



Challenges Reported by California Doula Pilot Programs

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Table of Contents

Executive Summary	4
Introduction.....	7
Most Frequent Challenges Reported	8
• Funding.....	8
- Inadequate Funding	8
- Mismatch Between Funding Structure and Scope of Services Provided	9
- Reimbursement Rates.....	10
• COVID-19 Pandemic and Other Timing Issues.....	11
• Administrative Challenges.....	13
• Data Collection.....	14
• Relationships with Hospitals and Medical Providers	15
• Balancing the “Heart” Work of Doula Care and Institutional Expectations	16
Additional Challenges Reported.....	18
• Racism.....	18
• Population Focus	19
• Payment Structure	20
• Vaccination Status	21
Conclusion	23
California Doula Pilots Lessons Learned Project Links.....	25

Executive Summary

California has had at least ten doula pilot programs from 2019 to the present, focused on providing free doula services to Black pregnant and birthing people or Medicaid enrollees. We interviewed doulas and program administrators at these ten pilots to gain insight into the common challenges they experienced in launching, implementing, and leading doula pilot programs. During our interviews, several common challenges emerged, which can be grouped into major themes.

The most frequent challenges identified were:



Funding - Doula pilot programs reported that the funding originally allocated for their pilots was not always sufficient, or did not anticipate administrative and other tasks involved with implementation of the doula pilot programs. The funding structure also did not accommodate the scope of services and hours that doulas were actually providing for their clients. All but one of the doula pilots stressed the need for adequate funding in order to be able to provide a sustainable reimbursement rate for the doulas providing the service.



COVID-19 Pandemic and Other Timing Issues - Five doula pilots reported needing more time for their initial planning phase and launch. The pilots did not always have a clear template for building the programs or what support systems were needed to do so. In March 2020, the COVID-19 pandemic disrupted half of the doula programs in process. This caused some pilot programs to be put on hold and shift to virtual training and birth support. Doulas in the pilot programs had to adapt to working with continuously changing and varied policies from hospitals.



Administrative Challenges - Most of the doula pilots reported a lack of sufficient administrative support in the set up and implementation of the programs. Interviewees reported a need for more support in human resources, community engagement, tech support, communications, web and graphic design, social media management, and marketing. The reimbursement process was also an administrative challenge. Seven of the ten doula pilots reported the billing, payment, and reimbursement systems were taxing to learn and manage. This led to hours of unpaid labor for administrators and doulas.



Data Collection - Most of the pilot programs had a formal evaluation built into their program to collect data to support the benefits of doula care. As doulas do not typically collect formal data in this manner from their clients, this aspect of the pilots proved challenging. The data collection requirement led to the need for training on data collection as well as an additional responsibility for doulas on top of supporting their clients. Some interviewees reported anxiety that data collection might undermine their ability to build relationships and trust with their clients. Data collection also introduced new software systems, data collection forms, and paperwork. These were sometimes adapted from other medical professions like nursing or midwifery care and were not entirely functional or appropriate for doula work.



Relationships with Hospitals and Medical Providers - Eight of the ten pilot programs noted that hospitals were a barrier to access for doula care. Some hospitals and clinicians did not always understand or agree with doula care, which led to a difficult working environment. As the pandemic progressed, most hospitals banned doulas completely. Later, when doulas were allowed in, hospitals still imposed additional barriers in the form of requirements.



Balancing the “Heart” Work of Doula Care and Institutional Expectations

- These pilot programs had to navigate the inherent “heart” work of doula care with the institutional expectations and priorities of the funder, county, or administrative agency. Two doula pilot interviewees noted anxiety around institutionalizing doula care and specifically pointed to the history of Black birth workers in the American South being largely regulated out of autonomy and ultimately, birth work. Additionally, one doula pilot noted that some of the services the community-based doulas typically provided were not allowed because of the funder and county agency’s concerns of liability. Finally, some doula pilots noted the power differential between the doulas and the funders, county, or administrative agency at times made honest and direct communication a challenge.

We also identified the following additional challenges:



Racism - Two instances underscored the pervasiveness of racism. One doula pilot had to change the contracted agency responsible for providing doula services due to a reported racist and hostile work environment. Another doula pilot had to make significant changes to their program after a key partner raised concerns that interviewees noted demonstrated a fundamental misunderstanding of community-based doula care and the importance of Black doulas supporting Black birthing people.



Population Focus - Two pilot programs that specifically recruited Black doulas and served Black birthing people noted pushback from non-Black birthing people and non-Black doulas who wanted to join the program. One pilot planned to focus on Black doulas, but after finding a lack of Black doulas in their community, added as a goal of the pilot to diversify and increase the Black doula workforce.



Payment Structure - Independent doulas often charge a flat rate for a package of services. However, this flat fee model did not always translate well to the payment structure of doula pilots as they managed multiple clients and sometimes multiple doulas providing services. Most pilots addressed this by using a fee-for-service model which allowed for doulas to bill individually for services. One pilot shifted from a fee-for-service model to a set salary structure with doulas as staff members to allow doulas to have more financial stability and employee benefits. Another used a monthly stipend model for payment.



Vaccination Status - Although this was not a commonly reported challenge, it was noteworthy. One pilot program instituted a COVID-19 vaccination requirement for doulas. Many of the doula participants were initially hesitant. The pilot program responded by holding special information and listening sessions about COVID-19 vaccinations that recognized the historical and recent medical trauma, navigated fears, and provided factual information about the COVID-19 vaccination. This ultimately led to a majority of participants agreeing to be vaccinated.

Despite the challenges that the pilot programs faced, many interviewees reported promising outcomes of improved maternal and child health, a celebration of what was accomplished, and a hopefulness for the future of expanding access to doula care. In addition, many felt gratitude to the broader community that supported them through the challenges and helped them make the necessary changes to improve the pilot programs.

The doulas and program staff from these pilot programs have vital insight for all entities starting a pilot program and for those in the process of implementing a doula Medicaid benefit. As California draws closer to the implementation of Medi-Cal coverage for doula care and we see the national interest in doula care increase, we hope that these challenges and lessons learned will be instructive in building sustainable, equitable, and inclusive doula care programs.

Introduction

From 2019 to the present, there have been at least ten doula pilot programs in California with a primary focus on addressing racial health disparities, and in particular on providing free doula services to either Black pregnant and birthing people or Medicaid enrollees. To our knowledge, it is the largest number of doula pilot programs of this nature that have taken place than in any other state.

The counties with these doula pilots are Alameda (two), Contra Costa (two), Fresno (two), Los Angeles (two), Riverside (two), Sacramento, San Bernardino (two), and San Francisco. Three of the doula pilot programs were initiated by Medicaid managed care plans: Anthem, HealthNet, and Inland Empire Health Plan. Seven of the ten pilots are still ongoing.

From October to November 2021, the Doula Medicaid Project embarked on an information gathering project, conducting interviews with doulas, funders, and/or administrative staff involved with each of these ten doula pilot programs. Overall, we found that the programs share remarkable consistency across some broader themes. At the same time, on a more granular level, the doula pilots have been quite distinct from one another, with different funding structures, scope of care provided, recruitment plans, training requirements, etc.

We synthesized the information from the interviews we conducted into a list of common challenges as reported by these ten doula pilot programs. We have broken up this list into the most frequent challenges reported, as well as additional challenges reported. Under each topic we have paraphrased the information provided in the interviews, and in some cases have included specific quotations without identifying information. In compiling this list, we were aware that some of the doula pilots are complete and have wrapped up, while others have still not yet formally launched. As such, some of the challenges will likely change or evolve as the pilots in their initial stages proceed towards full implementation. We also acknowledge that there may be similar doula pilot programs in California that we were not able to interview for this project. Nonetheless, we believe the information collected from these ten doula pilots at this static point in time will still be tremendously helpful for California's Department of Health Care Services, as well as other agencies, partners, and stakeholders working to implement Medicaid coverage for doula care in California. We are also confident that this insight will be very valuable for doulas, advocates, agencies, legislators, and other stakeholders across the country who are similarly implementing doula pilot programs or expansions of doula care in their own regions.

Most Frequent Challenges Reported



FUNDING

One of the challenges raised in every doula pilot interview was inadequate funding. This included inadequate funding for the administrative aspects of the pilot programs, a mismatch between the funding structure and the services provided, and inadequate funding to provide a sustainable reimbursement rate for the doulas providing the services.

Inadequate Funding

Five out of the ten doula pilots in the state are being funded by the California Perinatal Equity Initiative (PEI) within the California Department of Public Health. The PEI aims specifically to address racial disparities in health outcomes and mortality rates for Black infants.¹ One interviewee pointed out that: “PEI is funded [only] to a point, there’s this idea that we have all this money, but each county has a set amount based on Black births in the county. We have to work with what we have.”

Three of the doula pilots reported that it was very difficult to forecast their budget needs while setting up a brand new program with multiple unknown variables. One interviewee said that they “discovered different things during the process after the budget was already set. It’s hard to know what you don’t know.” Two doula pilots ended up having to secure additional funding to expand the scope of their work, and one doula pilot had to go through a second round of Request for Applications because they had not allocated

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– Doula Pilot Program Interviewee

¹ California Department of Public Health, Perinatal Equity Initiative (PEI), <https://www.cdph.ca.gov/Programs/CFH/DMCAH/PEI> (visited November 19, 2021).

sufficient funding in the first proposal. (In the second round, they doubled the funding.) “Doulas have been around in the world forever,” said one interviewee, “but many of these programs are new. And sometimes organizations that are rolling out need to pivot, and be flexible.”

There was also much work taking place in the doula pilots that was largely unseen and unpaid. For example, many of the doula pilots did not have specific funding earmarked for administrative work, mentorship, ongoing training, community and client outreach, travel, advocacy work, and other administrative tasks. These were all critical tasks the pilots had to engage in to support the doulas to do the work they needed to do, but there was largely no funding or reimbursement for these pieces. One of the pilots provided doulas an add-on fee of \$200 for administrative tasks, but doulas reported that even this was not enough to approximate the amount of administrative work they had to do. An interviewee from a different pilot program estimated that they had two full-time equivalent employees providing administrative support for about fifty doulas, and specifically recommended that the statewide benefit include funding for administrative support.

Mismatch Between Funding Structure and Scope of Services Provided

The way in which doulas themselves were paid also often did not accurately reflect their scope of services. Most doula pilots paid doulas based on specific services provided. For example, a specific amount for each prenatal and postpartum visit, and a specific amount for presence at a client’s labor and delivery. Yet in interviews, the pilots explained that the type of broader holistic support that community-based doulas provide means doulas are not simply there for the prenatal and postpartum visits, and for labor and delivery. Rather, the support they provide also comes in between medical appointments, to address the questions, anxieties, and other challenges that come up for pregnant and postpartum people throughout the process. “A lot of our moms need help with housing and transition, and also mental health support,” said one interviewee. Another interviewee explained: “we’re supporting the whole family, we’re not just supporting the pregnant person.” Indeed it is precisely through these types of support that community-based doula care fills a critical gap of support that currently exists in many perinatal health care systems. Yet there was no designated funding for that type of support.

The work of community-based doulas is very time-consuming. One pilot program, that asked their doulas to keep detailed logs tracking their hours spent with clients, estimated that each doula spent approximately 76 hours total with each client from the first prenatal meeting through the last postpartum meeting. Meanwhile, for each hour of care the doulas spent engaging directly with a client, the doulas spent on average 1-2 hours preparing. Moreover, Medicaid enrollees, low-income clients, and other vulnerable communities, often needed

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more than just doula support, whether it be additional coordination of care or resource referrals. Yet this scope of care was not accounted for in the fee-for-service payment models. “Nothing in medical billing covers that,” said one interviewee. “How do we cover all that care we’re providing outside of a prenatal visit?”

Reimbursement Rates

It is notable that in all but one of the interviews, the doula pilots specifically stated that having a sustainable reimbursement rate for the doulas was non-negotiable. One interviewee said: “It’s important to make sure people who have chosen to be doulas are able to do that, and pay their bills, and take care of their families, and not need to struggle.” Three doula pilots ended up scaling back the number of clients to be served in order to ensure the reimbursement rate they provided to the doulas would be sufficient. In another pilot, when potential contractors came to the county with a proposal that did not provide an adequate wage for the doulas, the county asked the contractors to go back and revise the contracts in order to provide a living wage.

“Anyone who believes in this job, who believes that doulas are important in helping to decrease the disparity, will believe that doulas deserve to be compensated,” said one interviewee. “They want to be paid an equitable amount of money to do this work,” said another. “They want to help improve birth outcomes and decrease the money spent on poor health outcomes. They should be paid and left alone . . .

. . . This is hard work emotionally and physically. Pay them and they will give you the data that you need. The [positive] birth outcomes are already happening.” One interviewee described the equitable payment in terms of program sustainability. “I don’t want to get the funds and train 12 people and then underpay them...I want to make sure they stay in the program and have good retention.”

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One interviewee said if they had been trying to run a for-profit business, it may have been easy to just pay the doulas less. But because their pilot was working from a place of valuing equity, dignity, and supporting their own communities of color, they knew they had to approach the work, and the reimbursement provided for that work, differently. “We are working as community, for community, with community, doing a community thing,” said the interviewee. “With this mindset, you can’t come in fake.”



COVID-19 PANDEMIC AND OTHER TIMING ISSUES

Five doula pilots reported they wished they had more time for their initial planning phase and launch. It was challenging setting up what was essentially a brand new program to provide doula services, and there was not always a clear template for how to do it or the necessary supportive systems or structures in place to do so. One interviewee described it as “building the plane as we were flying it.”

The COVID-19 pandemic hit in March 2020, while half of the doula pilots were still in process, creating entirely new and unexpected challenges. Carefully created implementation plans had to be entirely reworked as training and even doula support shifted to virtual. One doula pilot program was put completely on hold for months, when key staff working on implementation of the pilot were temporarily deployed to the county’s COVID-19 unit.

Particularly during the first several months of the pandemic, many hospitals effectively shut their doors to most visitors and other support people who would ordinarily accompany patients. This included labor and delivery patients, meaning that in many instances doulas and other birth support workers were not allowed to accompany their pregnant and postpartum clients, either for prenatal and postpartum appointments, or even to accompany them during labor and delivery. One interviewee summarized it as follows: “That was difficult, having to navigate and change the way we do things to help virtually support people. [We had to] equip clients with the tools and resources they needed before going in so they felt confident advocating for themselves in the absence of a doula, and connecting with their partner or whoever was able to attend the birth.”

COVID-19 policies also varied from one hospital to the next, and even some individual hospitals “went back and forth on if they would allow doulas to be in,” making it challenging for the pilot programs and doulas to develop consistent program policies. Even when hospitals began to allow doulas back in, they

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– Doula Pilot Program Interviewee

² State of California Health and Human Services Agency, California Department of Public Health, AFL 20-38.7, Visitor Limitations Guidance, <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-38.aspx> (June 16, 2021).

sometimes had additional restrictions, such as not allowing doulas in during triage, where patients can sometimes be stuck for hours, or not allowing one doula to shift out and have someone replace her in the event of a very long labor. Even after guidance came out from the state specifically permitting doulas to be present in addition to the partner or support person, some hospitals viewed the guidance “as a recommendation and not a hard and fast rule.”² Some hospital responses to doulas varied between staff as well. One interviewee mentioned how a hospital had stated that they accepted doulas

without any specific certification, but when she tried to enter the hospital, security was not aware of the hospital policy and did not allow her in. Another interviewee commented that the hospital policy was to allow doulas, but the physician working on that specific day did not want to work with doulas and so did not allow them in. This inconsistency caused stress and worked as a barrier to doulas providing care.

Administratively, the pandemic required that doula pilots think on their feet and be creative to ensure that the pilot could continue. Some programs were in the middle of training their doula workforce and had to abruptly shift to virtual. In some cases this was advantageous, with one doula pilot saying attendance improved when they switched to virtual. Other pilots struggled to ensure that their clients received the services and support they needed, particularly during labor and delivery. “It’s really hard not to be able to be physically present at a birth,” said one interviewee. “Sometimes you’re trying to connect with them and you’re not sure what’s going on and you’re just hoping for the best. Or their phone dies or they don’t have good service. COVID made things a lot more frustrating and confusing.”

While for the most part doula pilots were able to adapt to the hospital limitations, interviewees expressed frustration that doulas were put in the same category as visitors and partner-level support, when the service and support they were providing to their clients was so critical. One interviewee stated that “the whole health care system needs to know and understand the doula’s work for it to work, especially during the pandemic.” Said another interviewee: “We need doula advocacy to be viewed as essential care.”

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– Doula Pilot Program Interviewee



ADMINISTRATIVE CHALLENGES

Nine of the ten doula pilots discussed in their interviews a lack of sufficient administrative support in the set up and implementation of their programs. Doula pilots had to build up the infrastructure necessary to identify clients; provide doula services; and recruit, train, and pay doulas. In interviews, doulas and administrators said that human resources, community engagement, tech support, communications, web and graphic design, social media management, and marketing/outreach were all areas where they would have appreciated more support and expertise.

One interviewee who helped with the administration of her doula pilot said she did approximately 10-20 hours a week of unpaid labor in administrative paperwork, billing, and claims.

The process for reimbursement was an administrative challenge for many. Seven of the doula pilots said the systems involved with billing, payment, and reimbursement were taxing to manage and learn. One interviewee said that the “setup for payment is hard for people who aren’t used to working with computers . . . [T]o get better compliance, use people-friendly programs.” Documentation also took a lot of time and was typically unpaid. One interviewee who helped with the administration of her doula pilot said she did approximately 10-20 hours a week of unpaid labor in administrative paperwork, billing, and claims. “[In the beginning], we wouldn’t have known how to do it differently, but now we know we need more systems of support for the doulas,” said one interviewee. “The doulas just don’t have as much time to be completing invoices.”

Another interviewee said that she “feels comfortable with computers, but still felt that she needed a lot of support” with the paperwork, documentation, and filing claims.

“Think about how to make the bureaucracy fit the work of the birthworkers, not the opposite.”

– Doula Pilot Program Interviewee

She went on to say that any broader system in place for statewide reimbursement of doula care would need to account for individual doulas, and have dedicated time and space to support individual doulas in navigating the bureaucracy of reimbursement. “It’s a lot for one person to do,” she said. “Once this goes statewide, there is going to be a bigger need for support [. . .] Something has to change for it to be large-scale and be successful.” One interviewee had this recommendation for the state: “Think about how to make the bureaucracy fit the work of the birthworkers, not the opposite.”



DATA COLLECTION

Nine out of the ten doula pilots had some type of formal evaluation built into their program. The goal of the evaluations was to collect data from the doula pilots to demonstrate the benefits of doula support. However, the data collection piece proved challenging for the doula pilots, and the doulas themselves, to manage.

Doulas do not typically collect much formal quantitative data on their clients. One interviewee stated, “We’re normally not super data driven.” It was thus challenging for doulas to take on the extra data collection piece, especially as it was an additional duty on top of the doulas’ primary role focusing on supporting their clients. “I have to make sure the records are comprehensive and make sure they capture all the details of everything that I do,” said one interviewee. “It’s tedious and time consuming. I spend so much time charting.”

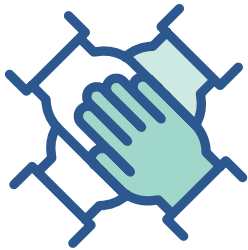
Doulas also had to learn how to navigate new software systems, data collection forms, and paperwork they were not accustomed to. Some of the programs the doula pilots used were adapted from medical professions such as nursing or midwifery care, and were not entirely appropriate for doula work. “It was a challenge to find a system or adapt a system that worked for doulas,” said one interviewee, and ultimately, the system that they settled on “wasn’t ideal for doulas.” Another interviewee specifically cited the “need for a software program specifically for community-based doula care.”

Additionally, the relationship that doulas have with their clients, especially community-based doulas, is based fundamentally on a client’s trust and comfort level with the doula. This is in contrast to other providers who may also come into a client’s home, but may be viewed more as agents of the state in part because of their role in collecting information, monitoring, and in some cases reporting. “Doulas establish a real relationship with the family, and can make more organic connections,” said one interviewee. “[In contrast], social workers don’t develop the same relationship, have historically sometimes had bad relationships.”

Some doulas therefore reported that they felt uncomfortable asking questions of their clients that the pilot programs required. They worried that the

Some doulas reported that they felt uncomfortable asking questions of their clients that the pilot programs required. They worried that the data collection might undermine their ability to build a relationship of trust with their clients.

data collection might undermine their ability to build a relationship of trust with their clients. One interviewee explained: “Sometimes the paperwork can make it awkward because I had to ask questions I wasn’t always comfortable with, like ‘How much money do you make?’ It was hard to have to ask questions like that rather than letting [the client] tell you things over time.” Another interviewee said that in the end, she felt that their priority was to “preserve what the birth worker’s role is. The core goal is the provision of [doula] services, not the data collection.”



RELATIONSHIPS WITH HOSPITALS AND MEDICAL PROVIDERS

Eight of the doula pilots reported that hospitals were a barrier to access for doula care, as they did not always “see the value of having a doula in the space” and in fact sometimes saw doulas as “obstructionist.” “The relationship feels like gatekeeping,” said one interviewee.

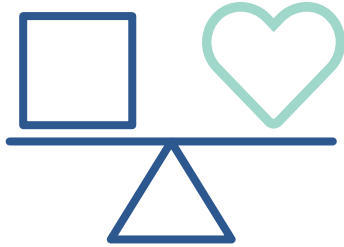
The doula pilot relationships with the hospitals became a serious issue during the pandemic, when hospitals first banned doulas altogether, and then even once doulas were allowed, continued to impose additional barriers. Some hospitals created their own internal requirements for when doulas were allowed to accompany their clients. But these requirements were not always based on an actual understanding of how doulas are organized. For example, one interviewee said some hospitals in her region were only allowing doulas access if they had a certification from DONA (Doulas of North America). Yet having a DONA certification “is not like a licensure [and] they’re not the authority on doulas and specifically Black doulas. We know DONA has done things that are harmful to the Black community . . . [I had to be] on the phone explaining that this doula is not DONA certified, but she is vetted by [our County] Department of Public Health.”

Seven doula pilots stated that they had challenges engaging with medical providers and staff, who at times did not understand or accept the role of the doula. In some cases the providers were openly opposed to the doulas’ presence. “I was aware that there could be conflict between clinicians and doulas,” said one interviewee. “The doulas were change makers that had to go into places that aren’t

“I was aware that there could be conflict between clinicians and doulas. The doulas were change makers that had to go into places that aren’t really friendly to them, which is hard.”

– Doula Pilot Program Interviewee

really friendly to them, which is hard.” Another interviewee said she felt that “MDs and nurses are trained to think that doulas are adversarial to them.” Other times, medical providers simply didn’t understand the role of the doula. “They still don’t know what a doula does. They don’t understand it all the way, so that leads them to fear it, which also means they don’t respect the work,” said one interviewee.



BALANCING THE “HEART” WORK OF DOULA CARE AND INSTITUTIONAL EXPECTATIONS

Many of the challenges reported by the doula pilots forced the doulas to find a balance between institutional expectations and what one interviewee described as the “heart” work of doula care. The priorities of the funder, county, or administrative agency, was not always aligned with the priorities of community-based doula care. One interviewee described it as “demonstrat[ing] the limits of the health care system conflicting with a model that doesn’t work in that system.” “This work is sacred,” said another interviewee, “and it’s difficult to fit it into what the county wants.”

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– Doula Pilot Program
Interviewee

Meanwhile, two doula pilot interviewees specifically pointed out the history of Black birthworkers, in particular granny midwives, to explain why “there is a lot of fear from the birthworkers on what institutionalizing their work means.”³ In the end, many doulas did find they had to compromise some aspects of their community-based doula practice. “When becoming part of something like this, you do lose a little autonomy,” said one interviewee.

For example, doulas participating in the pilots had to collect data from their clients to help support the evaluation of the pilots and demonstrate the benefits of doula care. Yet they also reported that the data collection undermined the natural development of a relationship of trust and understanding with their clients. Similarly, the typical scope of services provided by a community-based doula is wide-ranging, and not always reflected by medical billing codes that pigeonholed their work into simply prenatal visits, attendance at labor and delivery, and postpartum visits. Meanwhile, one

³ Granny Midwives were Black women in the American South who were community trained and experienced healers. They assisted in countless births starting as early as the 1600s, and continuing through the mid-1900s. From the late 19th century through the early part of the 20th century, granny midwives continued to provide most of the care for pregnant people in the rural south. Over time, male physicians, the growth of hospital births, and the increased medicalization of birth largely displaced granny midwives out of birth work. See <https://timeline.com/granny-midwives-birther-rural-babies-and-saved-lives-33f12601ba84> (Jan 11, 2018), <https://www.colorlines.com/articles/tbt-granny-midwives-south> (Mar 19, 2015), <https://ir.vanderbilt.edu/handle/1803/13563> (Jul 30, 2007).

interviewee said that the printed program and informational materials from her doula pilots had the branding of an institution, and as a result was “not the most community friendly.”

In one doula pilot, the doulas were not able to provide some of the services they typically offered clients, such as belly binding, yoni steaming, herbal remedies, and placenta encapsulation. This was because the funder and partnering county agency had liability concerns for these types of services. This left those doulas feeling frustrated that they could not provide their full range of services. “It felt like I had to water myself down as a doula to fit what the program wants me to be,” said one interviewee. “That can be really challenging to your whole identity as a doula. And then you will have clients who ask for [services I cannot provide through the doula pilot], and then having to refer them elsewhere for those services was really tough.” Another interviewee said, “We bring our whole selves to this work [so] you can’t say you’re rolling out this doula program and [then you] tweak it so that we’re not actually able to be doulas.”

“You need to pay attention to community voices. [We] started community engagement meetings and took the time to include community members and birth workers in the process. [Through this] we moved from a place of tension, to working collaboratively.”

– Doula Pilot Program Interviewee

Additionally, in some doula pilots there was a clear power differential between the doulas providing services and the funder, county, or administrative agency. This made honest and direct communication difficult. One interviewee stated that the funder/county/administrative agency needed “more direct discussion and communication with doulas in the program. [They] hold the funds and that can be intimidating and uncomfortable sharing information with them. This is important to name and try to address, so that the program can work better and address the needs of the community and the doulas . . . [They] are in a position of power and need to address how to make people comfortable giving them feedback and communicating.”

In the same vein, two of the doula pilots specifically raised in their interviews the importance of a close partnership, open communication, and early investments in doula and stakeholder engagement. “You need to pay attention to community voices,” said one interviewee. “[We] started community engagement meetings and took the time to include community members and birth workers in the process. [Through this] we moved from a place of tension, to working collaboratively.”

Additional Challenges Reported



RACISM

While this was not raised at great length in the interviews, it bears mentioning that there was one doula pilot that had to change the organization it contracted with to provide doula services because of the reported racist and hostile work environment of the first organization. After a hiatus, the doula pilot restarted its work through a new doula organization, under the leadership of two doulas who had been fired from the first organization for originally speaking out about racism and mismanagement.⁴

In this instance, the funding entity did address the situation by defunding that organization and continuing the pilot with a new doula organization providing services. But in the interim, the pilot program itself was in limbo, and until the new doula organization was formed to provide services, the program was unable to accept new clients. Moreover, the damage had already been done to the doulas themselves, who had been forced to encounter and then contend with the same type of racist behavior that they were intended to support their clients through.

⁴ While there is a good deal to unpack with what happened in the first iteration of this pilot, it is unfortunately outside the scope and capacity of this project to explore this in great depth. For additional background on what took place, please see LAist/KPCC, Mariana Dale, An LA Doula Program For Black Moms Derails After Accusations Of Racial Insensitivity, <https://laist.com/news/la-doula-program-black-moms-racial-insensitivity> (Dec 3, 2019), and LAist/KPCC, Mariana Dale, Free Doula Program For Black Moms-To-Be Gets New Life, <https://laist.com/news/free-doula-program-los-angeles> (Feb. 26, 2020).

“We as Black women understand the need, and we were trying to explain to people who were not Black, ‘We really need this and you need to fund it.’ That spoke to a lot of challenges and the racial dynamics. Also the challenges of how this kind of racial dynamic impacts Black leaders.”

– Doula Pilot Program Interviewee

Another doula pilot found itself scrambling to make fundamental changes to the scope and structure of their program after a critical partner in the work raised a series of concerns at the eleventh hour. Interviewees reported that in doing so, the partner demonstrated a fundamental misunderstanding of community-based doula care, and in particular expressed bias and misunderstanding about the importance of Black doulas supporting Black birthing people. “We as Black women understand the need,” said one interviewee, “and we were trying to explain to people who were not Black, ‘We really need this and you need to fund it.’ That spoke to a lot of challenges and the racial dynamics. Also the challenges of how this kind of racial dynamic impacts Black leaders.” As a result of the concerns raised by the partner, the doula pilot had to make substantive changes and scale back their original plans for the pilot. Among the things they were forced to eliminate were plans for a doula mentorship model, which is usually a critical element in community-based doula programs.

“The same racism and pushback from the medical system that birthing people face are also being put on doulas. The doulas need support and there’s a culture of support [for them] that can be increased.”

– Doula Pilot Program Interviewee

These events underscore just how pervasive racism and racist behavior can be, even in the context of programs that are set up quite literally with the intention of combating racism and addressing racial disparities. “The same racism and pushback from the medical system that birthing people face are also being put on doulas,” said one interviewee. “The doulas need support and there’s a culture of support [for them] that can be increased.”



POPULATION FOCUS

Many of the doula pilots, in particular the PEI pilots, focused on serving Black birthing people regardless of income. “Not all of the people we’re serving are on Medi-Cal,” said one interviewee from a PEI pilot. “Some are on Blue Shield Blue Cross, Kaiser, or other private insurance. But the whole point is to decrease the infant mortality rate. We know that not everyone is going to have the ability to have a doula even after [California implements Medi-Cal coverage for doula care]. We want to provide that for that African American mom. I wasn’t on Medi-Cal, and I still almost died giving birth to my child. So we want to make sure we are impacting that. And making sure that if these moms want to have a doula, they can have one.”

Yet two doula pilots that specifically recruited Black doulas and served Black birthing people, reported getting pushback from people questioning why the program could not accept and serve everybody. An interviewee from one of these pilots explained that: “The whole point [was to have] Black women or birthing people, have someone who looks like them as their primary support person.” She reported that she consistently had to explain this to doulas who did not identify as Black, but were insisting that they were nonetheless a good fit for the program and should be hired. Other times, community-based organizations and hospitals would refer clients to the program who were not Black birthing people, as was the focus of the pilot. “That was frustrating to continuously have to justify what we’re doing and why we’re doing it.”

Another doula pilot struggled with the opposite problem: their funding was intended to be used to serve Black pregnant and birthing people, but they were also committed to serving the Latinx and Pacific Islander communities in their region. That doula pilot ended up pursuing a number of alternate funding sources that enabled them to serve all of the communities for whom they wanted to provide support.

Still another doula pilot wanted to focus on Black doulas, but discovered there were not enough in their community. As such, the doula pilot, which is still in its initial implementation stages, decided to shift focus to not simply providing doula services to the Black community, but also increasing the workforce of Black doulas in the community.



PAYMENT STRUCTURE

Independent doula providers often charge their clients one flat fee for a package of services inclusive of prenatal visits, presence at labor and delivery, postpartum visits, and some type of on-call availability by text, email, and/or phone call. Often half of the flat fee will be due up front and the balance will be due at a later date, typically closer to

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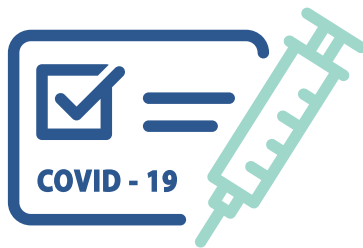
– Doula Pilot Program Interviewee

“[We need to] think of salary models that don’t hurt doulas if a birth doesn’t happen, or if a client doesn’t show up.”

– Doula Pilot Program Interviewee

the end of the pregnancy. This flat fee model did not always translate well to the payment structure for the doula pilots, which were managing doula services for multiple clients, as well as payment for multiple doulas providing services through the pilot. For various reasons, clients might be reassigned to a doula partway through their pregnancies. In other instances, a backup or second doula might provide some of the services. One interviewee said, “[We need to] think of salary models that don’t hurt doulas if a birth doesn’t happen, or if a client doesn’t show up.” Most pilots ultimately addressed this issue by using a fee-for-service model, allowing doulas to bill individually for prenatal and postpartum visits, and for presence at labor and delivery.

One doula pilot began with a fee-for-service model, and then part way through shifted to an employee model where doulas were paid a set salary as staff members. The administrators of this doula pilot believed it allowed the doulas to have greater financial stability. Importantly, it also allowed the doulas who were part of that pilot to have employee benefits, including sick leave. Another doula pilot had originally planned to hire doulas as employees, but because of pushback from a key partner in the project, had to shift instead to a fellowship program. The doula participants, or fellows, were given monthly stipends. The administrators of this doula pilot had wanted to provide benefits to the doulas, so instead increased the amount of the proposed stipend so that it approximated a monthly salary with benefits.



VACCINATION STATUS

Vaccination status was not a common challenge, but one that was noteworthy. One pilot program that recruited “Black women, serving Black birthing people exclusively,” decided to institute a COVID-19 vaccination requirement for their doulas “because we knew our community is at such high risk.” Many of the doula participants initially showed hesitation to the requirement. The doula pilot responded by holding a special information and listening session about COVID-19 vaccinations. At this session they “spoke very clearly about historical trauma, they navigated people’s fears, and they held space for those who were still not comfortable with vaccination.” They also provided factual information about the COVID-19 vaccines. Of the eight participants in the training, six ended up agreeing to be vaccinated.

At the COVID-19 information and listening session, they “spoke very clearly about historical trauma, they navigated people’s fears, and they held space for those who were still not comfortable with vaccination.” They also provided factual information about the COVID-19 vaccines. Of the eight participants in the training, six ultimately agreed to be vaccinated.

One interviewee who participated in this session said: “We knew that in dealing with the Black community, there is a lot of medical trauma. So [during the session] we addressed both traumas and the triumphs. That was a big part of allowing it to move forward. Address the trauma and then address the triumphs... So that then you can move past the trauma to the healing.” The ultimate goal of the session was to address the vaccine hesitancy of the participants and “open up the ability of the doulas to know they could change their mind on something that they believed strongly about.” One interviewee pointed out the helpfulness of this perspective in the doula’s work with their own clients: “We want this to reflect on the moms [that the doulas serve too], knowing that you might have something in your mind that you’re very firm on, but it can change, and that’s okay.”

Conclusion

During the course of our interviews with the ten doula pilot program, there certainly emerged some common themes. Key among these were funding issues, the pandemic, administrative challenges, data collection, relationships with hospitals and medical providers, and balancing the work of doula care with institutional expectations. Additional challenges reported were around racism, population focus, payment structure, and vaccination status.

Yet even with all the challenges that they faced, there were many silver linings. One interviewee reported that when the pandemic hit, it actually made scheduling doula training easier “because people could join virtually,” and as a result, attendance ended up being much better than originally anticipated. As time went on, doula pilot programs improved their offerings and incorporated additional types of support and training for their doulas in direct response to their feedback. “We evolved with every new doula we recruited, and quickly pivoted when we had issues,” said one interviewee. “With every new relationship, we got more efficient.” Another interviewee said of their community-based organizational partner, “There are some growing areas as we’re rolling out a whole new program, but it’s one where I feel like they’ve learned a lot, and we’ve learned a lot.” In meeting every new challenge head-on, the pilot programs improved their systems and structures, and ultimately became more resilient.

In our interviews, we also saw a celebration of what has been accomplished and great hopefulness for the future. One interviewee said of her participation in the doula pilot: “I think this is my greatest work.” The doula pilots reported that even initial outcomes data from their programs demonstrated improved birth outcomes for clients receiving doula support. “Outcomes were amazing,” said one interviewee. “[The rate of] c-sections lowered, there were no preterm births.” In one doula pilot, an interviewee reported that “within the first week [of providing services] we already have moms sharing rave reviews, putting it on their social media, ‘I love this! This is what I didn’t know I needed!’” An interviewee from another doula pilot said that even clients who went in for a vaginal birth and ended up with a cesarean birth still reported

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satisfaction with their doula experience, because “they were still supported in their birth and they felt like they got what they needed.” Many of the doula pilots also felt gratitude to the broader community that was invested in their success: one interviewee said that even in the most challenging times, when she worried they would not have sufficient funding to continue, there were still strong supporters and funders in her county that continued to work with them to find a solution.

“I think this is my greatest work.”

– Doula Pilot Program Interviewee

California holds the distinction of having the most doula pilot programs aimed at addressing racial disparities than in any other state. As the state moves forward towards full implementation of Medicaid coverage of doula care, we hope that the challenges and other information gained from these interviews will be helpful for the Department of Health Care Services, other state agencies, doulas, advocates, legislators, and other stakeholders. We also hope the challenges and lessons learned from California will be instructive for other states implementing their own doula pilot programs or statewide expansions of Medicaid coverage for doula care.

California Doula Pilots Lessons Learned Project Links

Main page for California Doula Pilots Lessons Learned Project

<https://healthlaw.org/cadoulapilots>

Summaries of California Doula Pilot Programs

<https://healthlaw.org/resource/summaries-of-california-doula-pilot-programs>

Challenges Reported by California Doula Pilot Programs

<https://healthlaw.org/resource/challenges-reported-by-california-doula-pilot-programs>

Lessons Learned from Panel Discussion on California Doula Pilot Programs

<https://healthlaw.org/resource/lessons-learned-from-california-doula-pilot-programs>

Panel Discussion on Wednesday, January 26 from 10:00 - 11:30 am PST, Doulas Know Best: Lessons Learned from California's Doula Pilot Programs

<https://healthlaw.org/resource/doulas-know-best-lessons-learned-from-californias-doula-pilot-programs-panel-discussion>

Q&A from Doulas Know Best: Lessons Learned from California's Doula Pilot Programs

<https://healthlaw.org/resource/qa-from-doulas-know-best>

Visual recording of panel discussion by Ashanti Gardner

<https://healthlaw.org/wp-content/uploads/2022/03/Doulas-Know-Best-Lessons-Learned-from-Californias-Doula-Pilot-Program-scaled.jpg>

Time-lapse video of Ashanti Gardner creating her visual recording during the panel discussion

<https://www.youtube.com/watch?v=g9qlmroB414>



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