NATIONAL HEALTH LAW PROGRAM

Building A Successful Program For Medi-Cal Coverage For Doula Care:

Findings From A Survey of Doulas in California

All pregnant and postpartum people deserve access to full spectrum doula care.

Building A Successful Program For Medi-Cal Coverage For Doula Care:

Findings From A Survey of Doulas in California

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Foreword

The National Health Law Program (NHeLP), founded in 1969, protects and advances the health rights of low-income and underserved individuals and families. We advocate, educate, and litigate at the federal and state levels to advance health and civil rights in the United States. Our lawyers and policy experts fight every day for the rights of the tens of millions of people struggling to access affordable, quality health care coverage free from discrimination.

NHeLP works to mainstream sexual and reproductive health in a seamless system of quality affordable care, and apply a reproductive justice framework to our advocacy and analysis. As such, our vision for that system includes the full range of reproductive and sexual health services, including abortion, family planning, and pregnancy care delivered with dignity in a culturally and linguistically responsive environment, free from judgment and coercion, and where cost is never a barrier.

This report is the distillation of an extensive survey of, and series of focus groups with, doulas across California. Doulas were asked about their current practice and expertise, as well as their thoughts about Medi-Cal coverage for doula care. Based on the input of the doulas who responded to the survey and participated in the focus groups, the report concludes with a series of recommendations for how to go about creating an equitable, inclusive, and sustainable program for Medi-Cal coverage for doula care here in California. The survey and focus groups were all held in California, so the recommendations here are specifically geared towards this state. However, they may also have resonance and relevance in other regions across the country.

Note on Terminology

At the outset, we note that this report occasionally uses the words "woman" or "women." This is not intended to be exclusionary. We recognize that different categories of people, including cisgender women and transgender men, are able to become pregnant. Accordingly, we have tried to limit the use of "woman" or "women" to conform to statutory and regulatory language, cited research and data, or quoted statements and material. Our underlying goal in this report is to share our findings and data to help ongoing efforts to ensure that all pregnant and postpartum people, regardless of gender, gender identity, and gender expression, have access to full spectrum doula care.

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ALL PREGNANT AND POSTPARTUM PEOPLE DESERVE ACCESS TO FULL SPECTRUM DOULA CARE.

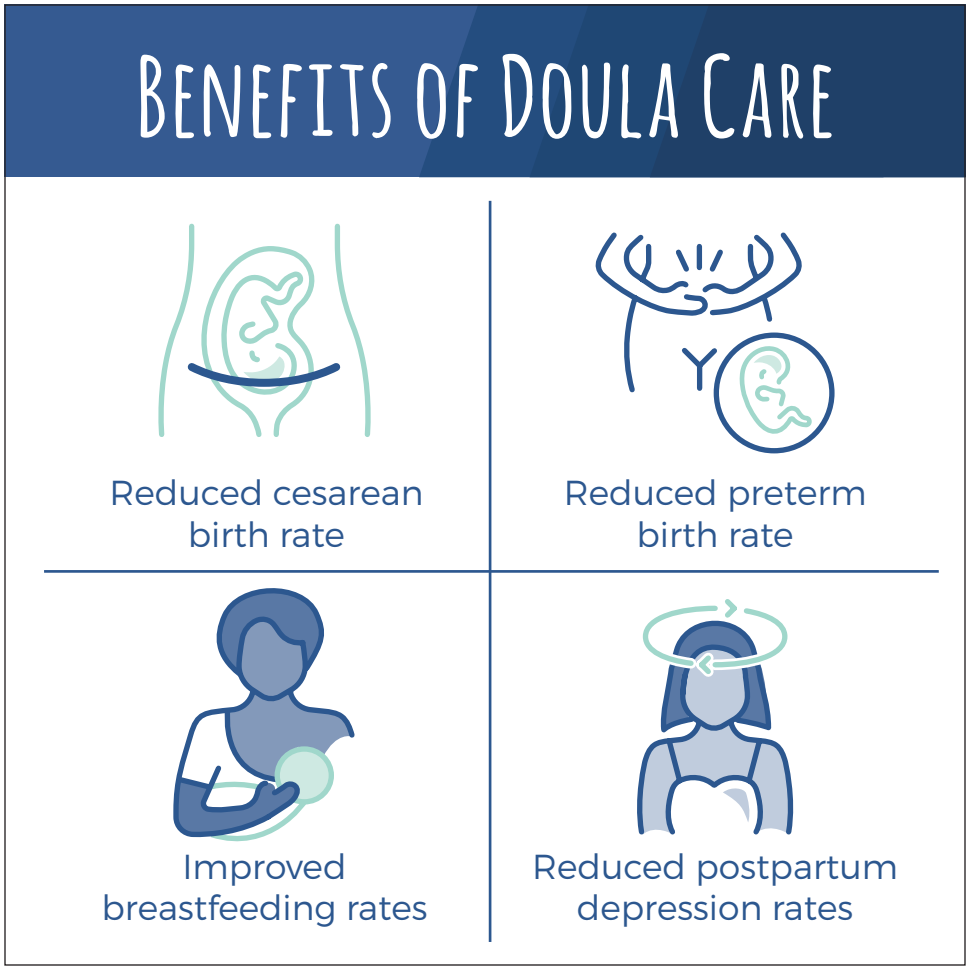
Introduction

The United States is in the midst of a crisis of maternal mortality.[1] Rates of maternal death are on the rise, in contrast to virtually every other similarly economically situated country. Thanks to concerted efforts in the last decade to make quality improvements to maternity care, California now has the lowest maternal mortality rate in the country.[2] However, broader institutional and structural racism, as well as the racial bias of individual providers in the provision of health care, continues to result in significant and disturbing racial disparities in maternal mortality and morbidity. The Centers for Disease Control found that between 2007 and 2016, Black and American Indian/Alaska Native women experienced pregnancy-related deaths at ratios four to five times that of non-Hispanic white women.[3] These disparities persist across socioeconomic status, age, and education.[4] These racial disparities hold true also for infant mortality and morbidity. The rates of prematurity and low birth weight, leading causes in infant deaths, are also highest for Black and American Indian/Alaska Native women.[5]

The United States also lags in the overall delivery of maternal care. One national survey of 2,700 women found that one in six reported mistreatment during childbirth, including such incidents as being shouted at or scolded by a health care provider, being ignored, and having their requests for help refused.[6] Women of color, women giving birth in hospitals as opposed to giving birth at home, and women with lower socioeconomic status, experienced mistreatment more frequently.[7] A survey of women in California also found reported bias in care based on both race and language.[8] A greater percentage of Black and Asian and Pacific Islander women reported unfair treatment, harsh language, and rough handling during their hospital stay, as compared to white women.[9] A greater percentage of women primarily speaking an Asian language or Spanish at home also reported unfair treatment during their hospital stay, as compared to women speaking primarily English at home.[10] Surveys of Black women in the San Francisco Bay Area reveal that they feel disrespected and coerced by their health care providers, and as a result are often fearful of institutionalized maternal health care systems.[11]

One potential solution to help improve both maternal and infant health outcomes is to expand access to full spectrum doula care.[12] Doulas provide individually-tailored and client-centered care to pregnant and postpartum people through information, education, and physical, social, and emotional support. Doulas also have the potential to help address health disparities by reducing the impacts of racism on pregnant people of color. In a 2018 survey, a majority of pregnant people who gave birth in California affirmatively expressed interest in having doula support for future births.[13]

While there is a limit to how much doulas can do in the context of individual and institutional racism in the provision of maternal health care, research has shown that the intervention of doula care can nonetheless have a profound impact on both maternal and infant health. Doula support has been found to reduce the rate of cesarean births and preterm births, among the key drivers of high maternity and newborn care costs.[14] Doula support also leads to improved breastfeeding rates and reductions in postpartum depression.[15]



Background

What is a Doula?

Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities, a report by Ancient Song Doula Services, Village Birth International, and Every Mother Counts, provide what we believe to be the best and most comprehensive definition of a doula that we have seen.[16] We quote from it here in its entirety (emphasis in original):

> ***Doulas are trained to provide non-clinical emotional, physical and informational support for people before, during, and after labor and birth.*** *Birth doulas provide hands-on comfort measures and share resources and information about labor and birth. Doulas can facilitate positive communication between the birthing person and their care providers by helping people articulate their questions, preferences and values.*
>
> *In addition to providing continuous support during labor and childbirth, birth doulas typically meet with clients one or more times at the end of pregnancy, as well as early in the postpartum period, although some hospital-based doula programs provide care only during labor and birth. In the postpartum period, doulas may offer help with newborn feeding and other care, emotional and physical recovery from birth, coping skills, and appropriate referrals as necessary.*
>
> *Doulas work with pregnant people to help them experience care that is individualized, safe, healthy, and equitable.* ***Doulas can be particularly beneficial for women of color and women from low-income and underserved communities and can help reduce health disparities by ensuring that pregnant people who face the greatest risks have the added support they need.***
> *Doula care can vary significantly depending on their training and approach. Community-based doulas offer an expanded model of traditional doula care that provides culturally appropriate support to people in communities at risk of poor outcomes. They are usually trusted members of the community they serve who are particularly well-suited to address issues related to discrimination and disparities by bridging language and cultural gaps and serving as a health navigator or liaison between the client and service providers.*
>
> ***Community-based doula programs include services tailored to the specific needs of the community they serve at no or very low cost.*** *In addition to birthing support, community-based doulas usually offer prenatal and postpartum home*

visits, childbirth and breastfeeding education, and referrals for needed health or social services. Many also support attachment and responsive parenting.

Because the benefits are particularly important for those most at risk of poor outcomes, ***doula support has the potential to reduce health disparities and improve health equity.*** *But for women in low-income communities living in maternal toxic zones, doula care is often out of reach due to financial constraints and the limited availability of doulas in their communities.*

Following is an abbreviated historical timeline of birth work in the United States and California.

Timeline of Birth Work in the U.S. and California

1850

Midwifery is legal but unregulated in the state

1900

Half of all children born in the United States are delivered with the help of a midwife attendant. Granny Midwives, typically Black women in the south, assist in countless births from the late 1800s through the mid-1900s. Immigrant midwives from Europe, Mexico, and Japan practice birth work in other parts of the country.

1911

New York City opens the first municipally- sponsored American midwifery school, called Bellevue Hospital School for Midwives. Births attended by Bellevue-trained midwives have lower maternal and infant mortality rates than the city-wide average.

1915

Prominent obstetrician Dr. Joseph DeLee speaks out against midwives at the American Association for the Study and Prevention of Infant Mortality annual meeting, spreading the falsehood that midwives cannot safely care for pregnant women.

1917

Midwifery becomes an official independent profession due to an amendment to AB 1375, California's Medical Practices Act, which creates a new category for state-certified midwives.

1930

Midwife-attended births drop to less than 15% of all births.

1949

At the request of the California Medical Board and medical lobby, SB 966 dismantles the midwifery licensing program and effectively makes midwifery illegal.

1969

Modern day concept of the "doula" emerges from the natural birth movement's desire low low-intervention, unmedicated births. The term is first used by Dr. Dana Raphael, a breastfeeding advocate who derives the term from the modern Greek term for "servant-woman."

1960s and 1970s

Direct entry midwives develop out of feminist efforts to reclaim bodily and birth autonomy.

1974

Nurse-midwifery law passes in California that requires Certified Nurse Midwives to practice under the supervision of an obstetrician.

1984

One of the first professional organization for doulas in the state, the National Association of Childbirth Assistants, is founded in San Jose by Claudia Lowe.

1992

Doulas of North America, now DONA International, is founded, becoming one of the first organizations to train and certify doulas.

1993

AB 1308, the Licensed Midwifery Practice Act, passes after over a decade of advocacy, facilitating access to home births by Licensed Midwives.

San Francisco General Hospital starts one of the state's early volunteer doula programs, to provide support to birthing women and their families

2012

Oregon's Medicaid program begins providing coverage for doula care. Minnesota follows two years later.

2020

States across the country begin introducing bills relating to Medicaid coverage for doula care. In 2019, Indiana and New Jersey pass bills providing Medicaid coverage for doula services, while Washington passes a budget item.

Assemblymember Eloise Gómez Reyes introduces California Assembly Bill 2258, which proposes to create doula pilot program for Medicaid enrollees in 14 California counties with the highest rate of birth disparities.

Medi-Cal Coverage for Doula Care

Most doulas are paid by their clients out of pocket, and the cost for their services range from several hundred dollars to over $2000. While people who are able to access health fare flexible spending accounts (FSAs) can sometimes use that mechanism to defray the cost of doula care, virtually no private health plans cover doulas. The high cost of doulas, coupled with the lack of coverage in public and private health plans, means that many pregnant people, especially those who are low-income and/or on Medicaid, are unable to afford the cost of doula care. One doula who responded to the survey said: "[S]o many people are being left unserved simply because they think they cannot afford a doula so they don't even consider it or they know they cannot afford it so they don't consider it."

Doula providing support to a client
Photo used with the permission of Kindred Space LA

As of April 2020, there are only a handful of states with existing programs for Medicaid coverage for doula care. Oregon has provided Medicaid enrollees with doula care since 2012, and Minnesota since 2014.[17] However, interest in expanding access to doula care for Medicaid enrollees is growing nationwide. In 2019, Indiana and New Jersey passed bills providing Medicaid coverage for doula services in their respective state Medicaid programs, and Washington passed a budget item pertaining to Medicaid coverage for doula care.[18] In 2019, Florida's state Medicaid agency also began exploring expanding access to doula care for Medicaid enrollees. In total, during the 2019 legislative session, over a dozen states introduced bills relating to Medicaid coverage for doula care, and thus far during the 2020 legislative session nearly the same number have.[19]

California's Medicaid program, Medi-Cal, does not currently provide doula care for the almost seven million women enrolled in the program.[20] If California begins providing such coverage to Medi-Cal enrollees statewide, it could have a significant impact on infant and maternal health in the state, given that half of all births in the state are funded by Medi-Cal.[21]

In February 2020, Assemblymember Eloise Gómez Reyes, who represents California's 47th Assembly District, introduced California Assembly Bill 2258, which created a statewide doula pilot program for Medi-Cal enrollees in the 14 counties experiencing the highest burden of birth disparities.[22] In April 2020, in the midst of the global COVID-19 pandemic and an emergency state budget, the bill was held in the Assembly Health Committee, and did not move forward that legislative session. In spite of AB 2258 not moving forward in 2020, the advocacy efforts that coalesced behind the bill continue to push for expanding access to doula care and addressing disparities in maternal health.

We know from the experience of other states that implementing a program for Medi-Cal coverage for doula care in California will be successful only if it is designed to address equity, inclusivity, and sustainability needs. It is for this reason that the National Health Law Program undertook to conduct a survey of, and series of focus groups with, doulas in California, both about their current practices as well as what they think about Medi-Cal coverage for doula care. Our purpose was to raise up the thought, concerns, and input of doulas, particularly with respect to Medi-Cal coverage for doula care. Our analysis of the survey results and focus group discussions, and the recommendations that come from them, should help California to build a successful program for Medi-Cal coverage for doula care.

Methodology

Survey Methodology

Conducting the Survey

This survey was conducted as part of the National Health Law Program's ongoing advocacy for Medicaid coverage for doula care. The goal of the survey was to collect input from doulas currently practicing in California. Survey questions touched on a variety of topics including their scope of practice, training, certification, and reimbursement issues. We also collected demographic information about doulas and their clients.

We conducted the survey through an online SurveyMonkey form that was posted at http://www.doulamedicaidsurvey.org. We originally held the survey open from October 1, 2018 to November 15, 2018. During that time we received responses from 243 doulas across the state. Unfortunately, we were not able to reach a sufficiently diverse pool of doulas in this first effort. Therefore, we decided to reopen the survey to do more targeted outreach and get more responses from diverse doula groups. We were particularly interested in hearing from doulas of color, including doulas who are Black, Latinx, Asian, Pacific Islander, and Indigenous/Native American. We were also interested in hearing from doulas who currently work with low-income and underserved clients, including clients on Medi-Cal and other types of public insurance.

The second iteration of the survey was open from January 3, 2019 to February 15, 2019. During this period, we received responses from 100 more responses from doulas across the state, bringing our grand total to 343 doula respondents. The proportion of doulas of color who responded to the survey this second time around was much higher than during the first iteration.

Survey Questions

The survey was comprised of eighteen mixed-method questions: nine multiple choice and nine short answer. One final question asked participants to provide any additional comments. Survey participants had the option to skip any questions they wished not to answer. Of the 343 total survey participants, 35 skipped at least one question.[23] For the complete list of survey questions, please see Appendix B.

Survey Distribution

NHeLP distributed the survey by email to local, regional, and statewide partners in health care access, maternal health, and reproductive health, rights, and justice. Additionally, individual doulas and doula collectives subsequently sent the survey to

their peers and fellow doulas and other birth workers across the state through personal channels including email, social media, and word of mouth.

Survey Participant Compensation

During each of the iterations of the survey, we held a drawing for eight $50 gift cards. Those who wished to be included in the drawing for the gift cards had to leave their name and contact information at the end of the survey, and also check a box stating they would like to be included in the drawing for the gift cards. After each iteration of the survey, we assigned a number to each doula who wanted to be entered into the drawing for the gift cards, based on the order in which they completed the survey. We then used the program at random.org to generate eight random numbers. We contacted each randomly selected doula to confirm the mailing address that they wanted their gift card to be sent to.

Survey Limitations

We would like to acknowledge that of all the doulas and other birth workers who provide support for pregnant and postpartum people in California, only 343 responded to our survey. Thus, while we believe that we can draw some important findings from these survey results, we also caution the reader not to take these survey responses as either reflecting a consensus on the part of doulas in California, or as a complete and thorough assessment of doulas in California. There are likely doulas that the survey did not reach, for a variety of reasons: some birth workers may not operate under the term "doula," some may not provide what are considered typical mainstream doula care, and some may not have been aware of, or had access to, the survey.

Focus Group Methodology

Conducting the Focus Groups

In addition to the survey, our team conducted four in-person focus groups in late 2019 in Fresno, Los Angeles, Oakland, and Sacramento. We also conducted two virtual focus groups in early 2020 with doulas from Sacramento and Fresno. These four locations were selected based on their approximate regional representation across the state.

Each focus group was compromised of between 3 to 14 individuals who were either doulas or doulas-in-training. Focus group participants were selected based on their availability and their willingness to attend. Participants ranged in experience, from doulas with decades of experience to doulas who were still completing their training. There was also a range in terms of training background, from doulas with formal training, to those with primarily hands-on training and/or training that composed of their having shadowed experienced birth workers. This variety was true across all four of our focus group locations. This gave us a wide range of opinions from doulas in different stages of their careers and experience level.

After completion of the focus groups, we notated and coded the transcripts of each of the focus groups to determine patterns on the following topics:

- patterns in length of time practicing as a doula,
- type of care provided (e.g. full spectrum, birth services, etc.),
- type of training received,

Doula focus group discussions in Oakland and Sacramento Photos by NHeLP

- views of certification,
- views on community based doulas,
- views on reimbursement,
- interest in serving a Medi-Cal population,
- policy recommendations, and
- the role of a doula.

The focus groups were an integral part of our report and analysis because they allowed us to see and connect directly with doulas across the state who were serving their communities. The focus groups gave doulas an opportunity to engage with the survey topics in a group setting, and to address questions, comments, and concerns dynamically as they came up in the context of discussion. We also used the focus groups as an opportunity for participating doulas to provide feedback on our analysis of the survey and the initial recommendations that we took from the survey results.

Focus Group Questions

We began each of the in-person focus groups by inviting the doulas to circulate around the room and provide written responses to a series of five questions we had up on large sticky note pads around the room. These questions related to how they currently received payment, the amount of Medi-Cal reimbursement that would be sustainable, recommended core competencies for doulas serving Medi-Cal population, their thoughts on working alone versus working as part of a collective, and recommendations for policymakers on sustainable and equitable Medi-Cal coverage for doula care.

For the remainder of the focus group time, we dived into the same set of seven questions for each focus group, and then concluded each focus group with two closing questions. In some cases, the focus group conversation proceeded in such a way that we ended up skipping discussion on certain questions. For the complete list of focus group questions, please see Appendix C.

Focus Group Participant Compensation

Focus group participants were each compensated for their time with a $50 gift card, which was either given to them in person or subsequently mailed to them after the focus group. We also provided lunch or dinner to all participants in the in-person focus groups.

Report Feedback Convening

Once we had an initial draft of the report completed, we then held a virtual report feedback convening in March 2020 with a small group of doulas. The objective of the convening was to get some high level feedback from the doulas on our initial draft report recommendations. At that convening, we shared a summary of the report and the initial report recommendations. We described and then discussed as a group each report recommendation. Based on the feedback we received at the convening, we revised some portions of the report and recommendation language. Report feedback convening participants were each compensated for their time with a $50 gift card.

Doula focus group in Los Angeles
Photo used with the permission of Kindred Space LA

Findings

Doula Care in California

Who are doulas and who are they serving?

The doulas who responded to the survey self-identified as follows:

- American Indian or Alaska Native: 2.95%
- Asian/Asian American: 2.65%
- Black/African American: 19.47%
- Latino/a/x: 12.98%
- Native Hawaiian or Pacific Islander: 2.06%
- White: 61.65%
- Mixed race: 8.25%
- Other: 0.88%
- Decline to state: 2.95%

The doulas who responded to the survey stated that their clients are:[24]

- American Indian or Alaska Native: 2.93%
- Asian/Asian American: 11.63%
- Black/African American: 12.56%
- Latino/a/x: 15.09%
- Native Hawaiian or Pacific Islander: 1.53%
- White: 38.93%
- Mixed race: 10.93%
- Other: 8.14%

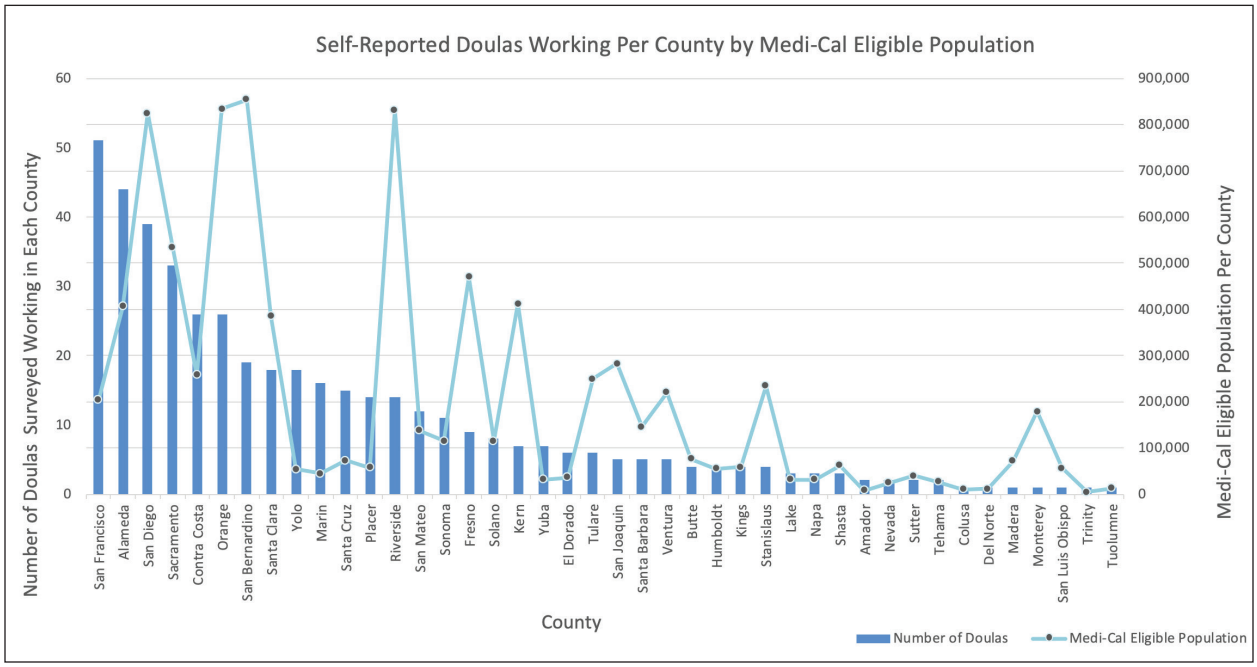
Meanwhile, the racial/ethnic breakdown of the Medi-Cal population is as follows:[25]

- American Indian/Alaskan Native: <1%
- Asian/Pacific Islander: 10%
- Black/African American: 8%
- Hispanic: 50%
- White: 18%
- Not reported: 13%

Participants in a childbirth class
Photo used with the permission of Kindred Space LA

The graph below shows the number of doulas who reported working in each county, along with that county's Medi-Cal eligible population. Counties where no doulas reported working in our survey are excluded from this graph. In our survey, doulas

were able to report working in more than one county. Thus, some doulas reported work in more than one county and are counted in each county they reported. Los Angeles County has a significantly higher Medi-Cal eligible population (3,774,032) than other counties in California, as well as the highest number of doulas (99) who reported working there. To preserve the ability to illustrate the other county distributions, the Los Angeles data points do not appear in full on this chart.



While we cannot say with certainty that the demographic data of the doulas who responded to the survey is consistent with the overall demographic data of all doulas practicing in California, we do believe the data demonstrates at least some level of mismatch between the racial/ethnic background of doulas currently practicing in California, and the population of individuals enrolled in Medi-Cal. This observation is important because studies have shown that doula care is most effective when a doula is able to provide culturally congruent care with their client.[26]

Relevant to the topic of cultural congruency, focus group participants discussed their anxiety around people wanting to become doulas for the money, but not necessarily having any connection to the community they were working with. One doula who participated in the focus groups said: "It can't turn into something else where it's not heart driven. There has to be enough of that born-to-be-a-doula part in there that it keeps the people who were born to be doulas and not people that are—so people do it for the outcome, not the income."

Some doulas participating in the focus groups also expressed anxiety that people from outside the community would use a marginalized community to train or gain experience, but would then leave to practice somewhere more lucrative. Because of

these concerns, focus group participants suggested that there be an incentive to encourage interested people in the community to become doulas and support them in their education and training.

At the same time, doulas participating in the focus group were unequivocal about the benefits that doulas can provide to their clients:

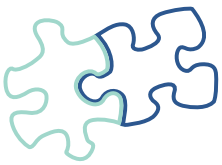
> *"As African Americans, we don't go to the hospital for—not even when we're sick. But if you have a good doula and Medi-Cal is supporting that full service, I guarantee you that mom is going to go to every last prenatal appointment that she needs to go to, and she will probably have a better turnout than if she didn't because she has that extra help, and she's not being eliminated from our society as society labels us."*
>
> *"It's about empowering these ladies so they can go and advocate for themselves, for one. For two, it's allowing them to stand the ground that they want—how they want the delivery, how they want to have their baby. Do they want to have the baby at home? It's about their birthing rights all together, and if they go into that room and they are empowered by what they know, they're going to be treated better, for one, for African Americans; they're going to be not labeled as, "Oh, she don't know what she's talking about, so let's just do what we want to do," and for three, it allows her to have an amazing childbirth journey in the end."*

Participants in a prenatal and postpartum support group. Photo used with the permission of Kindred Space LA

In order to be most effective and have the most positive impact, many of the doulas providing care would ideally come from the same communities as the Medi-Cal enrollees who are their clients. New community-based doulas must be trained up to serve the Medi-Cal population. This new generation of doulas would also draw from communities of color, in particular Latino/a/x, Asian/Asian American, Native Hawaiian or Pacific Islander, and Black/ African American communities.

Lastly, it is important to note that some people who wish to become doulas do not have the financial resources to undergo the training. Fee waivers and other types of financial assistance could go a long way in helping increase work force diversity and lower barriers to entry for doulas. One doula

who responded to the survey stressed the importance of reducing such barriers to entry for individuals from the community who wish to become doulas, but may not have the money to pay for necessary training: "If scholarships and fee waivers need to happen for doulas of color to access these certified trainings, then that needs to happen. Clients fare better when their health care providers, including doulas look like them and have shared experiences in terms of background, experiences of oppression, stories of resilience, healing modalities, and so much more."



RECOMMENDATION ON DOULA WORK FORCE:
Diversify doula care work force to be a better match to provide culturally congruent care to the Medi-Cal population. Provide fee waivers and other incentives to help recruit doulas from low-income communities to join the work force.

Where are doulas practicing?

Doulas who responded to the survey are practicing in 43 out of the 58 counties in California. The counties that have the highest concentration of doulas per capita, based on survey results, are Los Angeles, Alameda, San Bernardino, Fresno, San Francisco, Santa Cruz, Santa Clara, Riverside, San Diego, and Sonoma.

California still has some areas considered maternity care deserts, which the March of Dimes defines as "a region where access to maternity health care services is limited or absent, either through lack of services or barriers to a woman's ability to access that care."[27] This is particularly true in California's rural regions, where people often have to travel very long distances to access basic health care services.

"My community for example, is about an hour to the nearest hospital but many choose to deliver at the next one over [which is] 1.5 [hours away]. I don't get many clients from my community, so I travel those distances for interviews and prenatal visits."

It is clear that the presence of doulas and access to doula care can go a long way in helping to support the health and well-being of pregnant people in some of California's more rural regions. One doula who responded to the survey stated that: "My community for example, is about an hour to the nearest hospital but many choose to deliver at the next one over [which is] 1.5 [hours away]. I don't get many clients from my community, so I travel those distances for interviews and prenatal visits."

RECOMMENDATION ON ACCESS FOR RURAL AREAS:
More doulas are needed to serve in rural regions of California, where people often have to travel very long distances to access basic health care services. Provide fee waivers and other incentives to help recruit doulas from rural communities who plan to remain in and practice in rural communities.

What types of services are doulas providing?

In total of the doulas who responded to the survey:

- 82.46% provide prenatal care
- 93.27% provide support during labor and delivery
- 73.68% provide postpartum care
- 60.25 % provide lactation support
- 45.71% provide miscarriage support
- 31.87% provide abortion support

Fifteen percent of respondents stated that they provide additional types of doula support to clients, including fertility services, placenta encapsulation, belly binding, night nurse/doula support, massage and reflexology, yoga, traditional healing support, holistic nutrition, wellness services, surrogacy support, and end of life support.

Nearly all doulas surveyed provide support during labor and delivery. The majority of doulas surveyed also provide support during the prenatal and postpartum periods, and lactation support. Just under half provide miscarriage support, and just over roughly a third provide abortion support.

Of the doulas who responded to the survey who provide support during pregnancy, 34% estimated they had provided services to at least 50 pregnant people. Of those who provide support during labor and delivery, 30% estimated they had served at least 50 pregnant people. Of those who provide support in the postpartum period, 24% estimated they had served at least 50 pregnant people. Of the doulas who responded to the survey who provide miscarriage support, 41% had done so for at least three pregnant people. Of the doulas who responded to the survey who provide abortion support, 32% had done so for at least two pregnant people.

Doula at a cesarean birth
Photo used with the permission of Kindred Space LA

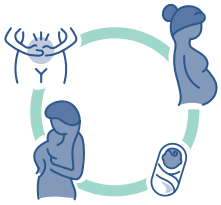
One doula who responded to the survey emphasized the importance of full spectrum care: "Miscarriage and abortion support MUST be included. Post partum doula care also must be included (distinct from post partum appointments with a birth doula)." However, we also found that the specific term "full spectrum care" was not well recognized by some doulas participating in the focus groups. When conducting the focus groups, we had to clarify the meaning of "full spectrum care." Once the term was clarified, most doulas agreed that they did do full spectrum work.

The doulas surveyed stated that there should be at least three prenatal visits for each pregnant person, and at least three postpartum visits. Note that these numbers were

Doula providing lactation support
Photo used with the permission of Kindred Space LA

recommended as minimums and not as overall recommended numbers. Additionally, doulas in one focus group stressed that the specific number of appointments, especially for the postpartum visits, should be negotiated and agreed upon between each individual client and the doula. As the doulas pointed out, individual clients will have greater or lesser needs, as well as desire, for an extended period of postpartum follow up by their doula. Doulas themselves also need to control their own caseload of current and prior clients.

Research shows that when pregnant people receive an adequate number of prenatal visits, the risk of complications for the pregnant person and the newborn is reduced.[28] Further, many maternal health complications arise during the broader maternal period, within one year postpartum.[29] Thus, doulas have a critical role to play in ensuring pregnant people with ongoing health conditions have those conditions addressed, stabilized, and/or resolved during pregnancy through regular prenatal care. They also can provide ongoing support and monitoring of maternal and infant health postpartum.



RECOMMENDATION ON SCOPE OF SERVICES:
Medi-Cal should cover the range of services that doulas across the state are already providing, which is full spectrum doula care. Medi-Cal should cover at a minimum three prenatal visits and at a minimum three postpartum visits.

How are doulas currently getting paid?

Doulas surveyed are compensated for their services in a variety of ways:

- 90% have clients who pay them directly out of pocket
- 30% do barter or trade
- 12.65% are reimbursed from health care flexible spending accounts
- 2.35% get some reimbursement from private insurance, with the remainder paid directly from their clients
- 55% provide some doula services on a pro bono or volunteer basis

Of the doulas who responded to the survey, 30% said that they are only paid directly by their clients out of pocket.

Responses from doulas participating in the focus groups was similarly varied, with reported forms of payment including out-of-pocket payment, bartering in exchange for doula services, gift cards, and payment through participation in doula pilot programs. Some doulas participating in the focus group reported that they work on a volunteer basis and are not paid.

Doulas as a profession have devised innovative ways to be compensated for their work. For example, almost a third of doulas surveyed said that they provide doula care in exchange for barter and trade of goods or services including bicycles, photography services, house painting services, and the use of business space. It is also clear that doulas themselves believe strongly in the value of the services that they provide, so much so that over half provide those services on a pro bono or volunteer basis. For example, some doulas in the focus group discussions said they had encountered situations where they knew their clients lacked a safety net to meet their basic human needs, and thus ended up providing a lot of services for free. Both the barter and trade compensation, as well as the large number of doulas who provide services on a pro bono or volunteer basis, highlight the community-based aspect of doula care.

Nonetheless, the vast majority of doulas practicing in California are paid for their services by their clients out of pocket. Survey results demonstrate that there is at present very little reimbursement taking place from private health plans. While some doulas accept paying clients as a means of offsetting their pro bono or volunteer doula work, this financial model is not sustainable as either an individual or institutional practice. Doulas as a profession cannot be expected to provide their services, which encompass a substantial amount of physical, emotional, and mental labor, for free. A successful program for Medi-Cal coverage for doula care must provide fair and equitable compensation to doulas who provide the service.

Further, doula care cannot continue to be only available to pregnant people who can afford to pay doula fees ranging from several hundred dollars to over $2000. For doulas to be able to meet the needs of the most underserved individuals and families in California, and make an impact on maternal health outcomes, their services must be made universally available, especially to low income pregnant people who cannot afford to pay for those services out of pocket.

On this topic, doulas who responded to the survey had this to say about the prospect of Medi-Cal coverage for doula care in California:

"I think this a potentially powerful first step in beginning to redress the injustices that marginalized folk face in this country."

"These are important steps towards addressing the black maternal health crisis and the maternal health of all women in California."

"This could potentially lower the overall costs of birth and save the public system millions."

"This is a necessity for women, not a luxury."

"So many women and families would benefit from having doulas covered. The trauma that can happen during childbirth from care providers who are meant to help but only hurt would be minimized as well as protecting the birthing persons childbirth experience. There is so much money to be saved in the long run by having a doula present and supportive during a birth. Doulas are SO beneficial and NEEDED."

RECOMMENDATION ON EXPANDING ACCESS TO DOULA CARE: Doulas provide a valuable service for which they should be fairly compensated. Their services should be made available to all pregnant and postpartum people on Medi-Cal.

Are doulas working alone or as part of groups/collectives?

Roughly a third of doulas who responded to the survey stated that they are currently part of a doula group or doula collective.[30] A slightly higher number, 35%, said they would be interested in accepting Medi-Cal coverage for doula care if they were paid as part of a doula group or doula collective, rather than as an individual doula. Almost half of doulas who responded to the survey, 48%, were noncommittal on this point, saying that whether they would be interested would depend on exactly what the arrangement looked like.

Doulas who responded to the survey stated that factors they would take into consideration in deciding whether to be part of a group or collective would include such things as:

- size of the group or collective;
- policies, functionality, and mission of the group or collective;

COMPARISON OF DOULAS WORKING SOLO OR AS PART OF A COLLECTIVE

About a third of doulas reported currently working as part of a doula group or collective

Most doulas reported that they currently work on their own

35% of doulas said they would be interested in Medi-Cal reimbursement for doula care if they were paid as part of a group or collective

48% of doulas reported that their interest in working in a collective would depend on how the collective functioned

Factors doulas take into account when considering working in a collective:

- Size of the group or collective
- Policies, functionality, and mission of the group or collective
- Whether joining the group or collective-would mean losing autonomy of their own business
- Membership dues or fees
- How doulas are partnered with clients

- whether joining the group or collective would mean losing autonomy of their own business;
- membership dues/fees; and
- how the group/collective would partner them with clients.

Some doulas participating in the focus groups said that benefits to working with a group or collective included collective vision, mentorship, working with likeminded and trusted colleagues, and having better support. However, they also cited potential challenges including interpersonal conflicts, stress, and potential coordination issues.

Meanwhile, doulas participating in the focus groups said that benefits to working on their own included being able to set their own fees and scope of practice, less interpersonal conflict, ability to better bond with their clients, and less stress. They also cited potential challenges including loneliness, lack of connection with their peers, and having to work long hours without backup support.

The majority of doulas who responded to the survey currently work on their own, which means they are self-employed and enter into individual contracts with each client to provide their services. This model may in some cases be preferable in the private pay context, as it allows each doula to set her own schedule, and determine for herself how many clients to take on at any given point, what services to provide, and how much money to charge. Many doulas participating in the focus groups said it was in part the flexibility and entrepreneurial nature of self-employment as a doula that drew them to the profession.

However, the model of doulas practicing on their own may not lend itself well to success in the context of Medi-Cal reimbursement. Medi-Cal has its own payment, billing, and reimbursement systems, which can be complex and burdensome. A doula working on her own might be hard-pressed to provide adequate care for a regular caseload of clients while also managing a large amount of billing paperwork necessary for Medi-Cal reimbursement. Doulas participating in the focus groups expressed concern about the difficulties of navigating and managing the bureaucracy of Medi-Cal, and in particular, Medi-Cal billing:

I think a lot of training's in order to help build competence in most doulas to about Medicaid reimbursement. It's that there needs to be clear communication about how that works.

What would the accountability process look like for Medi-Cal to reimburse care providers in a timely fashion? And then the other piece is insurance fraud is a really big issue that the State is taking on right now . . . And so like because the view of doula work is already devalued, would we be under a higher level of scrutiny for the services that we provide?

My concern is when you hear MediCal/Medicaid, the first thing I think of it is not getting the full amount of 800, or getting a smaller amount . . . . When I speak to midwives or other people that help or serve clients that have Medi-Cal and Medicaid, they don't get the full reimbursement.

Some doulas and policy advocates have proposed community-based doula groups and doula collectives as one way to help facilitate billing and payment for Medi-Cal coverage for doula care. In addition to taking on the administrative burdens attendant to Medi-Cal reimbursement, community-based doula groups and doula collectives could also play a significant role in providing member doulas with training, mentorship, and other types of support. This would be particularly crucial for the new doulas that would need to be recruited and trained to provide services to Medi-Cal enrollees.

One doula participating in the focus groups who is herself a doula trainer, described the support that common cohorts of doula trainees can provide to one another: "My doula clusters tend to support each other, and they'll stay connected to each other and also connected to me, even as they're moving off into their own practices. And it's not some obligatory thing, but it's just knowing that that person is there." Another doula participating in the focus group stated: "[I]t helps to have another woman in the birth world who get it when you call them at 3:00 a.m. excited about some other woman's baby that they don't know anything about."

Community attendees at the annual family picnic for Kindred Space LA, a community-based doula group
Photo used with the permission of Kindred Space LA

There may not be one specific model of care that will deliver the best care to Medi-Cal enrollees in the most efficient manner. Additionally, the optimal model of care may vary region by region. It is important for the state to exercise flexibility and openness to partnering with both individual doulas as well as doula groups and collectives in the provision of doula care to Medi-Cal enrollees.

RECOMMENDATION ON STATE PARTNERSHIPS:
A successful program for Medi-Cal coverage for doula care requires that the state find ways to partner with individually practicing doulas as well as community-based doula groups and doula collectives.

Doula Training

Are doulas pursuing formal training? If so, what type of training, and from what organization(s)?

The vast majority of doulas who responded to the survey, 94%, said that they pursued some type of formal training. Only 5% of doulas said they pursued informal training, such as shadowing experienced doulas or homebirth midwives, volunteering at birth centers, and learning from elders in the community. Less than 1% of doulas said they did not receive either formal or informal training.

Birthing People Foundation birth worker training
Photo used with the permission of Kindred Space LA

Of the 333 doulas who responded to the survey who did receive formal training, they received that training from 58 doula training programs.[31] These doula training programs include programs run by doula collectives of color, such as Roots of Labor Birth Collective and Sumi's Touch. They also include national doula training programs such as Doulas of North America (DONA), Doula Trainings International, and Ancient Song Doula Training. The top six doula training programs represented by doulas who responded to the survey are DONA, Doula Training International, Heart and Hands, BINI Birth Doula Training, Roots of Labor Birth Collective, and Cornerstone. A total of 153 doulas stated they received training from DONA.

Doulas who participated in the focus group included ones with many years of experience, as well as doulas who were just starting out in their careers. Those doulas with the greatest number of years of experience had a lot of hands-on training that

included shadowing of other birth workers. Most of the new doulas who participated in the focus groups had experience with one to a few discreet formal training programs.

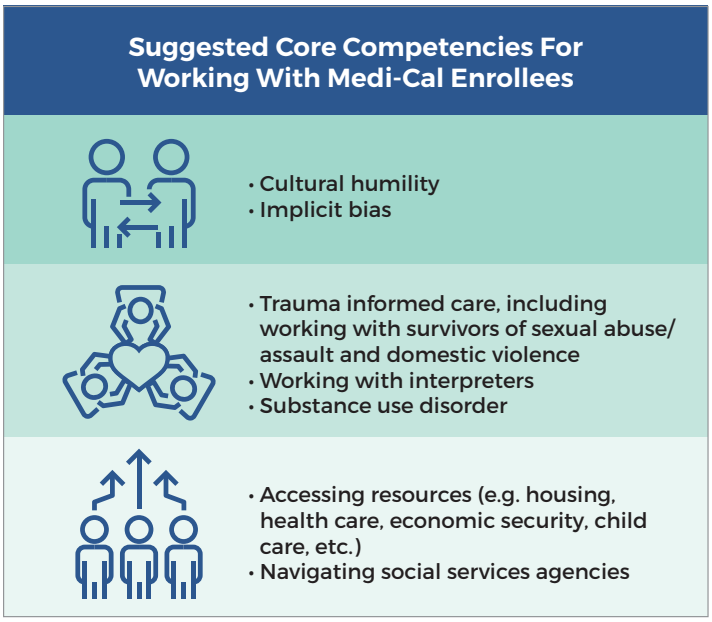
Regardless of the training they received, most of the doulas stated that their training did not adequately prepare them to serve a diverse population of clients, including clients who are low-income and clients who are people of color. Doulas also said they wished they had more training by doulas of color.

> One doula who participated in the focus groups said of her training experience: "I trained with DONA and it was a three-day training. And I made a decision to not certify with that organization. The training did not prepare me to adequately serve the demographic that I wanted to serve. I think it was useful for other people, and for their demographic, but it wasn't for mine. And so most of the learning that I did was with other people who are already doing the work that I wanted to do and that I was called to do . . . . So no, it was not adequate training or preparation for the demographic that I wanted to serve."

Many doulas who responded to the survey expressed the desire to receive training on cultural humility and trauma-informed care, both of which could help better equip them to serve the Medi-Cal population with sensitivity and understanding. One doula who responded to the survey went into more detail about the type of training she thought would be useful in serving Medi-Cal enrollees: "I also feel that Trauma Informed Care training should be included. Many women have been traumatized by sexual assault and previous experiences and it would be helpful for Medicaid covered doulas to be informed of ways that we can help our clients either not get 'triggered' or to help center them if they do get 'triggered.'"

Some doulas participating in the focus groups emphasized that part of their work overlaps with what might typically be considered the role of a social worker. This was especially the case for community-based doulas. For example, doulas talked about how their home visits for prenatal or postpartum care can be drastically different if their client is dealing with social services, food insecurity, or housing insecurity, all of which can impact a healthy pregnancy. Doulas working with the Medi-Cal population will likely need additional training on effectively connecting their clients to other services and resources, as well as how to best assist clients in difficult situations beyond those directly involving pregnancy and birth.

Doulas participating in the focus groups listed a number of core competencies that they believed would be helpful to obtain when working with Medi-Cal enrollees.



It is important to note that many smaller community-based doula groups led by doulas of color do in fact have training models, traditions, and practices that are more tailored to the local communities that they serve, including low-income clients. Many of these more tailored training organizations do not necessarily align with the more nationally well-known training organizations, but in many cases may be better equipped to serve the Medi-Cal population.

To this point, one doula who responded to the survey stated: "Please don't make it so that doulas need to train with white women and then serve communities of color. It doesn't work like that." Meanwhile, a doula who participated in our focus groups said: "I feel like if they're going to pay doulas that can . . . . become a vendor for Medi-Cal, they have to be trained by people of color in the same community that they're going to work."

In addition to the importance of the training organization and training topics, doulas who responded to the survey discussed the importance of good mentorship and shadowing in helping new doulas succeed in their work. Doulas participating in the focus groups almost universally agreed that the most effective training needed to incorporate hands on experience and some type of shadowing of more experienced doulas. However, they acknowledged that culturally congruent mentorship could also be difficult to find. One doula who participated in the focus groups stated: "[M]entors who look like you are in short supply, and they're in their elder years, so their capacity to do their work while also helping you in your work is something that we have to be sensitive about." Regardless, it seems clear that doulas and their clients alike could benefit tremendously from state, county, or local entities helping to facilitate mentorship programs for newer and more experienced doulas to connect to.

There is also the issue of cost – doula training can cost hundreds of dollars, which many people cannot afford. Of the 333 doulas who responded to the survey who did receive formal training, half said they would be willing to pay for additional training or certification if it was required in order to serve Medi-Cal enrollees, and 26% said they might be willing to do so. Both figures indicate the level of commitment of doulas who responded to the survey, to obtain Medi-Cal reimbursement and serve Medi-Cal enrollees as a regular client population. However, in order to build up an adequate and culturally congruent work force to serve the Medi-Cal population, fee waivers, scholarships, and other types of financial assistance must be available for people who want to have a career in doula care but cannot afford it.

There have been numerous state bills relating to Medicaid coverage for doula care. The bills have varied approaches in addressing the training requirements for doulas to bill Medicaid. A few bills list only a handful of the most nationally well-known doula training organizations, and require that doulas have received training at one of these organizations.[32] Such entry barriers to Medicaid reimbursement are problematic, especially given that many of the more nationally well-known doula training organizations are white-led and have traditionally catered to white middle-class doulas and clients. This is an entirely different population from that of Medi-Cal enrollees in California, all of whom are low-income, and at least 69% of whom are people of color.[33]

Other efforts to expand access to bills relating to Medicaid coverage for doula care instead require that doulas meet a set of core competencies to be eligible for Medicaid reimbursement. For example, Rhode Island Senate Bill 678, introduced in 2019, required that doulas attest to having met a minimum set of training requirements, which included at least 24 contact hours of childbirth education, birth doula training, antepartum doula training, and postpartum doula training; attendance at a minimum of two births, and completion of a cultural competency training, among other requirements.[34]

A third model, which was proposed in California Assembly Bill 2258, called on the legislature to convene a doula advisory board to meet and set core competencies for doulas to be eligible for Medi-Cal reimbursement.[35] The legislation required that a portion of the advisory board be made up of doulas who are providing services to Medi-Cal enrollees, as well as doulas who come from communities experiencing the highest burden of birth disparities in the state. The advisory board also had the power to create alternative ways to meet the required core competencies. Such alternatives could theoretically have included such things as permitting doulas to be eligible for Medi-Cal reimbursement based on their years of experience as a doula and number of clients served, rather than proof of having completed a specific set of core competencies.

RECOMMENDATION ON TRAINING:
Any training or core competencies required for Medi-Cal reimbursement must be inclusive of the wide variety of doula training models, traditions, and practices, including those by community-based doula groups and by doula trainers of color. Need-based financial assistance, such as fee waivers and scholarships, must be made available.

Doula Certification

Of the total number of doulas responding to the survey, 68% stated they had completed some type of certification for their doula work. Of those doulas who had completed some type of certification, 54% stated that certification had helped them attain greater legitimacy and credibility in the eyes of their clients, while 46% said they did not find the process of obtaining certification to be useful in either their training or their practice.

In some cases, there may be practical reasons to seek certification. One doula participating in the focus group described: "some community doulas who simply go through the paces of the more commonly accepted certifications, just so that they can't be questioned, and then their skill level changes, it's not their information level changes. It's just to keep people from questioning them or their collective." One survey respondent stated that in her experience, many health savings accounts would only reimburse doulas who had certification. Meanwhile, many of the state bills that have been introduced in the 2019 and 2020 legislative sessions have required some level of certification by the state.[36]

Doulas participating in the focus groups mostly agreed that some type of certification would likely be necessary for doulas to provide services to Medi-Cal enrollees. During the focus group discussion, doulas stated there needed to be a standard of care and practice that doulas are expected to provide and adhere to with respect to Medi-Cal enrollees. Doulas stated this would ensure quality of care for the Medi-Cal enrollees, and would also provide authority and validation to the profession itself.

However, they also raised concerns that certification is unnecessary, or worse may even run counter to the goal of expanding access to doula care. Many doulas who responded to the survey, and a small number of doulas participating in the focus groups, reported that their clients did not care, and almost never asked, if they had received doula certification. Rather, what clients valued above all was a doula's experience, in particular how many births they had attended.

Indeed, certification requirements might preclude some of the most experienced doulas, who may have been practicing and serving clients for decades, yet never have obtained certification. On this point, one focus group participant suggested that "maybe people who can demonstrate that they have experience and success working with this population, could be grandfathered in, and then maybe there is some future something, a unifying curriculum, a set of competencies, core competencies that are required. But I don't know if it's right to ask people who are doing it to prove that they can do it when they've been doing it the whole time."

Focus group participants also expressed concern that certification might undermine or discount their lived experience in favor of a less practically valuable certification, that could be obtained merely with classroom rather than hands-on learning and experience. These issues can have an impact on cultural congruency as well, as discussed by focus group participants:

> *I know a lot of women of color that are trained and that are helpful to the community, and I know a lot of white women that are certified and that are*

outside of our community. So if they're saying you have to be certified, the community that needs it the most will not get the help, or they will not seek it, because they want to be comfortable with their doula.

[It] is really important that the folks who are shouldering the majority of this Medi-Cal responsibility are disenfranchised folks themselves. It's not the folks who went through DONA and paid their money and are like shiny and brand new and then say, "I want to go and help brown people!" . . . . And so for me, it's like how do we uplift the folks who need it the most in order to really shift the entire barometer of what's going on.

During the focus group discussions, doulas also expressed concern that the larger and more well-known doula certification programs, such as DONA, would be chosen as proxies for state certification, and that the cultural congruency and community-based doula elements of training and certification would be lost. Doulas participating in the focus groups insisted that a wide variety of training and certification organizations must be accepted by the state. Doulas participating in the focus groups also noted that for many of them, birth work is spiritual and ancestral work, and they would not want to lose that aspect of their practice.

Doulas who responded to the survey as well as those who participated in the focus groups agreed that training and certification must not be a barrier to entry for doulas who want to serve, or who are already serving, the Medi-Cal population:

"[My doula] training was explicit and intentional in not giving out certification since the 'major' doula organizations act as 'gate keepers' to this work but yet don't reflect some of the most marginalized/highest rates of birth disparities."

"Please don't create an oppressive system for us. We don't need more barriers. We need more access and we need a simple way to get there."

"So I think that if the state provided another—created another hoop for doulas who are already out there serving Medi-Cal patients that it's going to undermine—it sort of suggests an invalidation of their credentials or their ability to do the work."

As with doula training, cost of doula certification is also an issue. Doula certification can cost several hundred dollars, and certification in specialized topics can each carry additional charges. One doula participating in the focus groups stated: "The problem with certification is that it's prohibitive . . . . For new doulas, it can be very difficult to become certified or maintain certification, especially if working in a low-income population and you're not getting paid much. It's difficult—I like to say—paying a lot of money so that I can go do something for free."

RECOMMENDATION ON CERTIFICATION:
Doula certification, like doula training, draws from a wide variety of doula care models, traditions, and practices. The state should be flexible and not require specific certification. Additionally, the state should consider alternatives to requiring doula certification in order for doulas to be eligible for Medi-Cal reimbursement.

Becoming Medi-Cal Providers

The majority of doulas who responded to the survey, 79%, said that they would be interested in providing doula care to Medi-Cal enrollees if California implemented a mechanism for reimbursement. Only 1% of doulas said they would not be. The remaining 20% stated concerns including reimbursement rates, billing and paperwork, possible surveillance around their business and earnings, and restrictions on how they practice.

For example, doulas must be assured that they will receive adequate compensation for their work in a timely manner. One doula who responded to the survey expressed the concern in this way: "[W]hat guarantee am I going to have that I will be reimbursed? I can't work for a promise. I need fast turnaround from services rendered to payment."

Doulas participating in the focus group also expressed concern regarding the timeliness of payments. They stated that unlike hospitals or community health centers, doulas cannot wait extended periods of time for reimbursement. They also questioned whether the administrative time they spent working through billing challenges with Medi-Cal would be included in the reimbursement.

The model that was originally in place in Oregon's Medicaid coverage for doula care program required doulas to partner with a licensed medical provider, typically an OB-GYN, who billed Medicaid on the doula's behalf and then paid the doula for their services. 28% of doulas who responded to the survey said they would be in be interested in Medi-Cal reimbursement if this was the model, and 24% said they would not. Most of the doulas responding to this question, a total of 48%, said their interest would depend on the specific circumstances. Overall, doulas had a number of questions about how this model of reimbursement might work in Medi-Cal.

Most doulas consider themselves to the advocate for, and in service of, the pregnant person. In the context of many births, in particular hospital births, doulas can provide

additional information and offer an important counterpoint to the priorities of pregnant person's medical care team. A doula's presence, particularly in the context of labor and delivery, often gives the pregnant person greater voice and agency to advocate for themselves. It is for these reasons that doulas have concerns about having to partner with a licensed Medi-Cal provider, and/or be part of a medical care team, in order to receive Medi-Cal reimbursement.

Many doulas who responded to the survey pointed out concerns about losing their autonomy and role as a patient advocate if they were to be required to work with a licensed Medicaid provider:

"Partnerships with hospital and medical care providers will likely limit the efficacy of doulas . . . . The role of the doula is to be an independent, third party provider independent of the client/family and of the medical care provider, otherwise the efficacy and potency of our impact is diminished. The beneficial statistics around doula care are a reflection of that autonomy and sovereignty from the system - pairing professional doulahood to an institution and tying a financial incentive to that bond will weaken the doula's practice by making them less objective and more likely to be of support to said institution than said client."

"I like having autonomy in my business and requiring me to work with a specific provider feels like I wouldn't have power over my own fee/ payment. Additionally, if I didn't agree with the practices of the provider that wouldn't necessarily be a good working relationship."

"What would be the benefit in being partnered with a medical provider? I'm not sure that medical providers would be thrilled to have yet more paperwork to do. Would the medical providers have the power to restrict, limit or otherwise influence the manner in which I serve my clients?"

"I would feel as if the obgyn would be my client when in reality the pregnant person is. I am advocating for the pregnant person, and I feel this may cause challenges."

"Could get complicated and change the nature of the work. Examples include: who are you responsible to? Client? Doctor?"

"I'm worried about the consequences of a doula essentially working for the government instead of the client. I'm worried that women who receive a doula for free may not understand the value of the support she's receiving. I'm worried doctors may try to dictate what a doula can or cannot do, thus eliminating advocacy."

At the same time, there are still many people, including medical providers, who do not understand what a doula is, confuse doulas with midwives, and/or feel threatened by the presence of a doula in the labor/delivery room. One doula who participated in the focus groups discussed the importance of ". . . . more representation of what a doula is . . . . It is a part of holistic medicine, but it's not like witchcraft . . . . it does come from a long tradition of mothers helping mothers or women helping women and I think it's, from a policy perspective, engaging the community on what a doula is, and the services that they provide."

Other doulas participating in the focus groups specifically emphasized the need for doulas to learn how to work in collaboration with medical professionals, so that they can effectively advocate to doctors, nurses, and other members of the medical care team, on behalf of their clients. Doulas acknowledged that this was a skill that could be better incorporated into doula training. However, they also stressed the importance of doctors and other medical professionals needing to be more familiar with doulas, and be willing to work with doulas as part of the birthing team. In order for a Medi-Cal coverage for doula care program to be successful, the state would likely have to implement or help facilitate a broader education campaign about what a doula is and the role of a doula.

Another model that could help doulas retain their role as a patient advocate, and as a birth worker separate from a pregnant person's medical care team, would be to have doulas reimbursed not as an individual, but rather as part of a group or collective. Doula responses were more mixed on this question, with 35% responding yes, 20% responding no, and 44% responding that it would depend on the specific circumstances. Many doulas are wary of giving up the flexibility that comes with being essentially independent contractors. At the same time, doulas also acknowledge that continuing a solo practice model could be difficult in the context of Medi-Cal reimbursement. Those doulas, in particular the 44% who responded that it would depend, stated their interest in maintaining their own independence and autonomy, and, as one doula put it, their "own personal brand and signature way of serving clients."

Doulas expressed legitimate concerns about maintaining their autonomy and independence, both as solo practitioners, as well as in the role of patient advocates separate from a pregnant person's medical care team. It is critical that the specific mechanism and model of Medi-Cal coverage for doula care address these concerns. As one doula who responded to the survey stated: "Doulas need to be at the center of the process creating a system like this."

"As one doula who responded to the survey stated: "Doulas need to be at the center of the process creating a system like this."

To facilitate input from doulas, other states that have looked into Medicaid coverage for doula care, such as Massachusetts and Rhode Island, have held a series of doula town halls.[37] Another method is to conduct surveys like the one that is the subject of this report. California can also consider convening a doula advisory board, as that which was contemplated in AB 2258. Such an advisory

board could be made up of doulas with experience serving the Medi-Cal population, and could meet on a regular basis to provide ongoing leadership and guidance to state agencies on implementation of a Medi-Cal coverage for doula care program.

RECOMMENDATION ON DOULA LEADERSHIP:
Regardless of the model for Medi-Cal reimbursement that California adopts, doulas must be involved at each step of the process, from initial policy development through implementation. The state should seek direct input from doulas through methods such as town halls, surveys, and a doula advisory board.

Reimbursement Rate

Doulas who responded to the survey stated that in order for Medi-Cal reimbursement for doula care to be sustainable, they would need a minimum reimbursement of $1151. Meanwhile, the answers from doulas participating in the focus groups ranged from $725 for presence at the labor and delivery, to $2500 for prenatal care, presence at labor and delivery, and postpartum care.

Many of the doulas participating in the focus groups were already working with Medi-Cal enrollees and were being paid on a sliding scale basis, or working pro bono. At the same time, focus group participants expressed some apprehension regarding reimbursement and other potential barriers in institutionalizing Medi-Cal doula care. One of the most frequently raised concerns was whether Medi-Cal reimbursement would provide doulas with a living wage for the hours that they worked. Doulas emphasized that Medi-Cal reimbursement would need to be sustainable.

Doulas who responded to the survey also stressed the importance of adequate compensation:

"It's got to be a true living wage."

"Doulas should be paid the going rate in their area and should be paid directly, not through a doctor or midwife."

"I hope people are able to receive necessary doula support while being compensated for their work."

"I think it would be helpful, so that doulas could afford to support more low income women per year while earning a living wage."

Doulas need to receive compensation that recognizes the social, emotional, and physical support that they provide for the pregnant person. This is also true in the context of Medi-Cal reimbursement. It is also critical to remember that California overall has a higher cost of living than other states, and in specific geographic regions, such as the San Francisco Bay Area, Los Angeles County, and Orange County, it is even higher.

We know that the participation of doulas providing care to Medicaid enrollees in Oregon and Minnesota was originally not very high, and the reason given was, in part, that the reimbursement rate offered for providing services to Medicaid enrollees was insufficient. There has also been concerns voiced about the low reimbursement rate in the New York doula pilot program. While Medi-Cal enrollees should be able to have the service and support of a doula, doulas who provide that service are also entitled to a living wage.

Doula practice is different from that of medical providers because a doula can only take on a very limited number of patients in any given month. Moreover, a typical doula often spends a great deal more time with the pregnant person than the person's medical provider. Thus, either connecting or contrasting doula services with the provision of medical care for a pregnant person, is neither appropriate nor accurate, especially when it comes to financial compensation. One doula participating in the focus group explained it in this way: "We provide a lot of services to the mothers. We're doing outside of the six visits, we're doing . . . . daily or weekly phone calls because we look at it as if we're dating the mother for those nine months or that pregnant woman for those nine months. [We also] personally provide a postpartum meal when we visit them, and a gift for the baby."

Lastly, it is critical that practicing doulas who are familiar with the market rates be in a position to help set the reimbursement rate, whether they are doing so for specific regions or more globally.

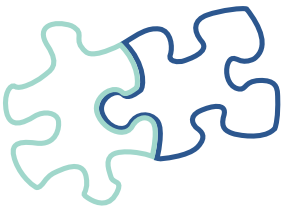
In order for Medi-Cal coverage for doula care to be successful, it will have to rely on a dedicated, committed, and culturally congruent work force to serve the Medi-Cal population. This work force must be fairly and adequately compensated for the tremendous work they are doing to support the social, emotional, and physical wellbeing of pregnant, laboring, and postpartum Medi-Cal enrollees.

RECOMMENDATION ON REIMBURSEMENT RATE:
Doulas deserve to be fairly and equitably compensated for their work with Medi-Cal enrollees. The reimbursement rate must offer doulas a sustainable living wage, and account for the realities of the number of clients that a doula can serve in any given month or time period.

Recommendations

Our survey and focus group findings gave us some insight into the needs, concerns, and considerations of doulas when thinking about Medi-Cal coverage for doula care. Here is a complete list of the recommendations that have come out of our analysis of the survey results and focus groups.

RECOMMENDATION ON DOULA WORK FORCE

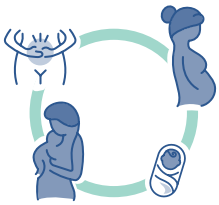


Diversify doula care work force to be a better match to provide culturally congruent care to the Medi-Cal population. Provide fee waivers and other incentives to help recruit doulas from low-income communities to join the work force.

RECOMMENDATION ON ACCESS FOR RURAL AREAS

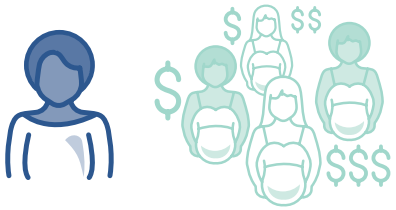
More doulas are needed to serve in rural regions of California, where people often have to travel very long distances to access basic health care services. Provide fee waivers and other incentives to help recruit doulas from rural communities who plan to remain in and practice in rural communities.

RECOMMENDATION ON SCOPE OF SERVICES



Medi-Cal should cover the range of services that doulas across the state are already providing, which is full spectrum doula care. Medi-Cal should cover at a minimum three prenatal visits and at a minimum three postpartum visits.

RECOMMENDATION ON EXPANDING ACCESS TO DOULA CARE

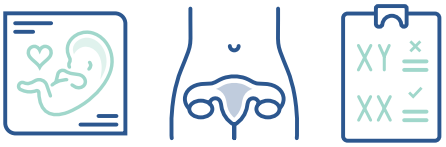


Doulas provide a valuable service for which they should be fairly compensated. Their services should be made available to all pregnant and postpartum people on Medi-Cal.

RECOMMENDATION ON STATE PARTNERSHIPS

A successful program for Medi-Cal coverage for doula care requires that the state find ways to partner with individually practicing doulas as well as community-based doula groups and doula collectives.

RECOMMENDATION ON TRAINING



Any training or core competencies required for Medi-Cal reimbursement must be inclusive of the wide variety of doula training models, traditions, and practices, including those by community-based doula groups and by doula trainers of color. Need-based financial assistance, such as fee waivers and scholarships, must be made available.

RECOMMENDATION ON CERTIFICATION

Doula certification, like doula training, draws from a wide variety of doula care models, traditions, and practices. The state should be flexible and not require specific certification. Additionally, the state should consider alternatives to requiring doula certification in order for doulas to be eligible for Medi-Cal reimbursement.

RECOMMENDATION ON DOULA LEADERSHIP

Regardless of the model for Medi-Cal reimbursement that California adopts, doulas must be involved at each step of the process, from initial policy development through implementation. The state should seek direct input from doulas through methods such as town halls, surveys, and a doula advisory board.

RECOMMENDATION ON REIMBURSEMENT RATE

Doulas deserve to be fairly and equitably compensated for their work with Medi-Cal enrollees. The reimbursement rate must offer doulas a sustainable living wage, and account for the realities of the number of clients that a doula can serve in any given month or time period.

Endnotes

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[3] Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016,* Morbidity and Mortality Weekly Report; 68: 762–765 (September 6, 2019), http://dx.doi.org/10.15585/mmwr.mm6835a3.

[4] *Id.*

[5] March of Dimes, *Preterm by Race: California, 2016-2018 Average,* https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=06&top=3&stop=62&lev=1&slev=4&obj=1/ (last visited May 4, 2020). *See also* California Department of Public Health, *California American Indian/Alaska Native Maternal and Infant Health Status Report* (June 2019), https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/AIAN-MIH-Status-Report-2019.pdf.

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[7] *Id.*

[8] Carol Sakala et al., National Partnership for Women & Families, *Listening to Mothers in California: A Population-Based Survey of Women's Childbearing Experiences, Full Survey Report,* 64-65 (Sept. 2018) https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf.

[9] *Id* at 64, 66.

[10] *Id* at 65.

[11] Julia Chinyere Oparah et al., *Battling Over Birth: Black Women and the Maternal Health Care Crisis* (Dec. 2, 2017).

[12] We use the term "full spectrum" to describe multiple doula services across the spectrum of reproductive care including prenatal care, support during labor and delivery, postpartum care, lactation support, miscarriage support, and abortion support.

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[14] Katy B. Kozhimannil et al., Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery, Birth 43(1): 20-7 (March 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5544530.

[15] Asteir Bey et al., *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (March 25, 2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf.

[16] *Id.*

[17] H.R. 3311, 76th Leg., Reg. Sess. (Or. 2011); S.B. 699, 88th Leg., Reg. Sess. (Minn. 2013).

[18] S.B. 416, 121st Leg., Reg. Sess. (Ind. 2019); S.B. 1784, 219th Leg., Reg. Sess. (N.J. 2019); H.B. 1109, 66th Leg., Reg. Sess. (Wa, 2019).

[19] National Health Law Program, *Doula Medicaid Project,* https://healthlaw.org/doulamedicaidproject/ (last visited May 4, 2020).

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[21] Kaiser Family Foundation, *Births Financed by Medicaid* (2019), https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid.

[22] A.B. 2258, Reg. Sess. (CA 2020) https://legiscan.com/RI/bill/S0678/2019. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2258.

[23] This figure does not include two-party survey question situations, in which the first part of the question was answered, but the second longer part of the question was skipped.

[24] Many of the survey answers did not quantify their responses to this question, and instead wrote out terms such as "many," "none," "few," "most," or "all." These narrative responses were not included in these figures.

[25] Department of Health Care Services Research and Analytic Studies Division, *Medi-Cal Monthly Enrollment Fast Facts* (September 2019), https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept2019.pdf.

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[27] March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.* (2018) https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf.

[28] March of Dimes, *Your first prenatal care checkup,* https://www.marchofdimes.org/pregnancy/prenatal-care-checkups.aspx/ (last visited May 4, 2020).

[29] Centers for Disease Control and Prevention, *Pregnancy related deaths happen before, during, and up to a year after delivery* (2019), https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html.

[30] Please see Appendix D for a full list of doula groups and doula collectives represented by the doulas who responded to the survey.

[31] Please see Appendix E for a full list of doula training programs represented by the doulas who responded to the survey.

[32] National Health Law Program, *Doula Medicaid Project,* https://healthlaw.org/doulamedicaidproject/ (last visited May 4, 2020).

[33] Department of Health Care Services Research and Analytic Studies Division, *Medi-Cal Monthly Enrollment Fast Facts,* (September 2019) https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Sept2019.pdf.

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[35] A.B. 2258, Reg. Sess. (CA 2020) http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2258.

[36] National Health Law Program, *Doula Medicaid Project,* https://healthlaw.org/doulamedicaidproject/ (last visited May 4, 2020).

[37] Summary of Doula Town Halls and Doula Survey in Massachusetts, Re: H.1182 An Act Relative to Medicaid Coverage for Doula Services, May 2019, https://www.facebook.com/download/2345588762190097/MA%20Doula%20Town%20Hall%20Feedback%20May%202019.pdf?av=219942&eav=AfYfEqkqjZFl8LbwCe6as7B4F-MGl9eN6tb7STzil2Laf96b59Jo43j-BI-ON9BRV7M&hash=Acpe_ZWVaYHzJwCD.

[38] Numbers in parentheses represent the number of doulas who responded to the survey who are part of that group or collective.

[39] Numbers in parentheses represent the number of doulas who responded to the survey who participated in that training.

Appendix A
Additional Resources

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Appendix B
Survey Text & Questions

Introductory text for survey conducted October 1, 2018 to November 15, 2018

> Thank you so much for completing this survey and helping us collect input from doulas in California about their current practice and their thoughts on the possibility of Medicaid coverage for doula care. This survey comes from the National Health Law Program. We are working in partnership with Monica McLemore, the Bixby Center for Reproductive Health, Carmen Maria Conroy, and other researchers, advocates, and doulas, to explore the possibility of Medicaid coverage for doula care here in California.
>
> This is an anonymous survey, and to the extent that we share results from the survey, there will be no names or identifying information connected to the results. However, if you are willing to be personally contacted by us and/or if you would like to be kept informed about our ongoing work on Medicaid coverage for doula care in California, please provide us with your name and contact information at the end of the survey.
>
> Also, as an incentive to complete the survey, we will hold a random drawing on November 15, 2018, for eight $50 Target gift cards. If you would like to be included in the drawing for the gift cards, please make sure to provide us with your contact information at the end of the survey.
>
> If you have any questions, please contact Amy Chen at chen@healthlaw.org or 310-736-1782. Otherwise, thank you for your time!

Conclusion text for survey conducted October 1, 2018 to November 15, 2018

> Thank you so much for taking the time to respond to this survey. If you have any questions, please contact Amy Chen at chen@healthlaw.org or 310-736-1782.

Introductory text for survey conducted January 1, 2019 to February 15, 2019

> Thank you so much for taking the time to provide us with input about your current practice as a doula and your thoughts on the possibility of Medi-Cal coverage for doula care. This survey comes from the National Health Law Program's Reproductive and Sexual Health Program. We are working in partnership with Monica McLemore, the Bixby Center for Reproductive Health, Carmen Maria Conroy, and other researchers, advocates, and doulas across the state to advocate for Medicaid coverage for doula care here in California. For more information about

the National Health Law Program's work on this issue, you can also read our report on Routes to Success for Medicaid Coverage for Doula Care, which we co-published with the California Preterm Birth Initiative.

We originally held this survey open from October 1, 2018 to November 15, 2018. During that time, we received responses from 243 doulas across the state. Unfortunately, we were not able to reach a sufficiently diverse pool of doulas in this first effort. As such, we have decided to reopen the survey to do more targeted outreach and get more responses from diverse doula groups. **We are particularly interested in hearing from doulas of color, including doulas who are Black, Latinx, Asian, Pacific Islander, and Indigenous/Native American. We are also particularly interested in hearing from doulas who currently do work with low-income and underserved clients, including clients on Medi-Cal or other types of public insurance.**

If you have already completed this survey, please do not complete it again a second time.

This is an anonymous survey and to the extent that we share and publish any results from the survey, there will be no names or identifying information connected to the results. However, if you are willing to be personally contacted by us and/or if you would like to be kept informed about our ongoing work on Medi-Cal coverage for doula care in California, please provide us with your name and contact information at the end of the survey.

This survey will remain open from January 3, 2019 to February 15, 2019. As an incentive to complete the survey, we will hold a random drawing after the survey closes, for eight $50 Target gift cards. If you would like to be included in the drawing for the gift cards, please make sure to provide us with your contact information at the end of the survey.

If you have any questions, please contact Amy Chen at chen@healthlaw.org or 310-736-1782. Thank you so much for your time and your input.

Conclusion text for survey conducted January 1, 2019 to February 15, 2019

Thank you so much for completing this survey. If you have any questions, please contact Amy Chen at chen@healthlaw.org or 310-736-1782. Also, thank you for the life-changing and life-saving work that you do as a doula.

Survey questions (identical for both iterations of the survey)

1) How long have you been a doula?
   a. [open text box] months
   b. [open text box] years
2) What is your race/ethnicity?
   a. American Indian or Alaska Native
   b. Asian/Asian American

c. Black/African American
d. Latino/a
e. Native Hawaiian or Pacific Islander
f. White
g. Mixed race (please specify below)
h. Other (please specify below)
i. Decline to state
j. More detail: [open text box]

3) In which county/counties or region(s) in California do you provide care?
4) What type of doula care do you provide (check all that are relevant)
a. Prenatal care
b. Support during labor/delivery
c. Postpartum care
d. Support during miscarriage
e. Support during abortion
f. Lactation support
g. Other (please specify) [open text box]

5) About how many individuals have you supported through:
a. Pregnancy? [open text box]
b. Labor/delivery? [open text box]
c. Postpartum period? [open text box]
d. Miscarriage? [open text box]
e. Abortion? [open text box]
f. TOTAL: [open text box]

6) What is the approximate breakdown in race/ethnicity of your client population? (please include estimation in terms of percentages, or descriptive terms such as all, most, many, few, none, etc.)
a. American Indian or Alaska Native [open text box]
b. Asian/Asian American [open text box]
c. Black/African American [open text box]
d. Latino/a [open text box]
e. Native Hawaiian or Pacific Islander [open text box]
f. White [open text box]
g. Mixed race [open text box]
h. Other (please specify) [open text box]
i. Decline to state [open text box]

7) What training did you receive to become a doula?
a. I received formal training
b. I received training other than formal training
c. I did not receive any training, formal or informal

7a) If you received formal training, please detail what type of training, and what organization(s) did you receive your training from. [open text box]

7b) If you received training other than formal training, please detail what type of training you received (for example, "I shadowed a peer doula"). Also, if possible, please explain why you did not pursue formal training (for example, "formal training was too expensive" or "I could not find a formal training program that fit my needs"). [open text box]

7c) If you received training, either formal or informal, do you feel that your training adequately prepared you for your work as a doula? Please explain your answer. [open text box]

8) Did you receive any certification for your doula work?
   a. Yes
   b. No
8a) If so, what type of certification and from what certifying organization? [open text box]
8b) Do you feel that your certification has been useful for you in your work as a doula? Please explain your answer. [open text box]
8c) Have you pursued additional training beyond your initial certification? Please explain your answer. [open text box]
9) How do you currently get paid? (check all that are relevant)
   a. Clients pay me directly out of their pocket
   b. I get some reimbursement from private insurance and the remainder directly from my client
   c. I get reimbursed from health care spending accounts
   d. I get reimbursed from public funds (please specify below)
   e. I do barter or trade
   f. I work on a pro bono/volunteer basis
   g. Other (please specify) [open text box]
10) Are you currently part of a doula collective, clinic, or some other group of doulas that work with one another? Please specify. [open text box]
11) We are exploring advocating for Medi-Cal, California's Medicaid program, to reimburse doulas who provide care for Medi-Cal enrollees. If it were possible for you to be reimbursed by Medi-Cal for providing care to Medi-Cal enrollees, is it something you would be interested in?
   a. Yes
   b. No
   c. Maybe/It depends
   d. Please explain your reasons why [open text box]

There are a few possible mechanisms for reimbursement, and we do not yet know what would make the most sense to advocate for here in California. The following questions explore some different possibilities.

11a) Would you be interested in receiving reimbursement from Medi-Cal for serving Medi-Cal enrollees if it meant that you would be required to partner with a licensed medical provider, such as an OBGYN, who would bill Medi-Cal on your behalf and then pay you for your services? [open text box]
   a. Yes
   b. No
   c. Maybe/It depends
   d. Please explain your reasons why [open text box]
11b) Would you be interested in receiving reimbursement from Medi-Cal for serving Medi-Cal enrollees if you were able to be paid by Medi-Cal not as an individual doula, but rather as part of a doula collective or group of doulas? [open text box]
   a. Yes
   b. No
   c. Maybe/It depends
   d. Please explain your reasons why [open text box]

12) What is the minimum level of overall reimbursement (i.e. total amount for prenatal visits, support during labor/delivery, and postpartum visits) that would make it sustainable for you to accept Medi-Cal enrollees as clients? Please explain your reasons for choosing the amount that you did. [open text box]
13) Should Medi-Cal cover a minimum number of prenatal visits from a doula, and if so how many should that be? [open text box]
14) Should Medi-Cal cover a minimum number of postpartum visits from a doula, and if so how many should that be? [open text box]
15) In order to serve Medi-Cal enrollees, the state may require some type of certification or training requirement for doulas. What kind of certification or training do you think should be required for doulas to qualify as providers who can be reimbursed by Medi-Cal? [open text box]
16) Would you be willing to pay for certification and/or training solely for the purposes of becoming a provider of doula services for Medi-Cal clients? [open text box]
17) Do you have anything else you would like to tell us about your thoughts around Medicaid coverage for doula care? [open text box]
18) Please indicate if any of the following apply to you, and if so, provide your name and contact information below
    a. I am willing to be contacted by you if you have any follow up questions about this survey.
    b. I would like to be kept informed about your ongoing work and any other advocacy opportunities around Medicaid coverage for doula care in California.
    c. I would like to be entered into the drawing for the eight $50 Target gift cards. Name & contact info: [open text box]

Appendix C
Focus Group Questions

Sticky Note Questions:

1)What are some ways you receive payment? (for example, out of pocket, reimbursement from health FSAs, barter/trade, pro bono/volunteer, etc.)
2) What amount of reimbursement would make it sustainable for you to accept Medi-Cal enrollees as clients?
3) What would you include in a list of core competencies for doulas who are seeking to effectively serve the Medi-Cal population? (for example, trauma informed care, cultural humility, implicit bias, working with interpreters, etc.)
4) Do you work alone or as part of a group/collective? What are the pros and cons of each?
5) Do you have any recommendations for policymakers who are interested in creating an equitable, sustainable, and inclusive Medicaid coverage for doula care program here in California?

Group Questions:

1) How long have you been practicing as a doula?
2) Do you or doulas in your collective provide full spectrum care?
3) Did you receive formal training to become a doula?
   a.If you did receive formal training, do you feel like the training was adequate for your current practice?
   b. If you did receive formal training, do you feel like the training was adequate to prepare you to serve the Medi-Cal population? If not, what training topics, if any, were you missing?
4) Do you feel like certification is necessary?
   a. What do you think is the difference between training and certification?
   b. Do you feel that certification has value apart from training requirements?
   c.Do you feel that the state should require some kind of certification from doulas who are seeking Medi-Cal reimbursement for doula care?
5) What role can community based doula groups play in helping to prepare doulas to serve the Medi-Cal population?
6) If you were ONLY serving Medi-Cal clients, how much would you need to make per patient (either total or broken down for prenatal, support during labor/delivery, and postpartum), and how many patients would you take per month, to make a sustainable living wage?
7) If it were possible for you to be reimbursed by Medi-Cal for providing care to Medi-Cal enrollees, is it something you would be interested in? What concerns, if any, would you have about this?

Closing Questions:

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

2) Do you have any recommendations for ways we should recommend Medicaid coverage for doulas to policy makers?

Appendix D
List of Doula Groups and Collectives Represented by Doulas Who Responded to the Survey[38]

Northern California

1. ACCESS (1)
2. Bay Area Doula Project (1)
3. Birthways (4)
4. Brilliant births (1)
5. Capital City Doula Collective (5)
6. CCRMC Volunteer Doula Program (1)
7. Collective Hearts (1)
8. Doulas by the Bay (1)
9. Doula Care Collective (3)
10. Doulahood (1)
11. Doulas of the East Bay (1)
12. Doulas of the South Bay (1)
13. Homeless Prenatal Program (2)
14. In a Pinch Doula Collective (1)
15. Marin Community Clinics (1)
16. Marin Doula Circle (1)
17. Mission Doulas (1)
18. Nectar Birth Collective (1)
19. Nor-Cal birth professionals network (1)
20. North State Doula Program (1)
21. Oakland Better Birth Foundation (1)
22. Roots of Labor Birth Collective (16)
23. SF Birth Center (1)
24. SF Doula Group (1)
25. Sisterweb: San Francisco Community Doula Network (2)
26. Stork and Sprout Collective (1)
27. St. Lukes Volunteer Doula Program (1)
28. Whatadoula (1)
29. Zuckerberg San Francisco General Hospital Volunteer Doula Program (2)

San Joaquin Valley

1. Birth Network Santa Cruz (1)
2. Collective Wings Prenatal Project (1)
3. Fresno Birth Collective (1)
4. Siena Maternity House (1)
5. Visalia Birth Network (1)

Southern California

1. Bini Birth (1)
2. Birthing People Foundation (1)
3. Carriage House (3)
4. Corazon Counseling (1)
5. Doulas of Long Beach (1)
6. Doulas of Orange County (1)
7. Heart and Hands Volunteer Doulas Services, San Diego (6)
8. Inland Empire Birth Workers of Color (1)
9. LA Birth Partners (1)
10. LA Doula Project (2)
11. LA Women's County Jail (1)
12. Long Beach Doulas of Color (2)
13. LOOM Doulas (4)
14. Mt. Diablo Community Doulas (1)
15. Operation Doula (5)
16. Santa Barbara Birth Keepers (1)
17. SBCC Thrive LA Doulas (1)
18. Sharp Mary Birth Doulas (1)

Appendix E
List of Doula Trainings Represented by Doulas Who Responded to the Survey[39]

Northern California

1. Alameda County WIC (1)
2. Bay Area Doula Project (2)
3. Cornerstone Doula Trainings (20)
4. Debbie Lavin: A Child is Born (2)
5. Doula Alliance (1)
6. Golden Gate Doula Training (1)
7. Hatch: Young Parents Creating Community (1)
8. Homeless Prenatal Program (2)
9. Natural Resources Doula Training Program (2)
10. Roots of Labor Birth Collective POC Doula Trainings (8)
11. Sumi's Touch POC Doula Training (1)
12. The Dolphin Method (1)
13. Zuckerberg San Francisco General Hospital Volunteer Doula Program (1)

San Joaquin Valley

1. Madriella Doula Network (2)

Southern California

1. Association for Wholistic Maternal and Newborn Health (1)
2. BINI Birth Doula Training (8)
3. Birthing People Foundation Doula of Color Training (5)
4. Dignity Health Methodist Hospital Doula Volunteer Program (1)
5. Esperanza Promotora de Salud Training (1)
6. HealthConnect One Doula Training (2)
7. Heart and Hands Volunteer Doulas Services, San Diego (15)
8. LA Doula Project (1)
9. Long Beach Birth Workers of Color Collective (1)

Out-of-State

1. Academy of Birth workers (1)
2. Ancient Song Doula Training (3)
3. Ayurvedic Mamas (1)
4. Bebo Mia Doula Training (1)
5. Birth Arts International (1)
6. Birth Coach Method (1)
7. Birthing From Within Doula Training (3)
8. Birthing People Foundation Doula of Color Training (5)
9. Carriage House Birth's Doula Training (4)
10. Childbirth and Postpartum Professional Association (34)
11. Childbirth International Doula Training (1)
12. Community Well (2)
13. Debbie Lavin-Heartful Birth (2)
14. Douas of North America (DONA) (167)
15. Doula Training International (5)
16. Esperanza Promotora de Salud Training (1)
17. Informed Birth and Parenting -- no longer active (1)
18. International Doula Institute (1)
19. Lamaze International (1)
20. Montreal Birth Companions (1)
21. Natural Birth Institute (1)
22. New Beginnings Doula Training (1)
23. ProDoula (3)
24. Project Motherpath (1)
25. Sacred Journey Birth Guardians (1)
26. Sierra Club Birth Institute (2)
27. SMC Full Circle Birth Companion (3)
28. Spinning Babies Doula Training (4)
29. Still Birthday Doula Training (1)
30. Tarzana Hospital (1)
31. The International Education Association Doula Training (1)
32. The Matrona Holistic Birth Doula Certification (1)
33. The Sanctuary Birth Center (1)
34. Tiny Love doulas (1)
35. ToLabor Doula Training (2)
36. Welcome Home Midwifery Services (2)

All pregnant and postpartum people deserve access to full spectrum doula care.

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