medicine that we view as the end all be all is evidence-based. So I know there's some evidence that doulas improve birth outcomes, and I first got interested in it because I was hearing the statistics about how racism alone can increase the risk of a bad outcome and that stress that has on a patient if a doula can make somebody feel less stressed, more heard, advocated for, safe – all of that, and that it's an evidence-based outcome. It's proof that this can actually improve outcomes. I think the medical community is always more likely to embrace things that [are] evidence based so I think that really educating… would be really important.

Category 2: Credentials and competencies of doulas

Having established the general role of a doula, providers then explained the ways in which doulas' credibility and legitimacy could be increased via certain credentials and skills. Two themes were identified regarding this issue: (1) certification and (2) training/competencies. It was clear that credentialing or certification, as well as training in specific skills and competencies, would lead to much higher acceptance of doulas in the hospital system and this was the focus of most conversations. The role of training and certification to promote better outcomes may have been assumed but was discussed as a secondary consideration.

Theme 1: Certification

Providers considered ways in which certification or credentialing could lend credibility to doulas. In the words of one provider, "If we're going to get credibility in hospitals, particularly, there has to be a level of credentialing that needs to occur." Others described their view of the value and necessity of credentialing as follows:

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

I think it's like the DONA nationally accredited doula program… they differentiate really well, the roles. As far as a health care perspective, that's the most important part.

I ask them (other nurses), what are the things that you would want, and what are things that you don't want, and all of them have said minimum standards. And so they either want a certification from something like DONA, or some kind of minimal qualifications.

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

According to providers, the trustworthiness of doulas working in the hospital system would be increased by a standardized certification or credentialing process. Were this to be the case, hospital care teams would feel safer and more accepting of working with doulas. As with the previously described importance of integrating doulas into the care team, the necessity of certification was also identified by Roth and colleagues (2016) as a way to increase trust and legitimacy.

Theme 2: Training/competencies

Along with stating that certification or credentialing would be a helpful step to increase acceptance of doulas in the hospital system, providers discussed the specific skills and competencies that should be included in training. These were things providers felt that doulas should know and/or be able to do to function efficiently in the hospital system. The fact that practitioners wanted to see specific education in doulas' training is consistent with findings by Neel and colleagues (2019). One point is that doula training should include both content and skill, and be broad in scope, as seen in the following three vignettes:

> *I would look for a combination of didactic and practicum. It cannot just be all OJT [on the job training]. There has to be a level of content in a classroom setting, whether it's an online or whether it's an in-person classroom setting where they can learn about childbirth. If they're going to establish the level of trust, they have to understand the complications of childbirth. They need to have significant training on social determinants of health and on ACEs. There needs to be information on, not heavy physiology and anatomy, but understanding the birth process.*

> *I think that a couple of things – And we're thinking about all doulas right? And we're thinking about all populations. I think doulas really should come in with a holistic lens. That's really what they're rooted in. But I think really kind of having an anti-racism understanding from a historical standpoint. I really think you know, kind of understanding the maternal health and infant lens around what's going on with our state from a historical aspect as well as now.*

> *I think that there's also gotta be a psychological training element like a mental health element to be able to – some sort of trauma informed training I mean, birth brings up a lot of stuff that is really intense, and so especially when you're in high-risk populations of women, I think it would benefit the communities that are being served to really have that integrated into the curriculum.*

Along with this holistic view, another provider emphasized that doulas should have training in the difference between birth settings, stating, "It would be beneficial to understand maybe the world of a hospital versus a home birth, and maybe how their roles may differ there. As well as how to interact with the clinicians within the hospital setting." In addition to the differentiation of birth settings, another provider explained that clear communication of the difference between care team members' roles would be beneficial:

> *I think definitely understanding what our training is like for nursing and physicians. How we are trained to provide care to our patients, and sometimes while we want it to be in parallel, sometimes the training is slightly different. While we understand their role, they also need to understand the type of training that we've received and the way we look at things when it comes to caring for the patient. I think that would really help us then truly be able to work in parallel with each other.*

And finally, providers stressed the need for doulas to be knowledgeable in evidence-based practice regarding prenatal care and birth practices:

> *I would say ... training in the evidence-based guidelines of prenatal care. Obviously they can't know all of them. But maybe you know, sort of the common recommendations, and then misconceptions things like vaccines is a big one.*

HIPPA things ... infectious disease … And you have criminal record check, right? All those things that make people safe so that would be part of it. And then it's how do you support a woman? So some trauma-based education. Diversity training. Positioning… How do you support women in positioning. What are the things in labor that support being peaceful? You know all those tools, the tools of labor.

In that training has to be a basic knowledge of pregnancy. I'm not talking, you know they don't have to be at the level of a nurse, midwife, or anything like that, but a basic understanding of pregnancy, and a basic understanding of the process of labor. The options that patients have. What are their options for different things in the labor process that can help them through the labor process. When is it time to say we're done.

Were this competency of basic knowledge included in training for future certified doulas, it would be another factor to increase trustworthiness, legitimacy, and acceptance of their role in the hospital system.

Category 3: Logistical considerations for policy and practice change

Should all doulas who aim to support birthing parents in hospitals acquire the necessary credentials and training, there are still logistical considerations that participating providers highlighted as necessary for discussion. Knowing that part of the purpose of these interviews was to inform policy surrounding reimbursement for doulas, providers stressed the logistical challenges that will almost certainly arise. Two themes were identified in this portion of the interviews: (1) supporting vulnerable populations; and (2) financial and legal concerns.

Theme 1: Supporting vulnerable populations

The race/ethnicity and socioeconomic status of the populations who would be most affected by potential policy changes are a factor in the reality of doula care. Providers explained that race/ethnicity and socioeconomic status play a role in the lived experiences of birth parents when it comes to social support, expectations, and language barriers to name but three factors. Doulas have the potential to provide value in this regard, but effectively serving this population is not without challenges. The providers discussed this point as follows:

The role of these doulas that would be covered by Medicaid in a lot of ways, I think, will be very different. A lot of the women who would really benefit from a labor doula are women who really haven't had prenatal care and need to have somebody supporting them during labor. They don't have good social support systems.

So I do think that it's really important to ensure that we have representation across the field – all fields in the medical industry, but that we're also culturally humble when caring for the patient and really sensitive to the fact that we're not able to speak for everyone, or assume culture and expectations, and all of those things for every person. So I do think that when it comes to black and brown women, or women specifically, who aren't white, they [may] come to the table with post-traumatic experiences dealing with bias in health care.

Yeah until Medicaid expands for… regardless of immigration status ... They would need some sort of grant funding or something in order to support that model, and in order to best support the community. And so, with the understanding that these children are going to be born U.S. citizens, and they're going to become the responsibility of the state as soon as they come out. So

why not take better care of Mom while she's pregnant? You know, so that you can have a healthier outcome and then less cost to the state is really what it comes down to on a very, you know, crude level.

The other piece is that I think we need to be in the communities where the health equity is not… Whether it's by zip codes, or household income, or whether we're looking at rates of morbidity and mortality and neonates, there's a billion different ways you can break it down.

The benefit of having doulas who are representative of the patients for whom they are providing care was also stressed by Schytt and colleagues (2021) who found that community-based bilingual doula support "improv[ed] women's well-being during labour and birth, and increas[ed] the possibilities for midwives and obstetricians to provide good and safe care" (p6). Another provider explained this value, stating, "I think it's really important too to make the training programs available to women from those communities so that people are being supported by other people within the community that maybe can help, you know, with language barriers." Others elaborated:

We're getting a larger population of Hispanics and Creole, especially in the Lower Sussex County, especially with the chicken plants being here. I think it would be wonderful if we could help some of these patients, and if we were able to have some bilingual translators/doulas that would definitely make a difference. I think we have to look at it in the equity piece and access to care because sometimes they've not had any prenatal care at all. They've just arrived here a couple of days ago and come in and deliver not really knowing anything. So I think that if we had those doulas present that that would take away a lot of angst for those patients. It's got to be pretty scary coming into a new country, a hospital, and not speaking the same language and our translation services that we have that are by phone, that a lot of them really don't speak Creole. So that communication piece is not really happening, and it can be kind of scary, especially if they need a stat C section, and you're not able to communicate … It pulls your heartstrings.

With all the inequities that are still going on today, especially with black birthing people in their communities. I think it is another layer of support and care for them, particularly. I know there is a huge push nationwide because, really a lot of the doulas are within their community. These doulas look like them, and they can form relationships prior to coming into the hospital, especially if there were any complications going on, especially with the patients. They're there. They have the full understanding and can really provide a lot of education and resources for these moms prior to coming into the hospital, during their day, and even post-delivery. I think that's a real added benefit to for a lot of these moms.

The reality, as described by the providers who are quoted in the following vignettes, is that many of the birthing people who would be affected by potential policy change live in fear of the birth process. Thus, the role of a doula becomes even more valuable for those birthing people from communities that have been marginalized and those with the highest risk of poor outcomes.

At [our hospital], we have a very large population of people that either arrive with no prenatal care like they're dumped off in the car, or they have folks that are severely underprivileged, severely underserved. They don't have a lot of help, and sometimes they're there by themselves. That's where a good doula will earn her keep. I'm telling you, she will change the reputation of all doulas if she's in that situation.

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

Theme 2: Financial and legal concerns

The potential financial and legal issues that may arise with future policy change were a concern of many interviewed providers. One concern that some providers raised in the interviews was regarding how doulas would be reimbursed. Providers discussed the nuance in care that doulas provide given the specifics of births and expressed apprehension surrounding the adequacy of compensation for that care. One provider explained:

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

This provider continued, explaining that depending on the nature of the labor and delivery process, compensation could become complicated. They recognized the value that doulas provide at different stages in the birthing person's experience and raised concerns about the coverage of at different stages if care became more complex:

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

In line with this point of adequate financial support for doulas, providers presented the option of potentially covering certification and/or training fees to support the inclusion of doulas. Further, as highlighted in several of these quotes, ease of billing and administrative processes, and/or support for those processes was believed to be important.

I think what we've heard from the doulas that the certification is expensive. Some of them have said they haven't gotten the certification because it's expensive. If that's the case, then the State could support that. I think if there are – with accepting Medicaid again, I think there's gonna be

a lot of responsibility on documentation, record keeping, billing, to ensure that there is not any fraud. And so I think the doulas are going to need support with that. Yeah, how to how to document how to make sure that they have great a good accounting for the money trail there.

Doulas should be certified too… I know there's the argument that it costs money to do that, and in certain populations that money is not available. In certain populations, people do not have the money to pay for the training and pay for the certification, but I think not being trained and not being certified is a disservice to the patient that you're supposedly serving. If the State thinks it's important the State should pay for it.

For the folks that say they can't afford it (training/certification), then maybe we need to have some scholarships. But I really think that in order for them to be able to get the credibility they deserve, they need to be certified.

In addition to financially supporting doulas, interviews with providers also included conversation surrounding the reality of covering doulas with insurance such as Medicaid. Beyond doula care for families before, during, and/or after labor and delivery, providers brought up the issue that some patients are currently delivering under emergency Medicaid. They stressed the importance of doula care in those situations being covered in future policy changes:

So about half the patients we see are uninsured. ... Medicaid is wonderful but it doesn't reach everybody, and our uninsured patients are some of the more vulnerable, and the ones that you know they still end up delivering – You know some of them get emergency Medicaid. So I'm not sure if that would be covered in that service. But if there's any opportunity for you know, uninsured or emergency Medicaid patients to participate in it.

Additionally, potential legal issues were considered which providers stressed should be addressed proactively.

A way to resolve like grievances, you know, like some sort of a responsible party within the State that can address any kind of concerns that are coming up, and you know, some way for that to be addressed if there is unsafe practices or something that's happening.

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

Category 4: Challenges regarding doula presence in hospitals

While all participating providers made clear that they want to see a healthy co-working relationship between doulas and hospital system care teams, clear challenges and barriers were identified across all interviews. Two themes were identified among these challenges regarding doula presence in hospitals: (1) Complicating decision-making and (2) potential barriers to cooperation.

Theme 1: Complicating decision-making

Having more people involved in the labor and delivery process has the potential to create challenges for the care team. As one provider described it, "When there's a third party involved, it makes it a more complicated the decision-making process." They continued:

Anytime you have a 3-way relationship ... it doesn't become a one-on-one conversation between a provider and a patient, or a patient and a provider. And so I mean, there are many things that should be shared decision making. But there are oftentimes where it's a challenging decision for a family or a patient about how to how to move forward. And any decision we make, whether it be with the doula or somebody else … if the doctor is recommending that we do A And then the patient thinks I don't know. Maybe we should do B. And the doula says, yeah, you should do B. Then it becomes an adversarial relationship, and it's difficult.

These concerns brought the conversation back to the role of a doula: non-medical support. Another provider explained the importance of this clarity:

I think that's also why I worry about it the most. In the sense also, you know and doulas they're not supposed to guide. You know they're supposed to support. They're not supposed to say, "hey, you don't need a C-section." But that's what happens sometimes is an obstetrician is recommending a C-section and a mom's like, "I'm not sure about that" and the doula says, "yeah, you should wait on that," or tell the mom that she shouldn't get antibiotics. Now, that's not right.

Theme 2: Potential barriers to cooperation

Providers discussed reasons doulas and hospital systems have not been able to cooperate as of yet. Many of the reasons identified, such as cultural differences and conflict between practitioners and doulas, are not unique to Delaware (Neel et al., 2019). Providers also shared stories of bad experiences that left lasting impressions but were open to doing the work to close the divide for the good of their patients.

The cultural differences between mainstream medicine and the more traditional approaches often used by doulas, and perceptions of those differences, was described by one provider as, "like an alternative kind of like a hippie type of thing. There's a lot of aversion to women coming with birth plans [for example]." Interviewed providers highlighted the "aversion" to doulas among nurses in particular. This echoes the findings of Liva and colleagues' (2012) work in Canada as well as Roth and colleagues (2016) in the U.S. and Canada. Thus, the barriers identified by interviewed providers in this study are not unique to the state of Delaware but are common among many groups attempting to encourage cooperation. The barrier of the aversion of nursing staff toward doulas on the care team is expressed in the following vignettes:

The conflict is, I mean, I think the first line of that conflict is going to be with nursing. So, if a doula – and again, this is an extreme example – tells a mom, "You know you don't need antibiotics, I wouldn't suggest that," for example, then the nurse is probably the first one to hear about it, and is going to go to the provider and say that. But yeah, they'd be there, kind of be the front lines.

I find that the nursing staff has a lot of judgment, and like kind of aversion to doulas, whereas I feel like they could be very useful and very helpful. But there doesn't seem to be a very connected or like cohesive workflow between nursing staff and doulas.

Additionally, some providers shared that nurses – as well as other members of the care team – can sometimes see advocacy on the part of the doula as threatening. In some providers' stories, there were

rare instances in which the doulas' efforts in the name of advocacy were considered threatening to the patients' well-being. These providers' experiences were described as follows:

> *It's like, well, this is what we're going to do, you know, and anyone that that wants to empower Mom to be more educated or to advocate, I think that seems like a threat from the nursing staff, and even from some of the medical staff as well.*

> *Some [doulas] feel as though they have to protect their patient from the health care team. And I think that that's really challenging. And it's almost become adversarial… There's a way to advocate for any woman or family, and we're not against advocacy. I don't think any one of us are against advocacy. I think it's very challenging when it's adversarial, when we are naturally just put in a position or where the patient is put in the position of seeing us as counter to her success.*

> *There are a large number of them that are incredibly supportive, helping patients to move forward in the process, support them in labor, incredibly helpful in the delivery process. There are also some that can set up an adversarial relationship and do that as their point of advocacy, by the way. Rather than advocating for patient desires, sometimes advocating for the disruption of care. There's been a lot of advocacy around Black maternal care, and there are a couple of pockets of doulas there that have set a very aggressive agenda where they are antagonistic to the health care system to the point that they're touching medical equipment, turning off pumps, things like that. They've come up with a birth plan that's not based in science, that is problematic. So please don't take this as I'm not pro doula. I'm incredibly pro doula but there are about 5% that unfortunately are really problematic.*

It is circumstances like in the previous quotes that leave a bad, lasting impression on providers. As one provider explained, "as they say, one bad apple ruins the bunch. And I think that because we don't really see doulas enough, we remember the one or two times we've had with doulas that were horrible." This negative impression, as described in the vignettes below, weighs heavily in providers' minds when they consider steps that could be taken to integrate doulas into their care teams.

> *We suggested even that we would put on our website the doulas that were certified so women can get it, and they didn't like that idea, and we've even started a birth companion program here with the University of Delaware, which is kind of not quite a doula, but again support for moms, they're nursing students and the doula community's up in arms about that.*

> *So you know, from our perspective...we treat them as visitors. And that's from that standpoint if we try to professionalize it and put criterion around it, we tried that and got tremendous, very angry push back from some members of the doula community.*

Even so, interviewed providers made clear that they do want to see these conversations and efforts at cooperation come to fruition for the benefit of all involved; they believe it is possible with time and hard work. To reduce the negative perceptions, providers think that education on both sides (as described earlier) is necessary to do bring all parties together.

> *I think in a lot of homebirth, midwife, and doula communities, you have a lot of misunderstanding and animosity towards modern medicine, and so you know it kind of creates*

this dichotomy of like an us and them. And I think a lot of it is just from a lack of knowledge and integration.

We want to make it work. We want to provide that support for women. And so I think that should be known. But it's – this stuff is hard. It takes a lot to work through the process. I think we'll get there. I think the doulas from what I sense, they just want us to say, like, yeah, sure, come on in and do whatever you want, but it's just not that simple on either side. So it's gonna take a while to get there and work through it. And I think it should be known that we want this to work. I mean, we want the best for our patients. We want support. If this is something that patients want, great, let's work on it, and let's make it work.

Discussion and Recommendations

Interviews with licensed providers elicited valuable insight into necessary considerations regarding policy and practice changes for improving access to doula care. While providers had varying experiences working with doulas, their concerns and recommendations are useful to help policy makers gauge the potential benefits and challenges that may arise. The recommendations that follow emerged from our analysis of interviews with physicians, midwives and nurses in Delaware, and align with existing scholarship regarding the incorporation of doulas as members of the maternity care team in other places as well (Lucas et al., 2019; Neel et al., 2019; Roth et al., 2016).

1. **Recommendation on Integrating Doulas onto the Care Team –** It is important to integrate personnel on the care team, and for doulas to become better oriented to the systems within which they would be working. Opportunities for doulas to get to know the institutions, doctors, and nurses – and vice versa – should be supported and promoted for cooperative working relationships to flourish. Further, all members of the maternity care team need more education about respective roles and expectations. Education and relationship-building should be an ongoing process as new doulas are trained and certified and/or new providers are established within the local health care system. There are many potential benefits of such efforts as "meet-and-greets" and institutional (e.g., hospital-based) orientations to help doulas and other licensed providers get to know each other. While hospital-based education and orientation sessions may be useful, state agencies and professional associations may have a role to play to educate their respective members about the role and value of doulas as members of the care team.

2. **Recommendation on Necessary Competencies, Training, and Certification –** Key competencies and skills, attained through structured training programs and validated through mandatory certification, are needed to improve access to high quality doula care and integrate doulas into care teams. Certification is an important avenue for promoting high quality care. Certification would ensure that doulas are knowledgeable in the necessary areas of pregnancy, childbirth, and postpartum care. In addition, certification would help to assure that doulas' scope of practice is well-defined and well-understood, including articulating boundaries between doula care and medical practice. In this way, certification would promote high quality care by building trust and respect across the care team. Financial support for doula training and certification should be considered, particularly as the state aims to improve outcomes for vulnerable populations.

3. **Recommendation on Preparing for Challenges –** Specific challenges are likely to arise and should be prepared for in advance (to the extent possible). For example, this study's interviewees identified potential boundary conflicts between doulas, birthing people, and licensed providers. Such conflicts could be prevented (or lessened) by having improved lines of communication between all parties prior to birth. Any barriers to cooperation between doulas and care teams that result from cultural differences or practical constraints can be mitigated by relationship- and trust-building activities. Challenges associated with referral and reimbursement systems should also be anticipated; advance planning can support a smooth transition to Medicaid-supported doula care as state policy is enacted. These and other challenges can be minimized through the efforts described in Recommendation 1 and facilitated by a neutral party and/or by leadership at the state level, such as the DHMIC.

These recommendations are relatively general and speak more to approaches than specific strategies. This is due in part to the identification of many concerns and outstanding questions raised by study participants. For instance, when discussing the importance of training and certification, providers were clear that certification should be required, but had few specific ideas about how such certification should look or how it should be implemented in the state. Similarly, some providers raised questions related to liability, handling of grievances, and other legal considerations but admitted to a lack of expertise needed to elaborate.

Based on these and other observations, the research team has two additional recommendations for policy maker consideration:

a. **Recommendation to establish an independent statewide advisory board –** Outstanding questions and issues will invariably arise, and these can be discussed by independent statewide advisory board or other organizational mechanism to convene licensed providers and doulas. Membership should include all relevant provider types and doulas representing all three counties, as hospital systems and cultural characteristics vary by community. Given the existing power differential between doulas and other members of the care team, a neutral party should facilitate the group, and representatives from relevant state agencies should also be included (i.e., the Division of Public Health (DPH) and the Division of Medicaid and Medical Assistance (DMMA)) to contribute expertise and listen to stakeholder concerns.

b. **Recommendation for the State to support a comprehensive evaluation of pending policy changes –** As discussed earlier, there is growing evidence that speaks to the value and benefits of doulas in terms of improved patient outcomes, patient satisfaction, and lower health care costs. However, more research, grounded in the Delaware context, is needed to ensure doulas are integrated effectively and that increased access to doula care, does in fact, contribute to improved outcomes. An evaluation of current and future efforts can offer useful information about needed adjustments or refinements and can support ongoing policy and practice changes. Further, evaluation data may help to allay ongoing concerns among providers and others who may be skeptical about proposed changes to the health care system.

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 sample was purposive; it was important to interview licensed providers to obtain relevant and useful information could be learned (Suzuki et al., 2007). However, the findings may not represent all varied perspectives of licensed providers in the state. Further, the number and demographic characteristics of participating providers limited any conclusions that could be drawn based on *their* race/ethnicity. Future investigations should aim for a more diverse sample since one of the resulting themes of this study was related to serving communities that experience disadvantage. While purposive sampling was necessary and this limitation does not void the findings, it did not allow for in-depth analysis of the experiences of providers who are of the same race/ethnicity and/or socioeconomic background of the patients who were the focus of conversations in this study. In addition, our analytical approach also did not allow researchers to draw conclusions based upon factors such as the type and gender of provider, location of service, length of time practicing, or other demographic information that may influence providers' perceptions of doulas. As this study was intended to be practical in nature, such nuances in participant characteristics were deemed irrelevant to addressing the research questions. Finally, qualitative research is subjective in nature, and therefore findings and interpretations of data are based on the subjective findings of the research team, who made choices of what to include and exclude in the conclusions of the study (Suzuki et al., 2007). However, the methods and measures of rigor assure credibility of findings.

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 licensed providers practicing in Delaware. The *Doula Stakeholder Engagement: Doula Focus Group Study Report* provides similar insights from the perspective of community-based doulas practicing in the state. Combined, the recommendations from both reports 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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References

Beck, A., Edwards, E., Horbar, J., Howell, E., McCormick, M., & Pursley, D., (2020). The color of health: How racism, segregation and inequality affect the health and well-being of preterm infants and their families. Pediatric Research, 87: 227-234. https://doi.org/10.1038/s41390-019-0513-6.

Bohren, M., Hofmeyr, G., Sakala, C., Fukuzawa, R., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 7*. Art. No.: CD003766. DOI: 10.10

Bohren, M., Berger, B., Munthe-Kaas, H., & Tunçalp Ö. (2019). Perceptions and experiences of labour companionship: A qualitative evidence synthesis. *Cochrane Database of Systematic Reviews 2019, 3*. Art. No.: CD012449. DOI: 10.1002/14651858.CD012449.pub2.

Bryman, A. (2004). Social research methods (2nd ed.). Oxford: Oxford University Press.

Declerq, E., Sakala, C., Corry, M., Applebaum, S., & Herrlich, A. (2014). Major survey findings of Listening to Mothers℠ III: Pregnancy and birth. Report of the Third National U.S. Survey of Women's Childbearing Experiences. *J Perinat Educ, 23*(1), 9-16. doi: 10.1891/1058-1243.23.1.9.

Delaware Health Statistics Center. (2023). Delaware Vital Statistics Annual Report, 2020. Delaware Department of Health and Social Services, Division of Public Health. Available at: https://www.dhss.delaware.gov/dhss/dph/hp/files////infant_mortality20.pdf.

Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2023). Pregnancy Mortality Surveillance System, Centers for Disease Control and Prevention. Available at https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

Falconi, A., Bromfield, S., Tang, T., Malloy, D., Blanco, D. Disciglio, S. & Chi, W. (2022). Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. *eClinicalMedicine, The Lancet*, 50(101531). https://doi.org/10.1016/j.eclinm.2022.101531.

Guenther, G., Kett, P., Skillman, S. & Frogner, B. (2022). The birth doula workforce in the U.S.: Rapid response brief. Center for Health Workforce Studies, University of Washington. Available at https://familymedicine.uw.edu/chws/publications/the-birth-doula-workforce-in-the-u-s-rapid-response-brief/.

Hill, L., Artiga, S., & Ranji, U. (2022). Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them. Kaiser Family Foundation Issue Brief. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.

Knight, E., McDonough, K., & Codes-Johnson, C. (2019). Health Equity Guide for Public Health Practitioners and Partners, Edition 2. Delaware Department of Health and Social Services. https://www.dhss.delaware.gov/dhss/dph/mh/files/heg2nded.pdf.

Knocke, K., Chappel, A., Sugar, S., De Lew, N., & Sommers, B., (2022). Doula care and maternal health: An evidence review (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Kozhimannil, K., Vogelsang, C., Hardeman, R., & Prasad, S. (2016). Disrupting the pathways of social determinants of health: Doula support during pregnancy and childbirth. *JABFM, 29*(3), 308-317.

Kozhimannil, K.B., Hardeman, R.R., Attanasio, L.B., Blauer-Peterson, C. & O'Brien, M. (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *Am J Public Health, 103*:e113–21.

Liva, S. J., Hall, W. A., Klein, M. C., & Wong, S. T. (2012). Factors associated with differences in Canadian perinatal nurses' attitudes toward birth practices. *J Obstet Gynecol Neonatal Nurs, 41(6*), 761-773. https://doi.org/10.1111/j.1552-6909.2012.01412.x

Lucas, L. & Wright, E. (2019). Attitudes of physicians, midwives, and nurses about doulas: A scoping review.

Marshall, C., & Rossman, G. (2006). *Designing qualitative research (4th ed.)*. Thousand Oaks, CA: Sage Publications.

Maternal and Child Death Review Commission, State of Delaware (2022). The Delaware Maternal and Child Death Review Commission 2022 Annual Report. Available at https://reviewtoaction.org/sites/default/files/2023-05/Delaware%202022%20Annual%20Report.pdf.

McComish, J. F., & Visger, J. M. (2009). Domains of postpartum doula care and maternal responsiveness and competence. *J Obstet Gynecol Neonatal Nurs*, 38(2), 148-156. https://doi.org/10.1111/j.1552-6909.2009.01002.x

National Health Law Program. (2022). Doula Medicaid Project. https://healthlaw.org/doulamedicaidproject/.

Neel, K., Goldman, R., Marte, D., Bello, G., & Nothnagle, M. (2019). Hospital-based maternity care practitioners' perceptions of doulas. *Birth, 46,* 355-361. doi: 10.1111/birt.12420.

Office of Health Equity, Centers for Disease Control and Prevention (2022). CDC's Efforts to Address Racism as a Fundamental Driver of Health Disparities. https://www.cdc.gov/minorityhealth/racism-disparities/cdc-efforts.html.

Patton, M.Q. (2002). *Qualitative research and evaluation methods.* Sage Publications.

Roth, L. M., Henley, M. M., Seacrist, M. J., & Morton, C. H. (2016). North American Nurses' and Doulas' Views of Each Other. *J Obstet Gynecol Neonatal Nurs, 45(6)*, 790-800. https://doi.org/10.1016/j.jogn.2016.06.011

Roulston, K. (2010). *Reflective interviewing: A guide to theory and practice.* Los Angeles: SAGE.

Schytt, E., Wahlberg, A., Small, R., Eltayb, A., & Lindgren, H. (2021). The community-based bilingual doula - A new actor filling gaps in labour care for migrant women. Findings from a qualitative study of midwives' and obstetricians' experiences. *Sex Reprod Healthc, 28*, 100614. https://doi.org/10.1016/j.srhc.2021.100614

Simkin, P. (2012). Position paper: The doula's contribution to modern maternity care. Available at https://www.agapedoulaservice.com/wp-content/uploads/2012/05/Birth-Position-Paper_rev-0912.pdf?x75311.

Suzuki, L. A., Ahluwalia, M. K., Arora, A. K., & Mattis, J. S. (2007). The pond you fish in determines the fish you catch: Exploring strategies for qualitative data collection. *The Counseling Psychologist, 35(2)*, 295–327. https://doi.org/10.1177/0011000006290983

Trost SL, Beauregard J, Njie F, et al. (2022). Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S. States, 2017-2019. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Available at https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.

Appendix: Licensed provider interview guide

1. **Introductions, including your current position, how long you have been in that position, and any other relevant background.**

2. **Tell me about your experience with or knowledge of doulas?**
   a. Have you worked with doulas in the past?
   b. If so, what has been your experience?
   c. If not, are you interested in working with doulas?

3. **Describe the role of a doula?**
   a. What role do you think doulas can play in relation to other maternity care providers? Or how do you think doulas can best support the pregnant person during labor and delivery and the postpartum period, while working with other maternity care providers?
   b. What value do you think doulas can provide? What do you think are some benefits of a pregnant person having a doula during the prenatal, labor/delivery and postpartum periods?

4. **What concerns, if any, do you have about the role of doulas?**
   a. If respondent has concerns – What would need to happen/change to allay your concerns?

5. **What concerns, if any, do you think your colleagues might have about the role of doulas as part of the maternity care team?**
   a. What do you think would need to happen/change to allay their concerns?
   b. If respondent appears supportive of doulas – How might you explain the value of doulas to a colleague that has concerns?

6. **What training/core competencies do you believe a doula should have?**

7. **What, if anything, is needed to help facilitate good working relationships among maternity care providers and doulas?**

8. **What other recommendations do you have for integrating doulas into hospital-based maternal care?**