NATIONAL HEALTH LAW PROGRAM

California Doula Workforce Analysis 2024

By Alexis Robles-Fradet

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Introduction

On June 28, 2021, doula services were included in **Governor Newsom's 2021-2022 state budget**. Additional details about implementation of the doula Medi-Cal benefit were included in **SB 65, the California "Momnibus" bill**. This bill was signed by Governor Newsom in October 2021. The original start date for the benefit was January 1, 2022.

Starting in September 2021, the **Department of Health Care Services** (DHCS) convened a doula stakeholder workgroup comprised of doulas, advocates, and other stakeholders. The initial goal of this workgroup was to provide feedback on **California's State Plan Amendment (SPA)**, which DHCS had to submit to the federal Center for Medicare and Medicaid Services in order to add doula services as a Medi-Cal covered benefit. In addition to providing feedback on the SPA, the workgroup also provided input to DHCS on the **Doula Provider Manual** and **All Plan Letters**, and discussed issues that doulas experienced as they signed up to be Medi-Cal providers. In order to adequately implement the benefit and take into account issues raised by doulas and the advocate community, DHCS ended up delaying the implementation of Medi-Cal's doula benefit from an initial intended start date of January 1, 2022 to an ultimate start date of January 1, 2023.

DHCS has since continued stakeholder engagement through the **SB 65 Doula Implementation Workgroup**. The SB 65 Workgroup continues to provide feedback on the implementation of the benefit, including sharing the challenges that doulas face as they enroll with DHCS, contract with Managed Care Plans, navigate relationships with hospitals and other providers, and bill for their services.

Several factors led to the creation of this research and report. Through our participation in DHCS' Stakeholder Workgroup and SB 65 Workgroup, we have heard repeatedly from doulas about the challenges they face enrolling as Medi-Cal providers and billing for their services. We have also seen how other states have faced similar challenges in implementation of Medicaid coverage for doula care. With all these factors in mind, we felt it was crucial to build a comprehensive picture of the current doula workforce in California. We wanted to understand where the doula workforce is, who they are, how they work, what populations they are working with, what kind of training they receive, and their perspective on the Medi-Cal benefit. We believe that this detailed knowledge of the current doula workforce can help us all gain a better understanding of where the gaps in coverage and community needs are. We hope this information can then be used to help doulas, advocates, foundations, state agencies, and others determine how best to make decisions on outreach, training, funding, and other necessary implementation tasks. Ultimately, we hope that this research will be used to better understand California doulas, and allocate resources to supporting and expanding the doula workforce.

Definitions

Doulas are birth workers who provide non-medical health education, advocacy, and physical, emotional, and social support for pregnant, postpartum, and post-pregnancy people.[1] Doulas provide this support during the prenatal period, labor and delivery, postpartum period, and during and after miscarriage, stillbirth, and abortion. Doulas' advocacy role makes them uniquely positioned to help pregnant and birthing people who are experiencing **health care access issues** and **health inequities**.

Community-based doulas provide culturally appropriate support to people in communities at risk of poor outcomes. Community-based doulas are often adept at supporting people with **diverse identities** and health care needs. Many doulas are also more likely to have experience with **medical institutions** that do not always attend to patients' unique needs. Further, community-based doulas often have similar lived experiences to their clients and can share first-hand knowledge and solidarity.

1 NHeLP endeavors to use the most up-to-date nomenclature and is aware of discussion surrounding the term doula. To learn more about the origins of the term see **NHeLP's Framing and Language in the Doula Medicaid Project**

Methodology

CONDUCTING THE SURVEY

This survey was conducted as part of the National Health Law Program's (NHeLP's) ongoing advocacy for Medicaid coverage for doula care. The goal of this survey was to create a current snapshot of the doula workforce in California. Survey questions touched on topics including doula and doula client demographic information, doula practice information, doula training, and Medi-Cal doula benefit specific questions.

As we at NHeLP are not doulas, we engaged the help of ten Cultural Connectors represented by a combination of individual doulas and doula organizations. The Cultural Connectors met with us four times over the course of the survey creation to conclusion. The Cultural Connectors advised the researchers on the creation of the survey questions, the outreach plan, the representativeness of the preliminary survey results, and offered general advice. They also assisted with promotion of the survey to their networks, on social media, and through word of mouth.

We conducted this survey using an online survey through Google Forms. The survey was soft launched on December 15, 2023 to allow us time to troubleshoot any potential issues.

The survey was officially launched on January 15, 2024 and was originally set to close on April 1, 2024. At the recommendation of the Cultural Connectors, we extended the survey deadline to April 15, 2024. The new closing date also allowed us an even three months from the January 15, 2024 official launch.

SURVEY QUESTIONS

This survey consisted of forty-two total questions with thirty-six questions specifically on doula experience and six additional questions. The six additional questions were Captcha style questions, opting-in to our survey raffle, and opting-in to **NHeLP's California Coverage for Doula Care information listserv**. These questions were a combination of mixed method questions including multiple-choice single selection, multiple selection checkbox, and open answers questions.

The survey questions were divided into eight sections: (1) Captcha questions, (2) Location, (3) Race and Ethnicity, (4) Language, (5) Gender and Sexuality, (6) Type of Doula Practice, (7) Training, and (8) Additional Questions. For a full list of questions, please see Appendix A.

SURVEY DISTRIBUTION

NHeLP also distributed the survey via email to local, regional, and statewide partners in health care access, maternal health, and reproductive health, rights, and justice. The survey was shared to NHeLP's two California specific listservs: the California Doula Access Listserv, an advocacy-based working group composed of doulas and advocates, and the California Coverage for Doula Care Listserv, a general listserv for sharing information, resources, and updates around efforts to expand access to doula care in California.

The NHeLP Communications team created a **social media toolkit** with graphics and sample text. NHeLP and the Cultural Connectors utilized this social media toolkit to promote the survey on various social media platforms including Facebook, Instagram, X (formerly Twitter), and LinkedIn. We also encouraged respondents to use the social media toolkit to further share the survey opportunity.

NHeLP staff also utilized several other resources for outreach. **The Department of Health Care Services** (DHCS) maintains a public **Doula Directory** that includes doulas who have completed the process of becoming Medi-Cal providers. Other databases were also used to identify doulas in California. These include: DoulaMatch, Bornbir, and **SisterWeb's Community Doula Referral List**. These directories were used to locate doulas in California. If a doula's contact information was available online, we sent them an email with information about NHeLP's Doula Medicaid Project, the purpose of this research, and a link to the survey. In addition, doulas were identified using Facebook's search function for doula business pages in California. We also used Google's search engine to identify individual doulas and doula groups or collectives. Doulas and doula collectives were invited individually to complete the survey via email or contact form. The survey was shared at DHCS' Doula Implementation Stakeholder Workgroup meetings in January, March, and April 2024 via Zoom chat. Finally, we reached out to individual doulas from our previous survey efforts who indicated that they are willing to receive follow-up contact with us.

SURVEY PARTICIPANT COMPENSATION

As an incentive to complete the survey, we advertised and held a drawing for forty $200 gift cards. After the closing of the survey, those who consented to be entered into the drawing were sorted alphabetically to ensure no duplicates and to assign numbers using Excel row numbers. We used a random number generator through the website **www.random.org** to identify winners. In the case of duplication, a new random number was generated. Gift cards were distributed via email using **www.tremendous.com**.

SURVEY LIMITATIONS

We acknowledge several limitations to this research. First, the survey was conducted entirely virtually, and shared primarily virtually through email and social media. This mode of surveying leaves behind those that are less technologically savvy, engaged online, or who may have privacy concerns. Second, the survey was written only in English, which limits our results to those that read and write

in English. This research is further limited by our compensation choice, as some may not be willing to provide their time and input for merely a chance to win, rather than every respondent receiving compensation for their participation. In addition, as much of NHeLP's advocacy takes place in the Medi-Cal realm, some doulas that are uninterested in the Medi-Cal doula benefit may not have been reached by our outreach efforts. Further, surveying of doulas has increased as the popularity of doulas as a maternal mortality intervention has increased and state and federal attention has increased. We acknowledge that many doulas in California may be experiencing survey fatigue and may also not realize that multiple surveys were circulating at the same time as ours. Finally, we acknowledge that with the creation and implementation of the Medi-Cal doula benefit and the increasing popularity of doula care, doulas may be simply busier and may not have the time or inclination to complete a survey.

All this being said, while this is the best effort of NHeLP and the Cultural Connectors to reach as many doulas as possible in the state, it should not be taken as a complete survey of all doulas in California.

DATA METHODS

While we anticipated some bot (non-human) responses, we received many more bot responses than expected. We think this is likely due to the financial incentive offered. We received a total of 3,534 responses. After coding, we identified a total of 425 accepted responses. Though we included two captcha-like questions, Google Forms does not include a built-in captcha and does not offer a way for users to identify IP addresses. Thus, we had to create our own protocol for identifying bot responses from human responses. We also received responses that appeared to be submitted by humans but did not seem to be from people familiar with doula care or in California. These responses are excluded from the data. Responses that were identified as bot responses shared several characteristics. Many responded to our captcha questions incorrectly and answered something other than "doula" or "birthworker" when asked: "What do you call someone who provides emotional and physical support before, during, and after childbirth?" Other characteristics that excluded responses from our survey include:

1. Identical or almost identical responses submitted within seconds of each other;
2. Responses to questions on city and county were incongruous indicating an unawareness of the geography of California;
3. Responses that included doula training or organizations that did not exist or did not provide the service being referenced;
4. Other inconsistent responses such as answering "yes" to being a Medi-Cal provider and later in the survey responding as if they are not a Medi-Cal provider;
5. Responses that had very inflated numbers of years or experience or clients served;
6. Responses that indicated reimbursement by Managed Care Plans (MCPs) that do not operate in the county or city referenced;

7. Nonsensical responses to questions (e.g., responses referencing “certified guided music training”);

8. Non-English responses that, when translated, did not make sense to the question asked,

9. Some responses indicate a lack of awareness of doula work (e.g., referencing midwifery or physicians),

10. Some bot responses skipped many questions, sometimes only answering the required questions. Some of these responses were repeated verbatim or almost verbatim from several respondents, indicating that they are likely bots.

The survey included several open-ended questions that at times created such a range of responses that it was difficult to present the information in a clear way. When open-ended survey questions resulted in responses with a range larger than the coding guide, the higher number was used. For example, if a response was that a doula served between ten and twenty five clients a year, the response was coded into the higher category of twenty-one through thirty.

Respondents were able to select “other” and write in an answer for many of the multiple-choice questions. At times, this resulted in the addition of new categories into the data. For example, our original survey did not include American Sign Language as a language doulas and clients might use. However, doula respondents included American Sign Language in the “other” write in section and it was added to the data analysis.

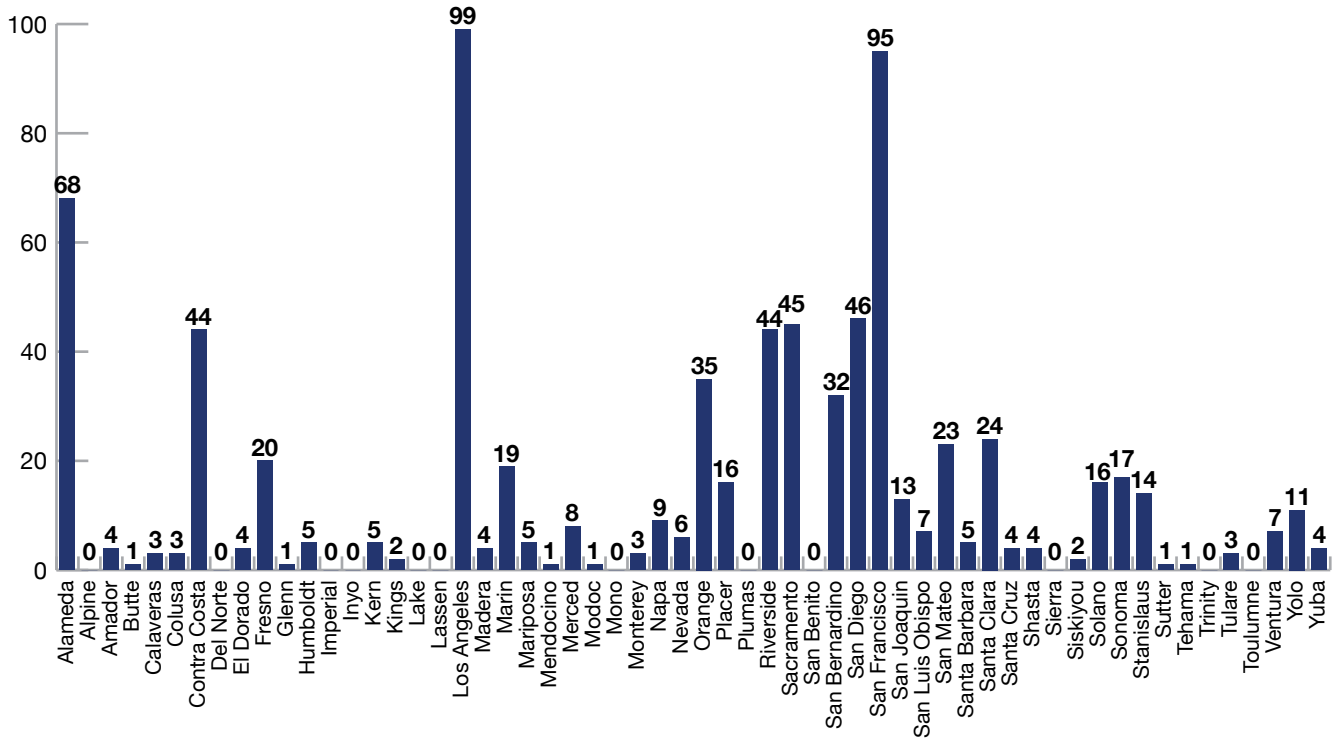
Findings

LOCATION

The geographic location of the doula workforce is key to understanding the gaps in the availability of doula care for pregnant and birthing people in California. In this section of the survey, respondents were asked what counties where they provided doula care. In our survey, doulas were able to report working in more than one county and are counted in each county they reported working in. Respondents often reported working in more than one county.

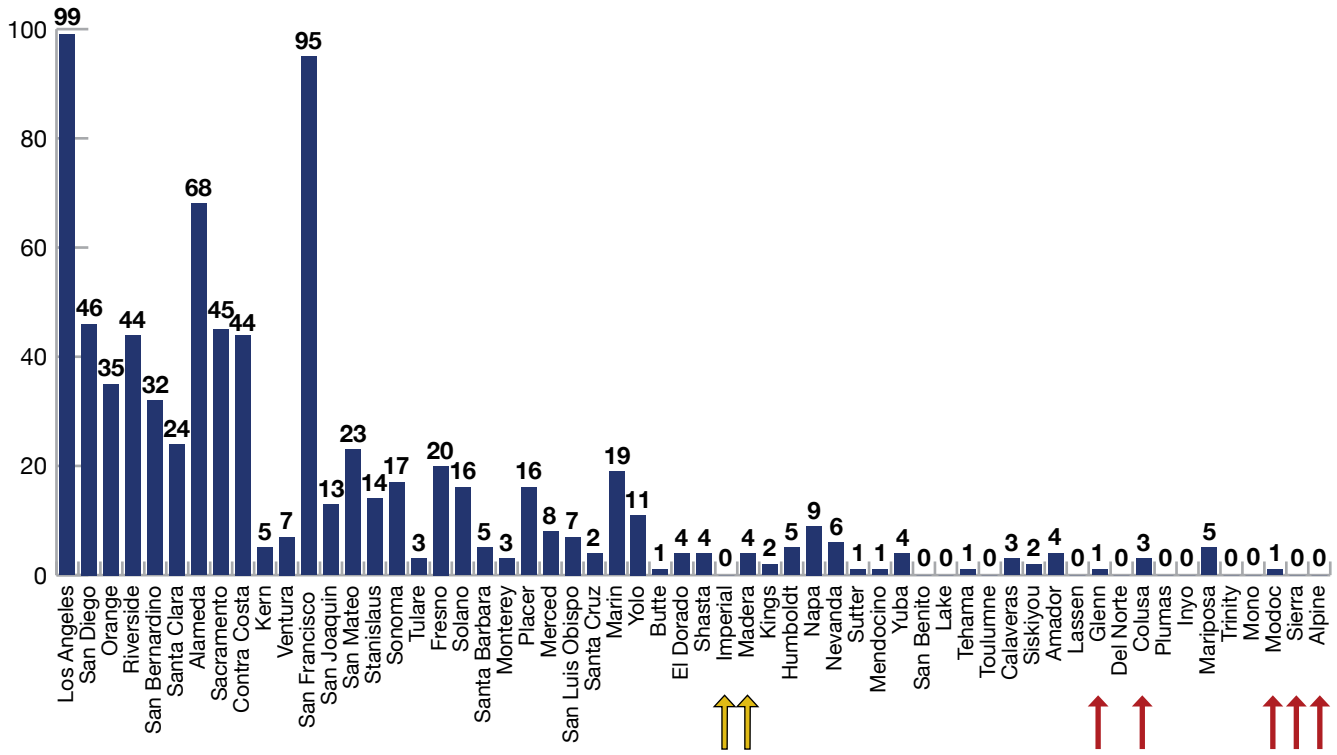
Doula respondents reported working in forty-six of California's fifty-eight counties. The following graph shows the counties in alphabetical order that doula respondents reported working in.

Counties Respondents Work In



The next graph shows the respondents by county with the counties sorted by population size rank (1 being the highest population and 58 being the lowest population). The red arrows indicate a “maternity care desert” and the yellow arrows indicate low access to maternity care according to the **March of Dimes Maternity Care Desert Report**.

Doula Respondents by County (Sorted by Population Size Rank)



It is not surprising that the counties with the highest amount of doulas are also counties with high populations. Los Angeles County is the most populated county in the state and had the highest number of respondents. Los Angeles County also benefits from a strong doula community and multiple doula organizations who are deeply invested in promoting and improving maternal health and the doula workforce. Alameda County is in the top ten most populated counties in the state and had the third highest number of respondents. San Francisco County is the thirteenth most populated county and had the second highest number of respondents. This could be due to the very active doula community and several robust doula organizations in the Bay Area. San Francisco is also a county with many resources. Several counties had similar numbers in the thirty to forty range such as San Diego, Sacramento, Riverside, Contra Costa, Orange, and San Bernardino Counties. These six counties also rank in the top ten most populated counties.

Counties with little to no doula representation in this survey also tended to be less populated counties. Twenty-two counties had one to five doula respondents, and twelve counties had zero doula respondents. Of the twenty-two counties with between one and five respondents, Kern County is the largest, ranking eleventh in terms of population, with five doula respondents. This is interesting compared to Mariposa County, which also has five doula respondents, but ranks fifty-third in terms of population.

Alpine, Sierra, Modoc, Colusa, and Glenn Counties are noted as **maternity care deserts**. March of Dimes classifies a county as a maternity care desert if there are no hospitals providing obstetric care, no birth centers, no OB/GYNs, and no certified nurse midwives. Imperial and Madera Counties were classified as having low access to maternity care, which is defined as counties with one or less hospital offering OB-GYN services, fewer than sixty OB providers per 10,000 births, and a proportion of women without health insurance at ten percent or greater.[2]

Though there are likely doulas that do live and work in these maternity care deserts and counties with low access to maternity care, the survey results indicate that the lack of maternal care resources identified by March of Dimes may extend to doula care as well. However, the lack of doula representation and the low-to-no access to maternity care does not mean that no births are occurring.

KidsData is a program of the Population Reference Bureau that promotes the health and wellbeing of children in California by providing high quality, wide ranging, and local data. KidsData reports that the **birth rates for these counties** are as follows:

Birth Rates of Select California Counties Compared to the Rest of California

Location	Birth Rate per 1,000 Women in 2021
California (statewide)	53.5
Alpine	S*
Colusa	65.7
Glenn	62.6
Imperial	66.3
Madera	57.9
Modoc	14.2
Sierra	53.4

*S indicates that the value is suppressed because there were fewer than 20 births. Data retrieved from **KidsCount.org**

This chart shows that only two counties had low birth rates as compared to the statewide average. In 2021, Alpine County had fewer than twenty births and Modoc County had the second lowest birth rate of these specific counties. All other counties that are indicated as low access or a maternity health desert, and have low representation of doula respondents

2 We occasionally use the words “woman” or women,” it 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 the word “woman” or “women” to conform to cited research and data, or quoted statements and material.

in our survey, have birth rates that are similar or higher than the California birth rate.

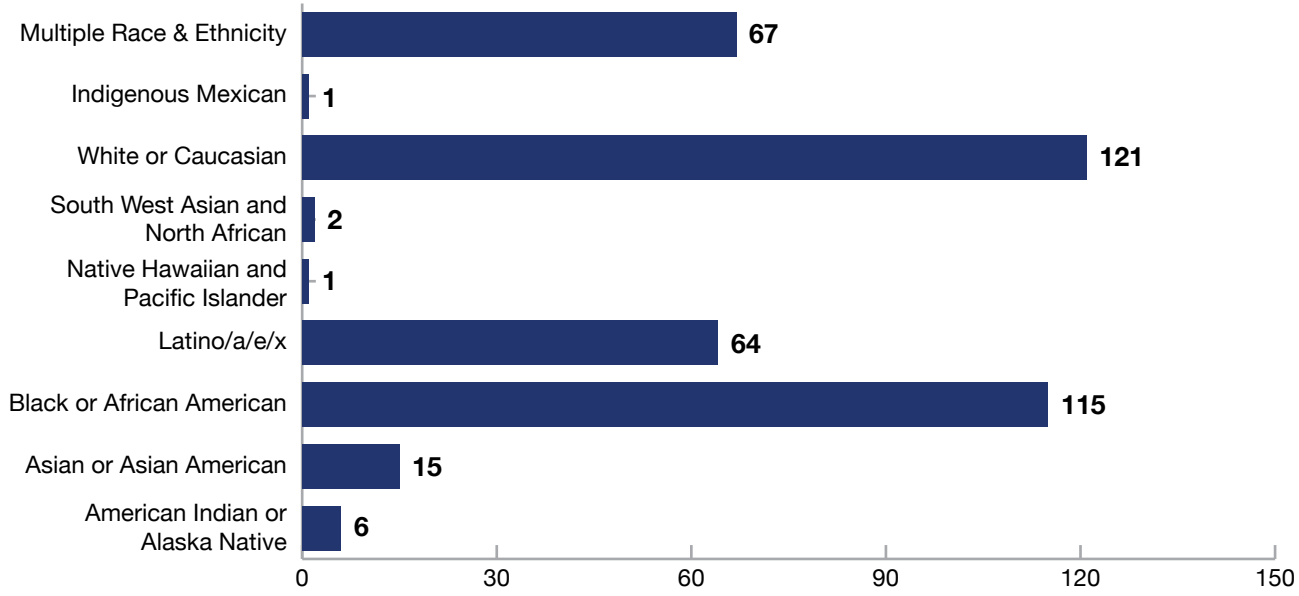
Of these counties, according to the **Public Policy Institute of California**, Alpine, Sierra, and Modoc are considered to be entirely rural, and Glenn, Colusa, and Madera are considered to be over thirty five percent rural. Doulas are especially important in rural communities as pregnant and birthing people in these areas have sometimes drastically less access to maternal care than their urban counterparts. **One article** discussing doula access in rural communities notes that doulas act as a "lifeline" for expectant parents. A doula from this article notes that the pregnant people she works with are in a "sheer panic" over the distance and fear giving birth on the drive. She helps them plan and gauge when to leave for the hospital. Rural doulas' unique position of understanding the geographical distance that acts as a physical barrier to care and the needs of a pregnant person.

RACE AND ETHNICITY

Doulas who share a common identity with their clients are often community-based doulas. **Community-based doulas** are able to reflect the needs of, and understand the experiences of, their clients. In this survey, we asked respondents to self-identify their race and ethnicity and that of their clients.

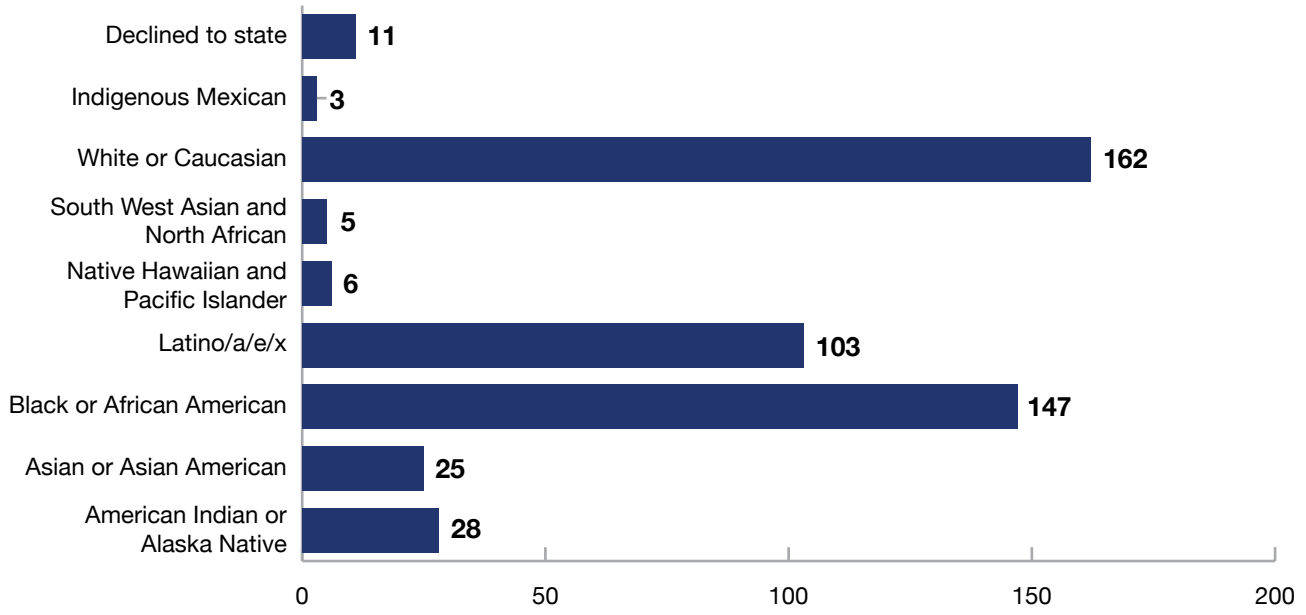
The following graph represents all of the individually reported race and ethnicity categories of respondents. The category of "multiple race & ethnicity" includes the total number of respondents who reported more than one race or ethnicity category. For example, if a doula reported both "White or Caucasian" and "Latino/a/e/x," they are counted once in the multiple race and ethnicity category.

Individual Respondents Race & Ethnicity (Single Race & Ethnicity Reported)



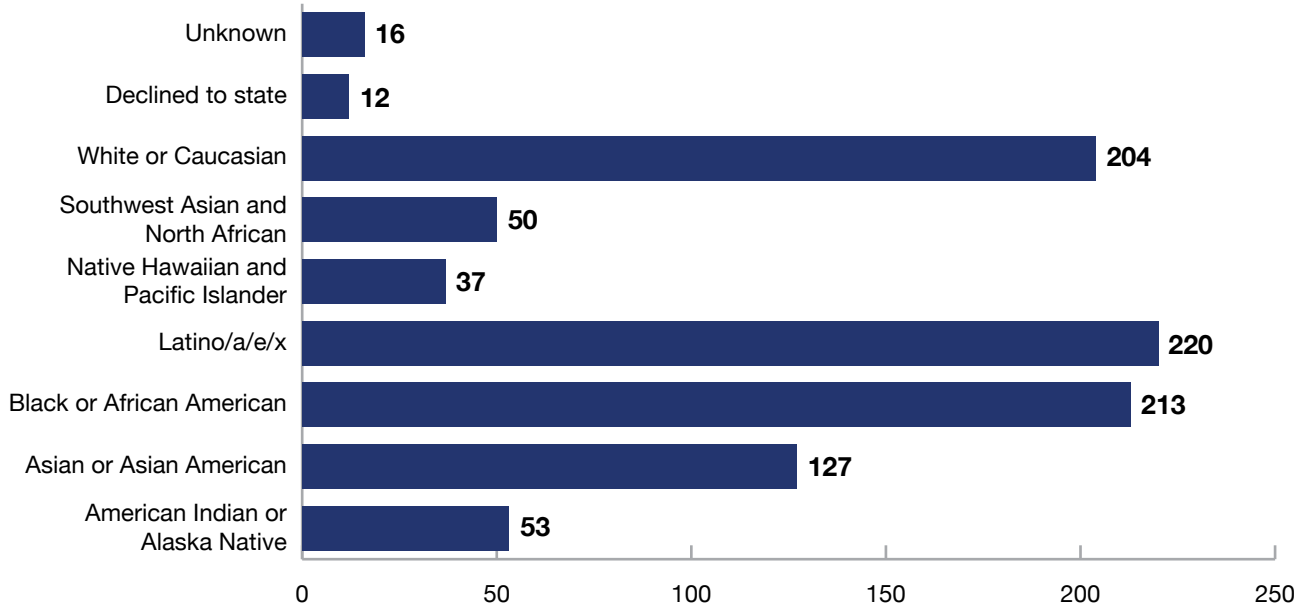
The next graph represents every mention of race and ethnicity. Those that mentioned more than one race are disaggregated so each part of their identity is represented. For example, if a doula reported both “White or Caucasian” and “Latino/a/e/x,” they are counted once in the White or Caucasian category and once in the Latino/a/e/x category.

Cumulative Respondent Reported Race & Ethnicity



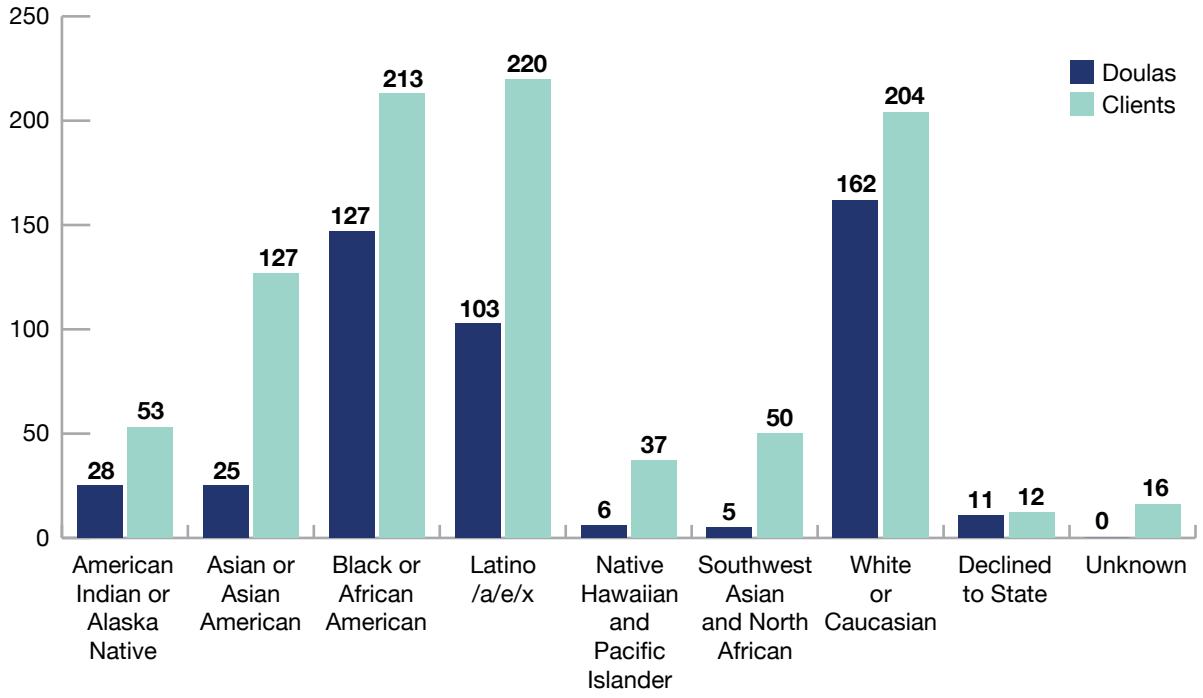
This graph represents the race and ethnicity categories of the respondents’ clients as reported by the respondents.

Respondent Reported Race & Ethnicity of Clients



The next graph represents the cumulative reported race and ethnicity categories of the respondents compared to the reported client race and ethnicity categories.

Race & Ethnicity Categories of Doulas and Clients



The first two graphs indicate the three highest number of respondents identifying as White or Caucasian, Black or African American, and Latino/a/e/x. The next most reported race and ethnicity categories are Asian or Asian American, and American Indian or Alaska Native. We see significantly less representation in the Native Hawaiian and Pacific Islander and the Southwest Asian and North African categories. The Indigenous Mexican category was added as three respondents identified themselves this way.

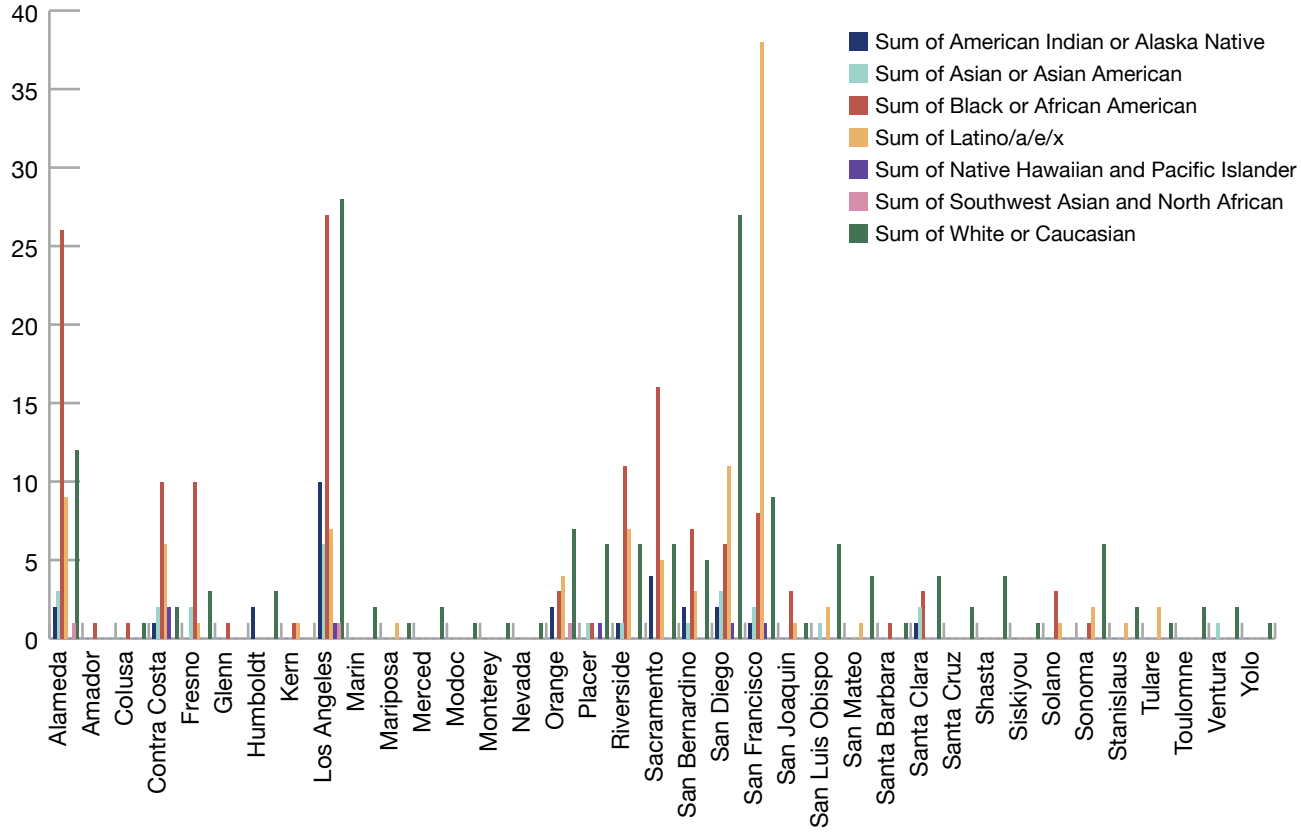
The respondent-reported client race categories follow a similar pattern to the doula reported race and ethnicity categories. We see the highest representation in the Latino/a/e/x category. This category also increased significantly from the individual-reported race, where sixty-seven reported multiple race and ethnicity categories to the cumulative graph that shows every instance of a racial category. Despite the increase in doula representation of the Latino/a/e/x category in the cumulative data, the client data reflects a disparity between Latino/a/e/x doulas and the needs of that community. This is reflected to different degrees in every racial and ethnicity category. The Asian or Asian American category reflects a client-doula gap almost as large as the Latino/a/e/x category.

The category that had the smallest gap between client and doula was the White or Caucasian category. This makes sense as the individual and cumulative data reflects White or Caucasian doulas as the most populated category. Similarly, the American Indian or Alaska Native category shows the second smallest gap between clients and doulas.

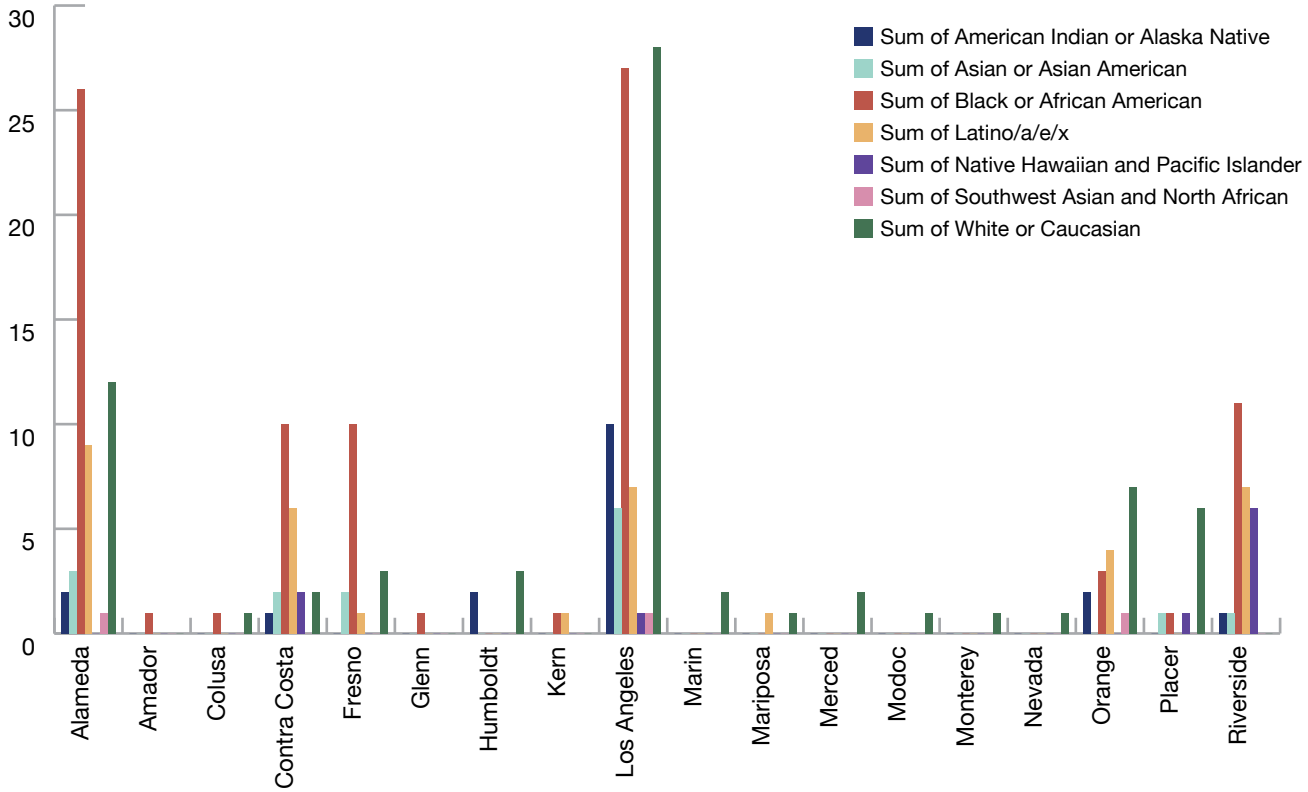
However, both the client and doula categories are much smaller.

The following graphs represent the sum of doula respondent race and ethnicity categories by county. The second and third graph are the same information separated into two graphs for visibility.

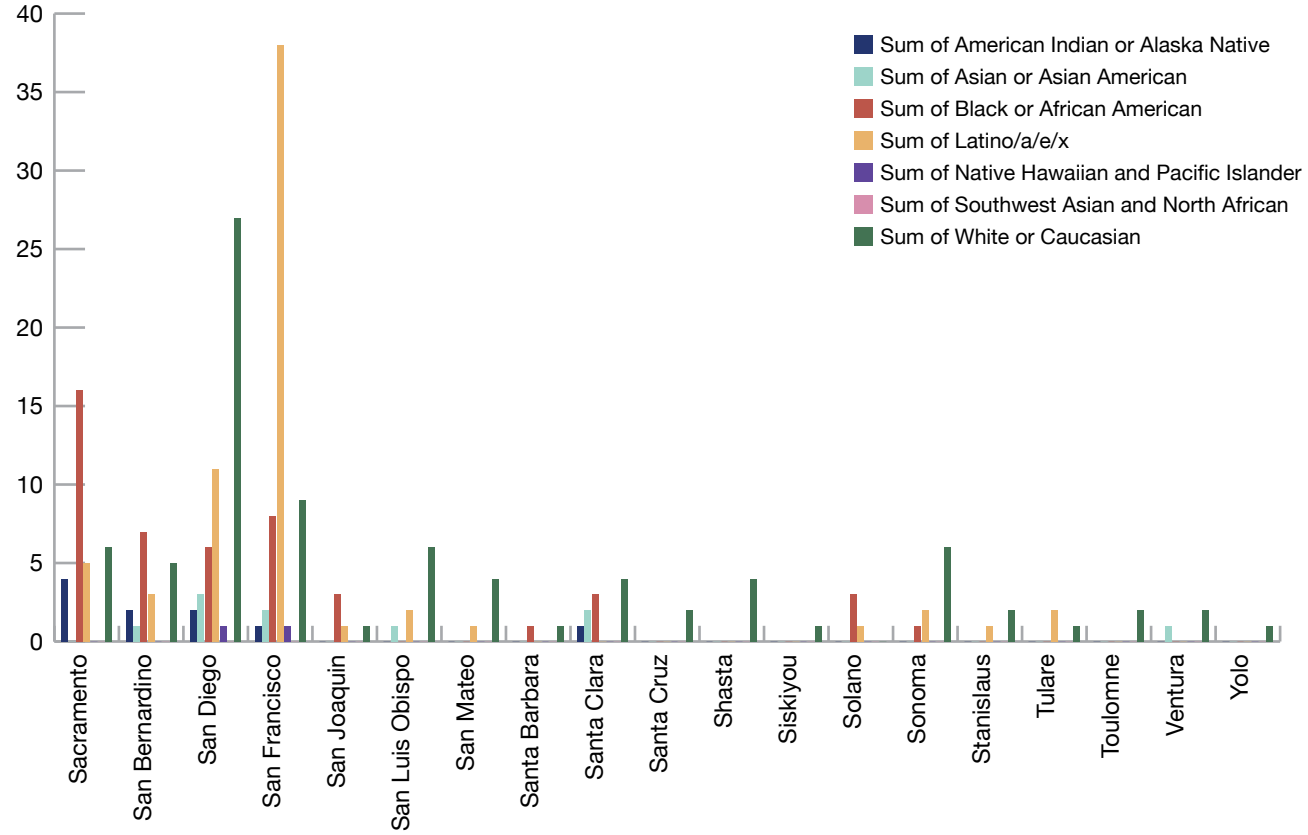
Doula Race & Ethnicity Categories by County (Full)



Doula Race & Ethnicity Categories by County (Alameda – Riverside)



Doula Race & Ethnicity Categories by County (Sacramento – Yolo)



From this data we can create a snapshot of the racial distribution in California counties. White or Caucasian doulas had the most frequent presence across the counties followed by Black or African American doulas, and Latino/a/e/x doulas. White or Caucasian doulas had the highest concentration in Los Angeles and San Diego counties. Black or African American doulas were most concentrated in Alameda and Los Angeles. Latino/a/e/x doulas were most concentrated in San Francisco County. American Indian or Alaska Native doulas and Asian or Asian American doulas were both most represented in Los Angeles County. Native Hawaiian and Pacific Islander doulas were most represented in Contra Costa county though the respondent total for this racial category is much lower. Southwest Asian and North African doulas were evenly split between Alameda, Los Angeles, and Orange counties though this racial category is also very small. Los Angeles was the county that had the most race and ethnicity category diversity. This is unsurprising considering its large population size and geographical area, in addition to the presence of several strong doula organizations.

This data suggests the need for doulas across all racial categories is high, including White or Caucasian doulas. Further, doulas of color specifically show a larger disparity between clients and doulas. To lean into the research on the benefits of community-based doula care, doulas of color must be supported. In addition, there is a need for doulas of color in most counties. Both urban and rural counties show varying levels of diversity of the doula population, but it is clear that a more targeted effort is needed to engage with doulas of color and with communities of color in most counties. In order to provide these key maternal health supports to their communities, doulas of color and those interested in becoming doulas must be supported by funding and administrative support to access trainings.

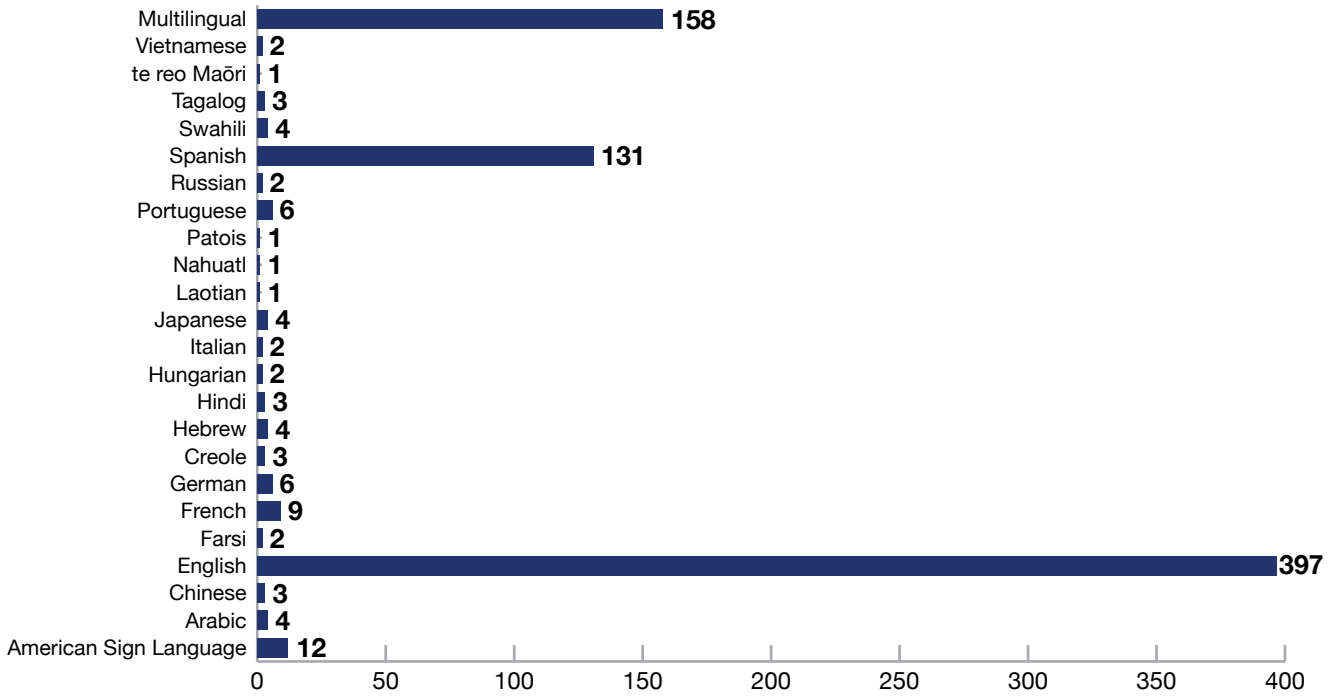
LANGUAGE

In this section of the survey, doulas were asked what languages they spoke, what languages they provided services in, and what languages their clients speak. This survey was only provided in English and thus likely missed non-English speaking doulas.

The following graph represents all of the languages spoken by doula respondents.

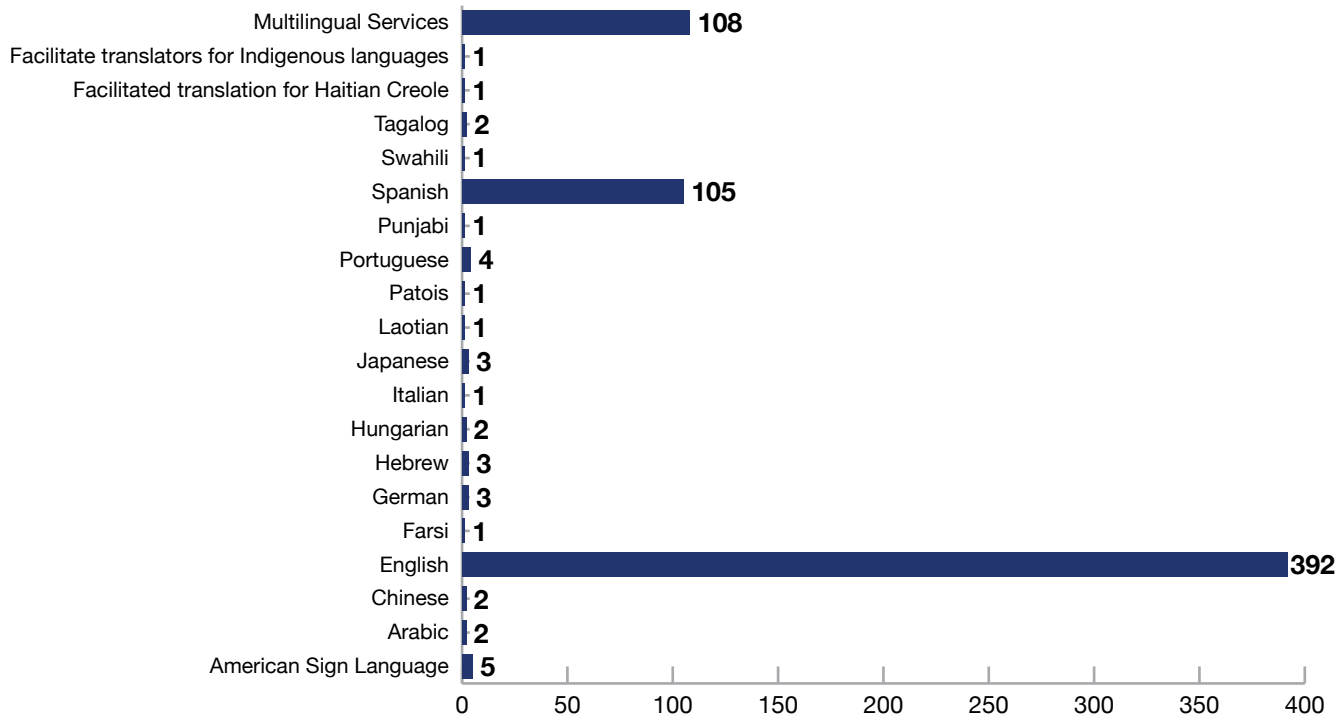
Doula respondents reported a total of twenty-three languages spoken, with 158 doulas reporting that they spoke more than one language. The most reported spoken languages were English and Spanish.

Languages Spoken by Respondents



The next graph represents all of the languages that doulas reported providing services in.

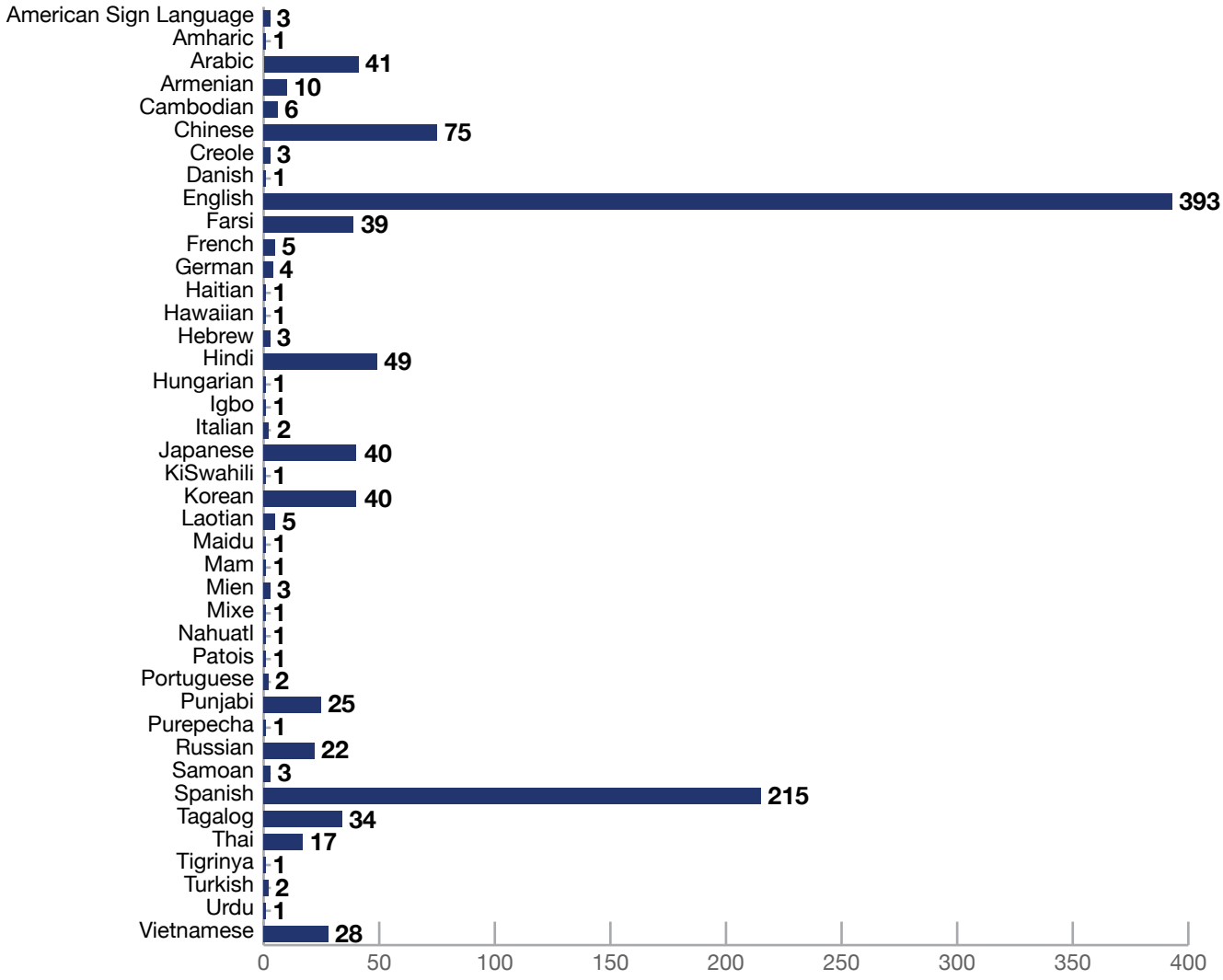
Languages Used In Providing Services



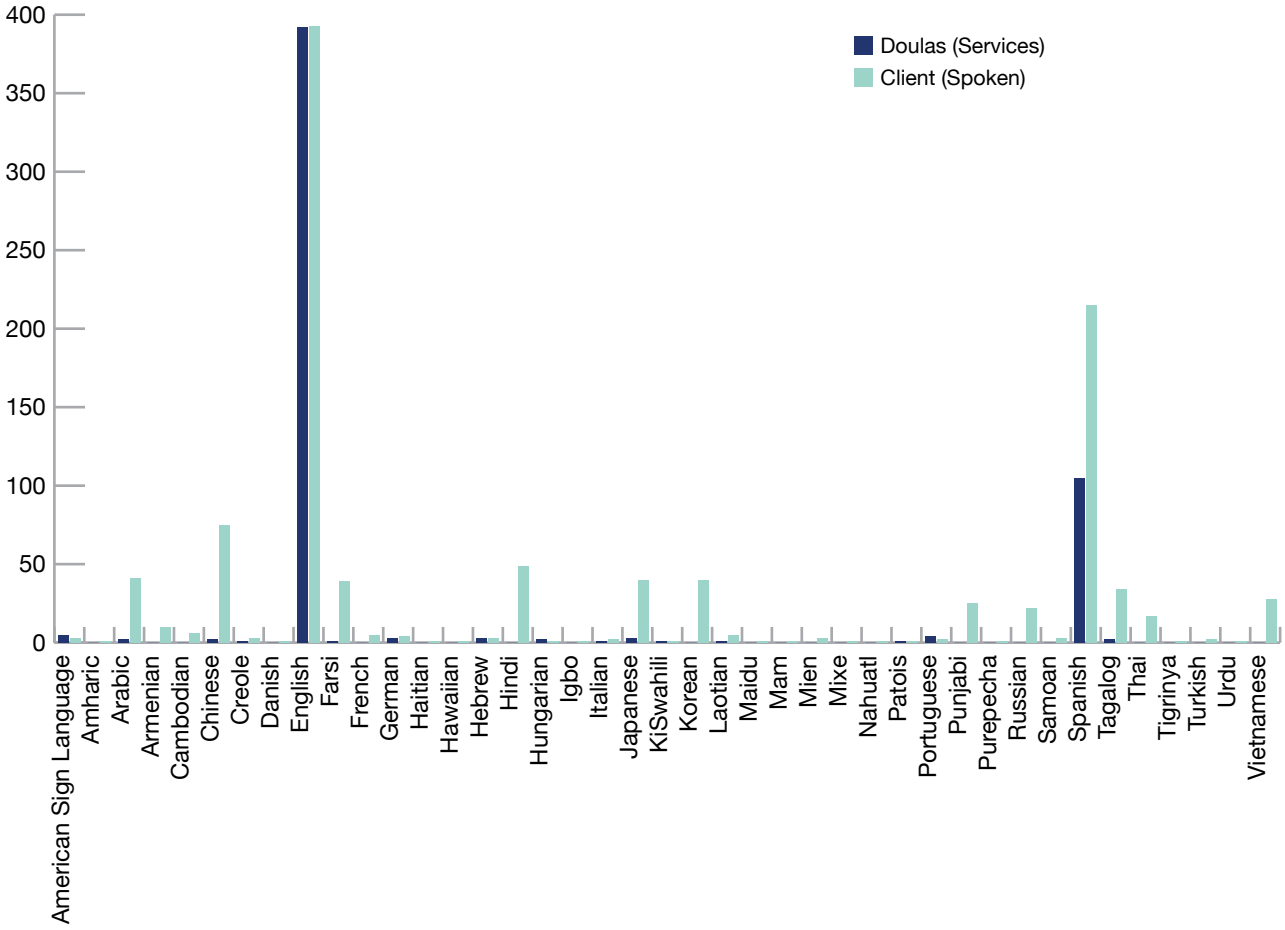
Doula respondents reported providing services in languages that generally reflect the languages they reported speaking. This includes 108 respondents indicating that they provide services in more than one language. This indicates that many doula respondents are comfortable enough to provide services in a wide range of languages. Impressively, two respondents noted that they use a facilitator to assist with translation of Indigenous languages and Haitian Creole. However, some disparities exist when comparing respondents' spoken languages and languages they can provide services in to the languages that doulas reported their clients speaking.

The following graph represents the language that doula respondents reported their clients speaking. The graph immediately following it compares the languages respondents provided services in to the languages respondents reported their clients speaking.

Reported Languages Spoken by Clients



Languages Doulas Provided Services In and Client Spoken Languages



These two graphs show that doulas reported their clients spoke many more languages than doulas reported speaking or providing services in. This is not to say that doulas are not providing language-concordant care with their clients, as we did not investigate if clients only spoke one language, if clients were also multilingual, or their clients' English proficiency. Doulas may also be seeking resources to work with pregnant people who speak different languages from those they provide services in through translation services or facilitation as noted by the two doulas we mentioned above.

The issue of language concordance is a more widespread concern. **Language concordance** is defined as when a provider and patient can communicate directly in the same language. There is growing evidence that language barriers lead to **worse quality of care and health outcomes** with medical institutions in general. While language concordance directly relates to understanding of care and informed consent during care, that is not the only impact. Non-English speakers face **intersectional** issues with other forms of discrimination like xenophobia and racism that correlate with **worse health care experiences and outcomes**.

While doulas are not responsible for solving the language access issues in health care, their position as advocates can inform patients of their rights. In California, **language access laws** require that services must be delivered in thirteen threshold languages and must involve **interpreters**. If patients have problems accessing services in their language, they are instructed to file a **Consumer Complaint**. However, patients must be informed of their rights to language access and the complaint filing process. Doulas, especially multilingual doulas, can increase access by informing their clients of their rights and assisting with potentially filing a complaint or referring their client to an organization that assists with health consumer clients like the **Health Consumer Alliance**. Further, doulas can advocate for their clients to receive language access services during care in a similar way that doulas advocate for their clients' voices to be heard in medical decision making.

GENDER AND SEXUALITY

In this section, we asked doulas questions about their gender, if they consider themselves a part of the Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQIA+) community, and if they serve clients who are a part of the LGBTQIA+ community. The chart below shows how respondents identified themselves with regards to gender.

Respondent Gender Identification

Gender	Total Respondents
Woman	395
Man	2
Transgender	4
Non-binary	20
Genderfluid	2
Multiple Gender Categories	14

The vast majority of respondents identified themselves as women. A very small number of respondents identified as men. There was a small number of respondents that identified as genderfluid and a slightly larger number identified as transgender. The second biggest gender category was non-binary with twenty respondents.

Respondents were able to choose multiple categories to best describe their gender. This led to fourteen respondents identifying with more than one gender category. From these fourteen, respondents identified as both women and non-binary or transgender and non-binary.

While these numbers are considerably lower than the number of respondents who identified as women, it is still significant to see representation of gender expansive doulas. Transgender and gender expansive people face additional barriers to care including stigma, discrimination, misgendering, and lack of knowledgeable care. A **survey of transgender people** found that thirty percent reported harassment in a medical setting and twenty-five percent

reported having to instruct their medical provider about transgender care. **Another study** found that for transgender, non-binary, and other gender expansive people (TGE), the best source of information about pregnancy and lactation were informal networks of those with similar experiences. Research also suggests that **seek care from a midwife** instead of a physician and decide to give birth at home or in a freestanding birth center instead of a hospital. This may be due to the availability of information online on which birth centers and midwives will be affirming and supportive of their identity, which may be more difficult to determine with clinicians and hospitals due to a lack of information.

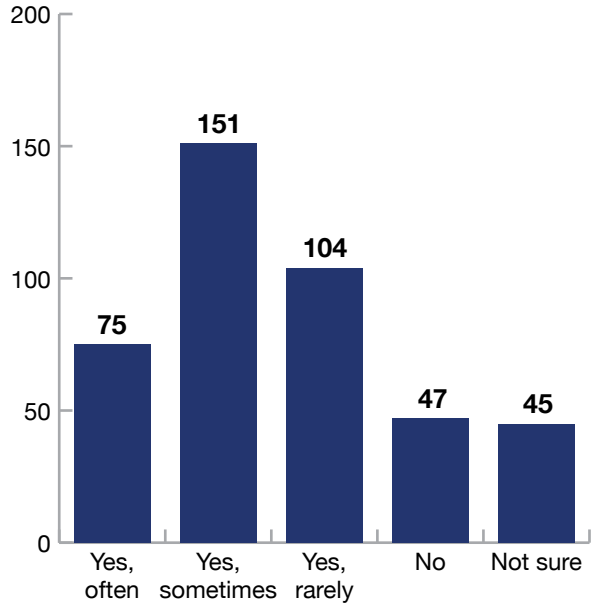
TGE people have reported not being able to get an appointment for prenatal or pregnancy-related testing because the systems used by medical practices do not allow patients classified as male to **schedule those types of appointments**. **Similar systems also do not account for the legal name** versus the name that the patient uses, which can further alienate TGE people from care. TGE people **may also experience dysphoria** during labor and delivery, with medical staff using feminine pronouns and gendered language that is contradictory to a TGE person's identity. Despite the higher rates of depression in the TGE population, TGE postpartum people report that they receive no counseling about the risks of postpartum depression. The Edinburgh Postnatal Depression scale, a common tool used to screen for postpartum depression, **does not account for gender dysphoria** and thus may increase the difficulty of diagnosing postpartum mental health conditions.

The following chart shows the respondents' identification with the LGBTQIA+ community.

Identification with LGBTQIA+ Community	Total Respondents
Yes	101
No	286
Prefer not to answer	31

The following chart shows how often respondents reported working with LGBTQIA+ identified clients.

Respondents Serving LGBTQIA+ Clients



Most doulas surveyed do not identify themselves as a part of the LGBTQIA+ community. However, there are a significant number of LGBTQIA+ identified doulas (101). Also, most doulas reported working with LGBTQIA+ clients (226 doulas reported working with LGBTQIA+ clients often or sometimes, and 104 reported working with

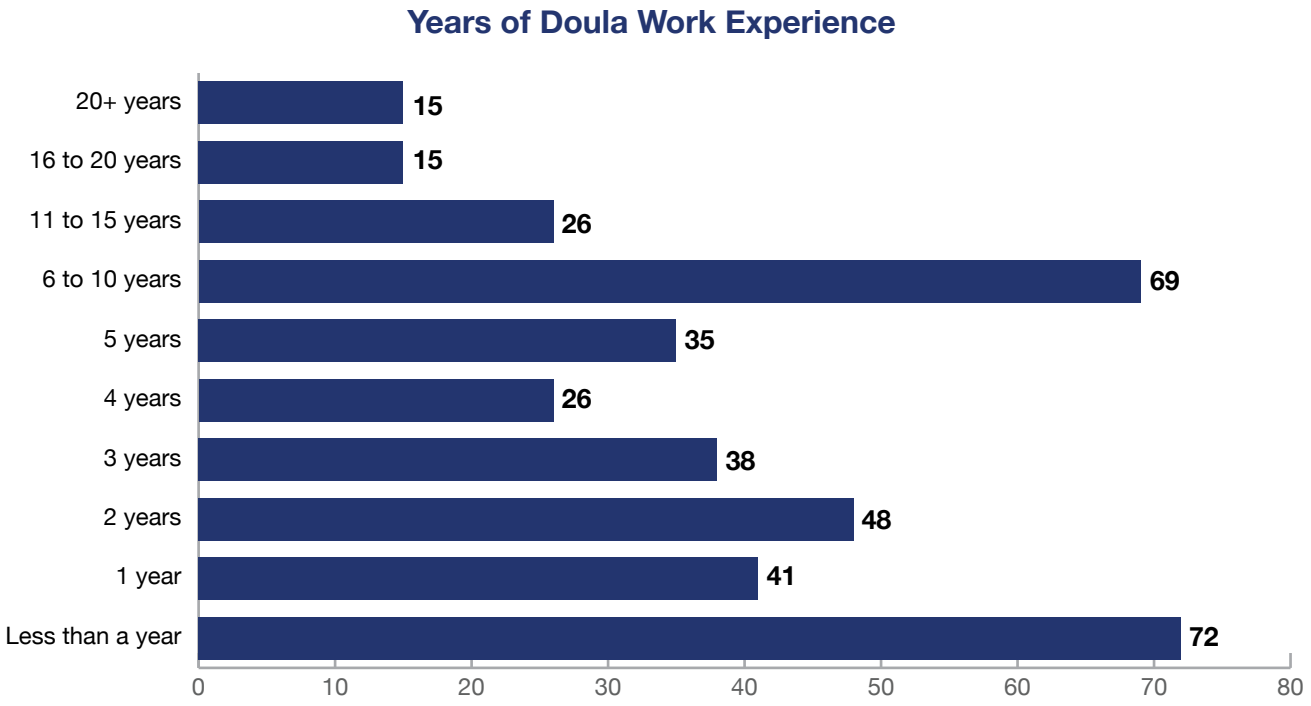
LGBTQIA+ doulas rarely). As with TGE people, the wider LGBTQIA+ community faces additional barriers to care. One study found that **Black and Latina lesbian and bisexual women experienced worse birth outcomes** than their heterosexual peers.

LGBTQIA+ prospective parents can pursue **biological** or **adopted** children. For those pursuing biological children, many will need to work with fertility specialists in the formal medical system through **fertility treatments** and forms of **assisted reproductive technology**. This can include vitro fertilization (IVF), intrauterine insemination (IUI), intracervical insemination (ICI), or surrogacy. Assisted reproduction can be a lengthy process with many steps and decisions while also being a deeply emotional experience. **Doulas can help guide prospective parents** through these fertility processes, explain procedures, prepare for appointments, and be available for emotional support, and questions. Fertility support is not just used by LGBTQIA+ prospective parents and doulas can provide similar support to cisgender and heterosexual prospective parents. **Fertility and conception doulas** provide emotional, physical, and general support during the potentially challenging journey through assisted reproduction.

This is where an LGBTQIA+ informed doula can advocate for their patients. They can remind medical staff to use the correct pronouns and advocate for a more inclusive and affirming environment during their clients' engagement with the medical system. **Doulas also spend a significant amount of time** with their clients and are often more accessible to clients for questions. Doulas often build a closer relationship to their clients than other medical professionals and this can increase the trust with their clients. Thus, clients may feel more comfortable being honest with their doula about their symptoms. With this increased time, availability, and trust, doulas can more effectively spot warning signs of postpartum depression. LGBTQIA+ community-based doulas may also share the experience with their clients that can lead to more effective advocacy and information to their clients. One Oregon-based doula collective, **Birth First Doulas**, an organization that provides LGBTQIA+-inclusive and affirming care, states that "queer affirming doula care advocates for your family by placing extra emphasis on navigating medical systems and offering a counter-balance to the tendency for reproductive spaces to be heteronormative and strongly gendered."

DOULA PRACTICE

This section asked respondents to reflect on their doula practice. It included questions about how long they have been practicing, what kind of doula care they provide, how many clients they serve over different time periods, their income, and their perception of and engagement with the Medi-Cal doula benefit.

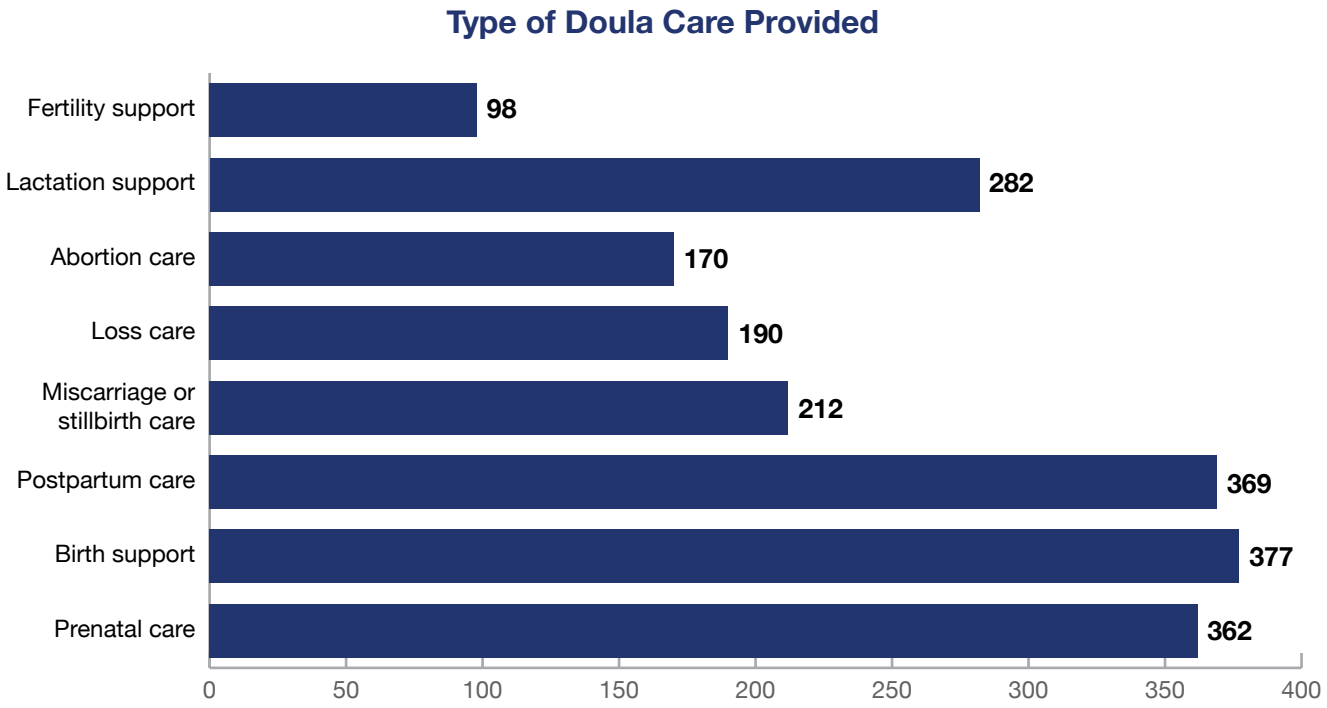


Length of Experience

The following graph shows how long respondents have been working as a doula by year.

The years of doula practice shows the wide range of experience in California's doula workforce. From this sample of doulas, about sixty-seven percent of the doula workforce has five or less years of experience. Almost eighteen percent of respondents had between six and ten years of experience. Finally, about fourteen percent of respondents indicate they have over ten years of experience. Almost nineteen percent of doulas indicated they have been practicing as a doula for less than a year.

The high percentage of doulas on the less experienced side can be a good indicator of a strong interest in doula care as a profession and a positive sign of a strong future for the doula workforce, if this population is sustained. While experienced doulas are very important in terms of improving maternal health outcomes, the presence of more experienced doulas is also key to the sustainability of the doula workforce. Experienced doulas often serve as trainers and mentors for new doulas. In addition, more experienced doulas may be more confident in navigating new workforce situations like the Medi-Cal doula benefit. Anecdotally, **NHeLP** has been fortunate to partner with many experienced doulas who have been key advocates in designing and implementing the Medi-Cal doula benefit. Future research is needed to explore if the Medi-Cal doula benefit itself has encouraged more people to become doulas.



Type of Doula Care

The next graph shows the type of doula care that respondents provide. This question allowed for more than one response as many doulas provide a range of services.

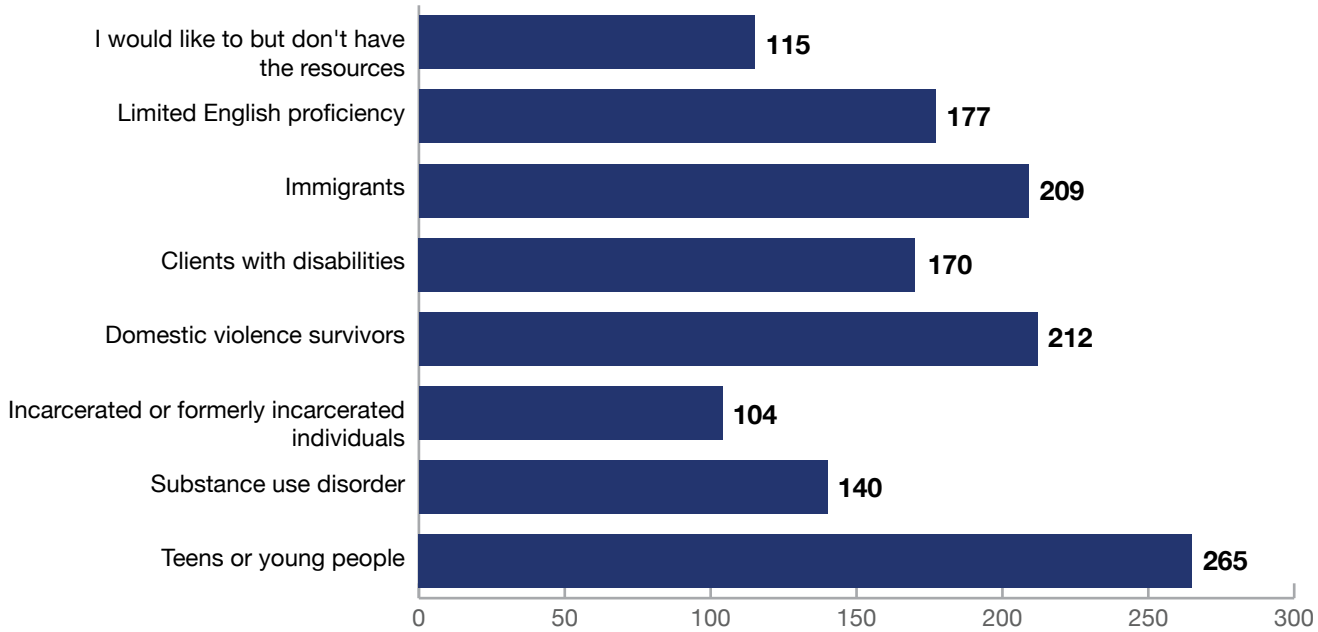
Most doulas reported providing prenatal care, birth support, and postpartum care, followed by lactation support. From these categories, the most reported type of care provided is birth support, and the least reported type of care was fertility support. The wide range of services that doulas provide is indicative of the varied strengths of the doula workforce in California. Less frequently reported categories can also be attributed to the demand for services (e.g. less people seek fertility support than prenatal care and thus doulas provide less fertility support).

During prenatal care, doulas can help their client create a birth plan, offer emotional support, and provide education throughout pregnancy. Throughout the pregnancy, doulas can provide touch-based support like massages and guided focused breathing exercises. Multiple studies show the effectiveness of doula support. Women who are supported by a doula during labor and childbirth are **less likely to require a cesarean birth or use pain medication**, and **more likely to give birth spontaneously**, **have a shorter labor**, and **feel satisfied with their birthing experience**. During the **postpartum period**, doulas can support their clients with lactation information and guidance, infant soothing, provide education on recovering from birth, and coping skills for new parents. Doulas can also share common warning signs of **postpartum depression** and encourage their clients to seek further support.

Abortion care, miscarriage, ectopic pregnancy treatment, and stillbirth care, as well as loss care are particularly important as they tend to be less often recognized support that doulas often provide. As abortion access is increasingly limited and stigmatized, abortion doulas are an invaluable resource for those seeking abortions. Even in states like California that have sought to **protect access to abortion**, limited research shows that **abortion doula care can improve mental health**, **improve the experiences of their clients**, increase **respect for reproductive autonomy**, **improve education on abortion and post-abortion care**, and **reduce demand on clinicians**.

Doulas also often provide care during miscarriage, ectopic pregnancies, stillbirth, and through loss. **Loss care** can extend past birth, such as when an infant has a **life-limiting diagnosis** that means the infant may not survive very long post-birth. Doulas support their clients through reproductive loss by **providing physical and emotional support including through grief** and helping clients **make informed decisions**. With full-spectrum doula care covered through insurance programs like Medi-Cal, low-income people have a range of care options from the California doula workforce. Doula training should support this diversity of care by covering the topics of doula support for abortion, miscarriage, stillbirth, and loss care. Benefits like the Medi-Cal doula benefit should reimburse and support the range of services that doulas can provide.

Specific Populations Served by Respondents



The following graph shows how doulas support people from many backgrounds that may fall through the cracks of traditional reproductive care.

This sample of the California doula workforce underscores how doulas are already serving diverse populations who face stigma, lack of access, and may have additional health care needs throughout pregnancy. Doulas frequently reported serving clients who are teens or young adults, who may face **stigma and discrimination** during their pregnancy due to their age. Pregnant and parenting teens also face increased **challenges and barriers**, such as depression and posttraumatic stress disorder, along with a higher chance of social and economic disadvantage.

People with disabilities have about the same rates of pregnancy as compared to people without disabilities, but are more likely to experience **health inequities** and have a **greater risk of birth complications and death** during pregnancy. There are also barriers that disabled pregnant people experience in their prenatal, birth, and postpartum care. People with disabilities have about the same rates of pregnancy compared to people without disabilities but are more likely to experience **health inequities and have a greater risk of birth complications and death** during pregnancy. In addition to inequities in health outcomes for pregnant people with disabilities, there is an increasing body of research that demonstrates the many barriers that disabled pregnant people experience in their prenatal, birth, and postpartum care. **One literature review** of the existing research on the experiences of physically disabled women during childbirth shared barriers like provider inexperience, negative attitudes of medical staff, non-cooperation between health care settings of clinicians, inadequate equipment and facilities, and the lack of a birth plan. People with disabilities also face **social stigma** and **negative attitudes** towards their ability to have and parent children.

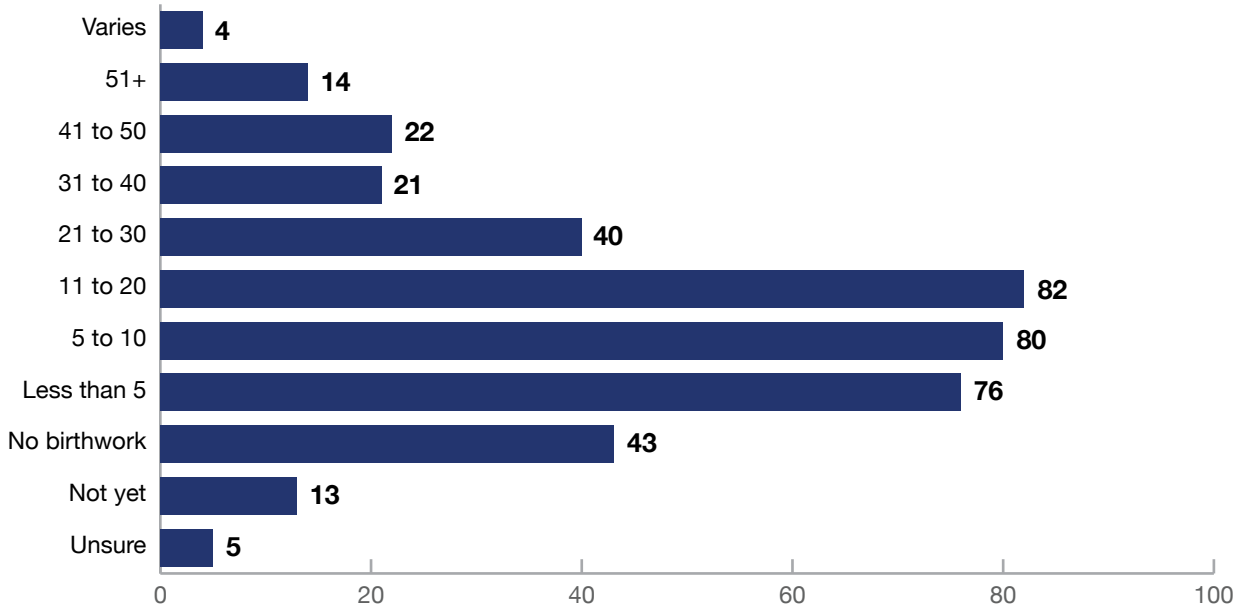
People who experience intimate partner violence also have increased risks during pregnancy. **They may experience increased depression, anxiety, and post-traumatic, stress disorder as well as a range of adverse fetal outcomes**.[3] Identifying clients who have experienced intimate partner violence and providing appropriate support **can mitigate these negative outcomes**. Like people who have experienced intimate partner violence, other populations like immigrants, people experiencing substance use disorder, and incarcerated people also show increased levels of trauma. While not all doulas have had **trauma-informed training**, this is an area where doulas' advocacy and support role can intervene to improve maternal health outcomes and experiences of these populations. The role of doulas for improving maternal health for those with **substance use disorder** and **those that are incarcerated** is also increasingly being recognized.

3 The original survey question included the terminology "domestic violence survivor." In this report we use the following updated terminology "intimate partner violence" instead of the original wording of the survey.

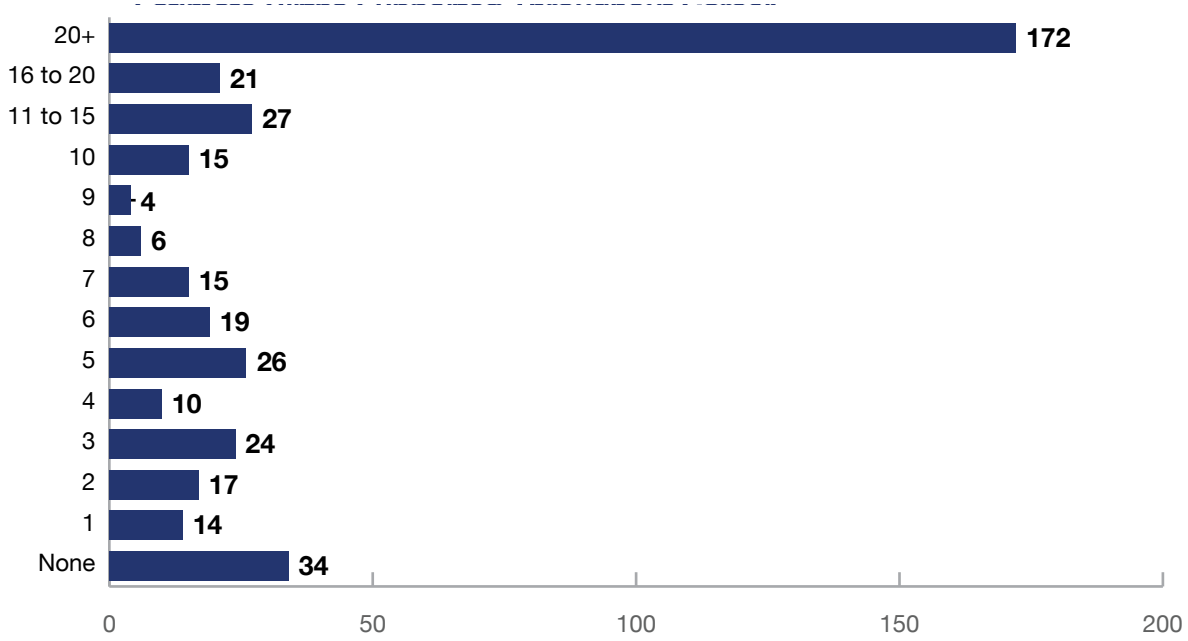
Doula Work Experience

The following three graphs show the estimated births supported yearly, estimated births supported throughout a doula's career, and the estimated clients supported monthly. Some respondents reported ranges that were larger than the categories or spanned multiple categories, for these responses, the higher value is included.

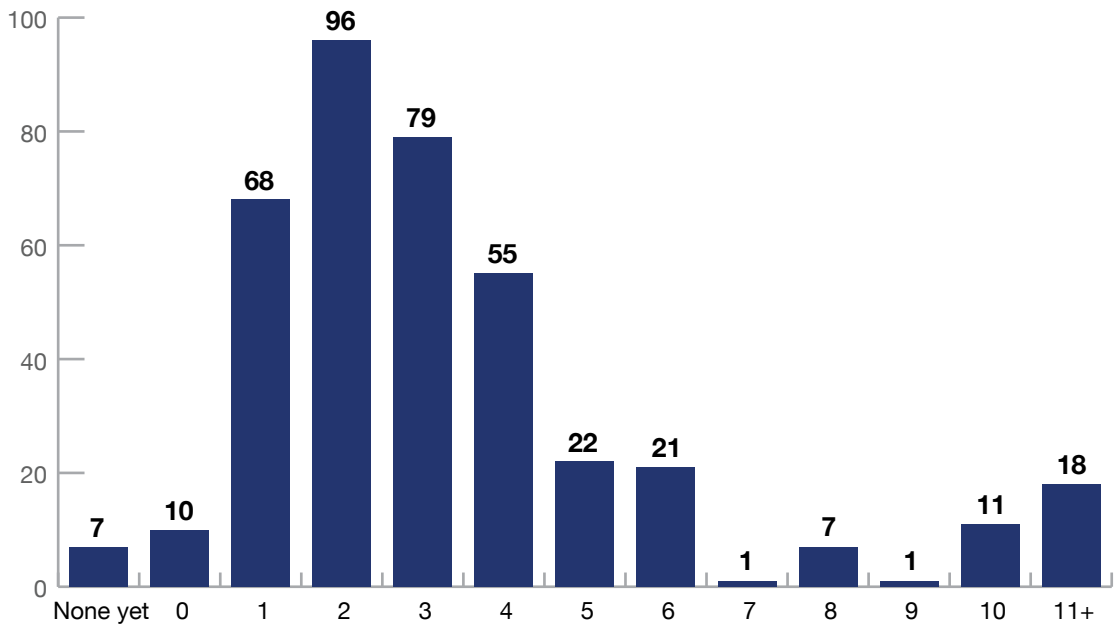
Estimated Yearly Births Supported



Estimate Births Supported Throughout Career



Estimated Clients Supported Monthly



This data indicates that the doula workforce in California is very productive. Doulas are consistently supporting clients across all lengths of time and throughout their careers. As demonstrated here, many doulas in this survey are earlier in their doula careers. This is an opportunity to support a growing doula community through more targeted workforce development support like mentorship programs, financial support for training, and opportunities for peer support within the doula community.

Income

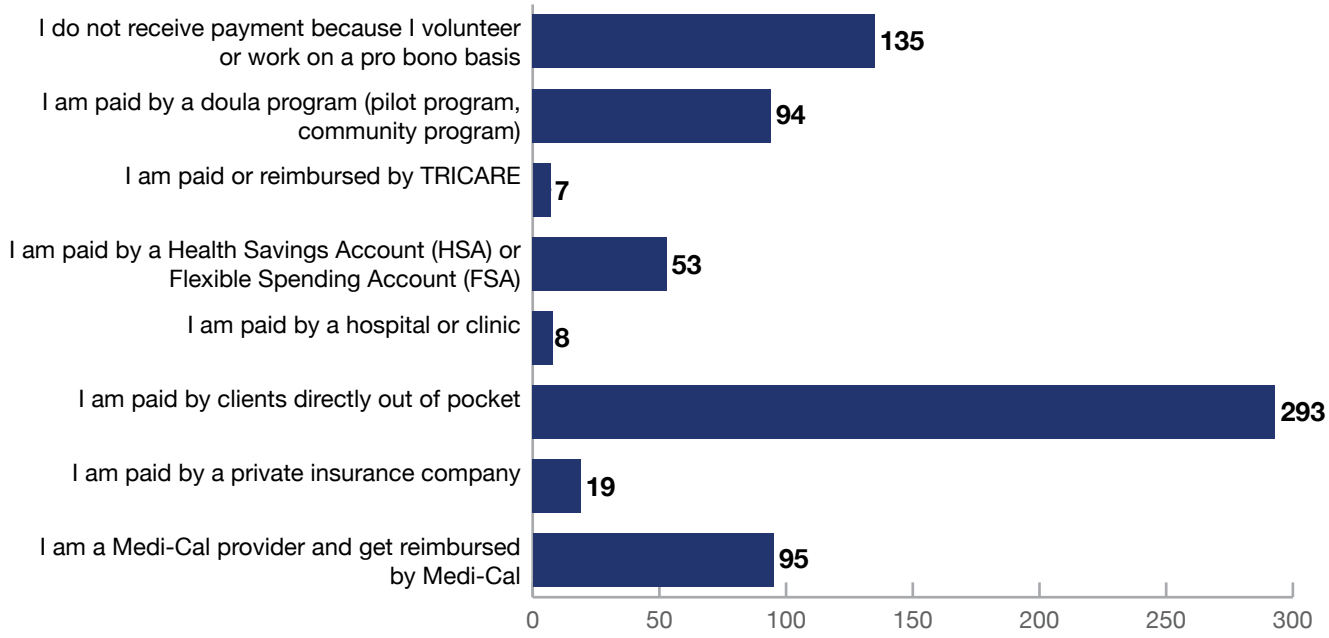
The following chart shows if the respondent's doula work is their sole source of income.

Doula Work as Only Source of Income	Total Count	Percent
Yes	155	37.09%
No	263	62.92%

This data shows that despite the productivity of doulas shown in the previous section, for most doulas, this work is not their only source of income. Some doulas are responding as volunteers and thus not expecting to be compensated for their work. However, several note that they rely on a partner, have had to take on another full time job, pick up work as independent contractors like Instacart, or pursue other types of work. Others report expanding their offerings to include adjacent services like yoga, reiki, breathwork, and other somatic healing work. Several respondents also note that they teach childbirth education in addition to their doula work.

This graph shows the type of payments that respondents reported receiving for their doula work. Doulas were able to select more than one answer as many doulas can tailor their work to different contexts, such as providing volunteer support when needed and having private pay rates.

Types of Payment Received for Doula Work



An overwhelming majority of respondents reported that they are paid by clients directly out of pocket for their services. The second most common type of payment is no payment. One hundred and thirty-five doulas reported working on a volunteer or pro bono basis. The next most common payment methods were Medi-Cal reimbursement and doula programs like pilot programs or community programs. Ten doulas responded that they only receive reimbursement through Medi-Cal with the other eighty-five Medi-Cal doula provider respondents indicated that they are paid in more than one way. With about **forty percent of births** in California financed by Medi-Cal, more Medi-Cal doula providers are gravely needed.

Doula Partnerships, Groups, and Collectives

The following chart illustrates the respondents' membership in a doula partnership, group, or collective. Doula partnerships are typically smaller with doulas partnering to cover births and doula groups or collectives tend to be larger. The data indicates an almost even split between respondents who work in a formal or informal partnership with other doulas and those who do not. This is not to suggest that doulas who are in a partnership or group always work collaboratively or that doulas who are not in a partnership never work with other doulas. Rather, this indicates that there is value in both forms of doula work with slightly more deciding to seek partnership, community, or communication with other doulas.

Membership in a Doula Partnership, Group, or Collective	Total Count
Yes	214
No	200

Medi-Cal Doula Benefit

DHCS added doula services as a covered **Medi-Cal benefit** on January 1, 2023. This benefit covers:

1. One initial visit.
2. Up to eight additional visits that may be provided in any combination of prenatal or postpartum visits.
3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
4. Up to two extended three-hour postpartum visits after the end of a pregnancy.

Medi-Cal enrollees can also access up to nine additional postpartum visits with an additional recommendation from a physician or or other licensed practitioner of the healing arts within their scope of practice.

Doulas are able to enroll as **Medi-Cal providers** either through the Training Pathway for doulas who are early in their career or the Experience Pathway which is for doulas with at least five years of experience. Doulas may work with **Medi-Cal enrollees through the managed care or fee-for-service delivery systems**. Doula must contract with Managed Care Plans (MCPs) to work with Medi-Cal enrollees in their networks.

We asked doulas seven questions about their thoughts on and engagement with the Medi-Cal doula benefit. First, we asked doulas if they are currently enrolled as a Medi-Cal provider. The following chart illustrates their answers.

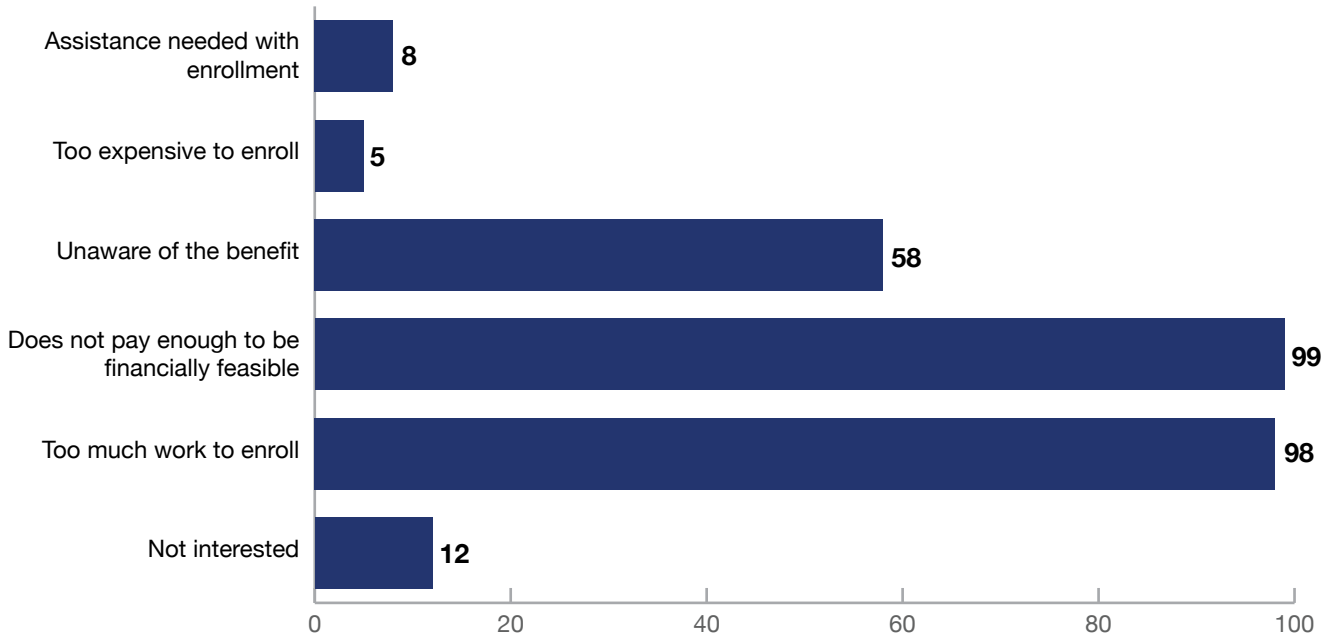
Enrolled as a Medi-Cal Provider	Total Count	Percent
Yes	107	25.54%
No	186	44.39%
In progress	126	30.07%

When combining those that responded that they are currently a Medi-Cal doula provider and those that are in the process of becoming one, about fifty-five percent reported being engaged with the Medi-Cal doula benefit in some way. About forty-four percent of doulas responded that they are not engaged with the benefit. While this is a smaller percentage of respondents, it is still a large portion of doulas who are not engaged with the Medi-Cal doula benefit in any way.

Accordingly, we asked doulas for their reasons for not enrolling as a Medi-Cal provider. The following graph represents those responses.

The responses from doulas on why they are not engaging with the Medi-Cal doula benefit is not surprising but is a place for growth. The **increased reimbursement rate** in Medi-Cal was introduced in 2024. Some doulas have reported not receiving this new rate and doulas may also not be aware of the increased rates, particularly as fifty-eight respondents noted they were unaware of the benefit. A significant number of doulas responded that they felt like it was too much work to enroll as a Medi-Cal provider. The third most frequently cited reason for not engaging with the benefit is because

Respondents' Reasons for Not Enrolling as a Medi-Cal Provider



respondents were unaware the benefit existed. A smaller number of doulas noted that it was too expensive to enroll as a Medi-Cal doula provider or that they needed assistance with enrollment.

All of these reasons can be addressed. More effort and support can be put into providing resources for doulas on how to enroll, continuing advocacy for higher Medi-Cal reimbursement rates (particularly as **more states** recognize the value and **time investment** of doulas), and raising awareness of the benefit to doulas and Medi-Cal enrollees.

Anecdotally, NHeLP has seen many community-based doula organizations providing free training and assistance with Medi-Cal provider enrollment including **SisterWeb**, **Frontline Doulas**, **BLACK Wellness and Prosperity Center**, **Sankofa Birthworkers Collective**, and **Birthworkers of Color Collective**. One doula summed this up: "Community organizations deserve better funding particularly for capacity building as they have been doing so much of the work of not only advocating for community birthworkers but also supporting them as they learn about the benefit, move through the enrollment process, contract with managed care plans and begin billing for care provided. They are part of the communities they serve and with continued investment can make this benefit more sustainable and equitable." These doula groups and organizations are providing an invaluable community service to ensure the success of the Medi-Cal doula benefit, and a service that one might argue should be provided by DHCS, health plans, or other entities. Further, these doulas and doula groups are rarely provided with funding or compensation for this work and are often teaching from their own experience in a train-the-trainer model.

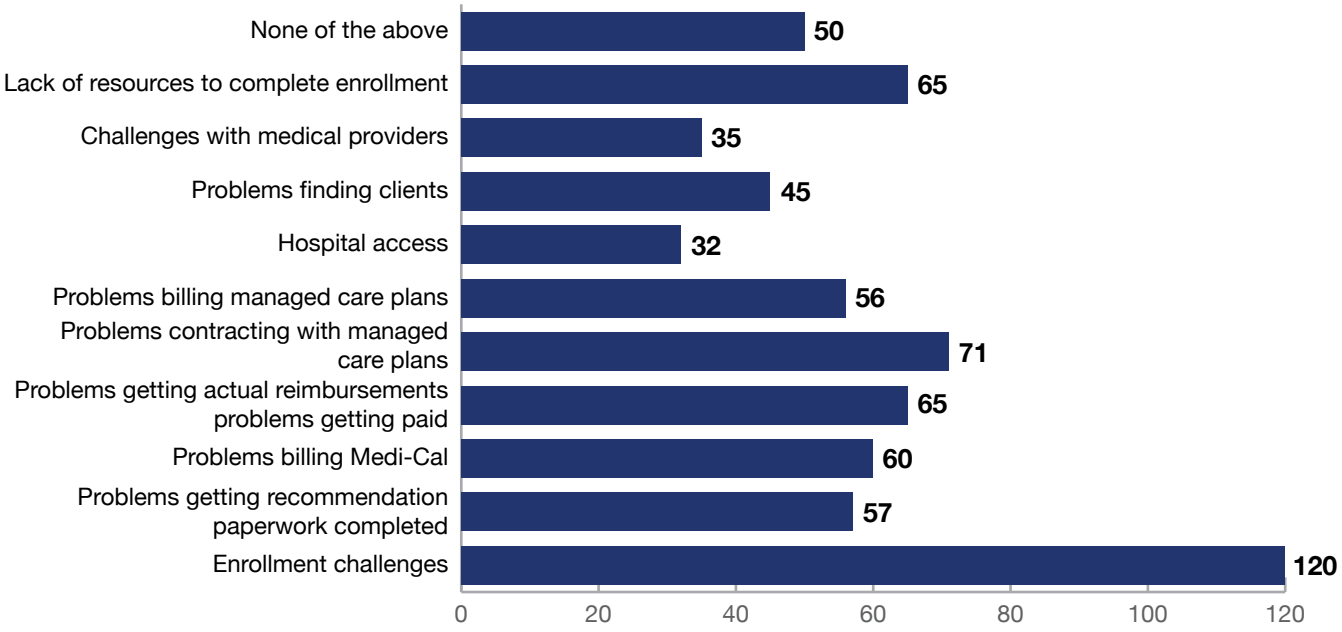
Raising awareness of the benefit should not be left only to community-based doula organizations or advocacy organizations. State and local agencies, MCPs, funders, and others should shoulder the responsibility of promoting the benefit and providing enrollment training and support in a way that is accessible to doulas to ensure that the efficacy of doula care for mitigating negative maternal outcomes is effective for low-income people.

The following graph shows the experiences of barriers or challenges either enrolling in the Medi-Cal benefit or as a Medi-Cal provider.

Doulas most frequently noted enrollment challenges as a challenge they experience when engaging with the Medi-Cal benefit. Doulas also noted a lack of resources to complete enrollment and problems completing the recommendation paperwork completed as issues with enrollment.[4]

Billing and reimbursement were also frequently cited as barriers. Doulas reported this challenge with both billing Medi-Cal and managed care plans. In addition, doulas reported problems being reimbursed for this work. Anecdotally, NHeLP has spoken with doulas who have

Barriers or Challenges as a Medi-Cal Enrolled Doula Provider or with Enrollment



4 In November 2023, DHCS issued a statewide standing recommendation that fulfills the federal requirement for a provider recommendation. See **https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Doula-Standing-Recommendation.pdf**

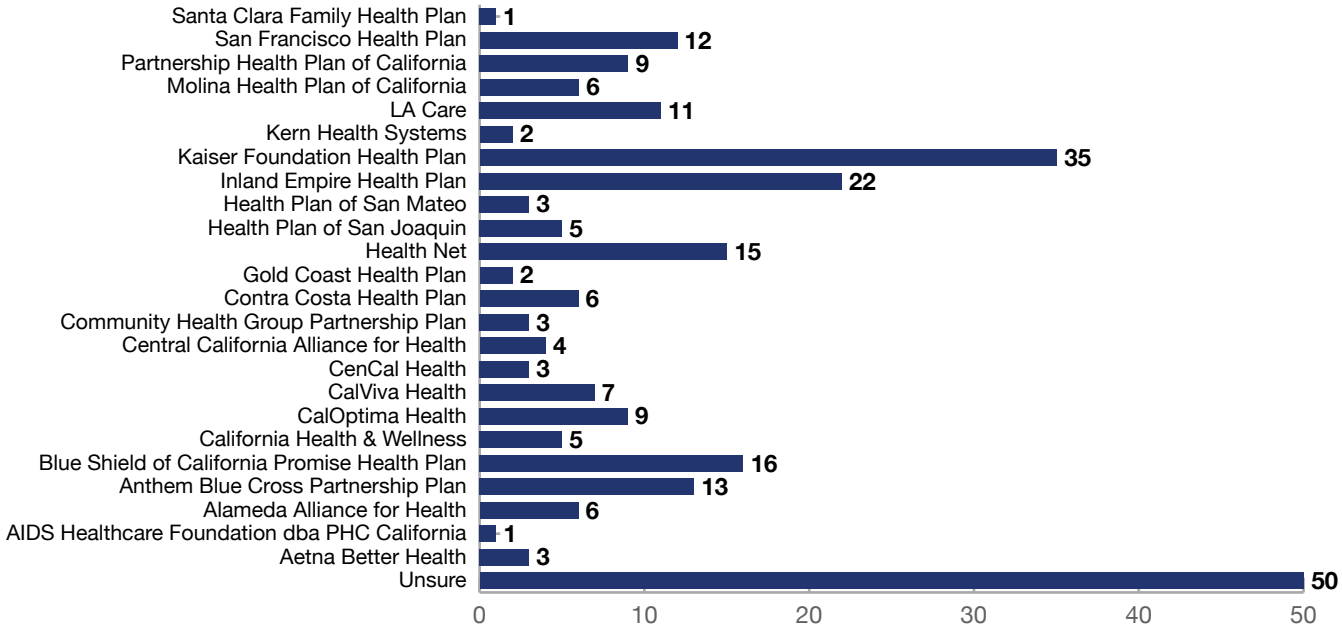
reported waiting months to be reimbursed and who are not receiving the 2024 reimbursement rate.

Another frequently cited set of challenges is with managed care plans. Doulas are required to contract with managed care plans to provide services to Medi-Cal enrollees in managed care; more than **eighty percent of Medi-Cal beneficiaries** are enrolled in managed care plans. Thus, issues with contracting should be top of mind for those interested in doulas' ability to actually work with Medi-Cal enrollees.

Challenges with hospital access (e.g., doulas not being allowed to attend births or appointments with their client) and challenges with medical providers (e.g., medical providers refusing to work with doulas) are less commonly reported in this survey. However, these issues are still impacting doulas and their clients. They are also occurring in other states, with some states passing **legislation** to ensure doulas are able to access their patients. Anecdotally, we have heard from doulas that both of these issues persist in California despite the survey data indicating these are less frequently mentioned barriers.

We asked doulas who are enrolled as Medi-Cal providers to list the managed care plans with whom they are contracted. The following graph represents this information.

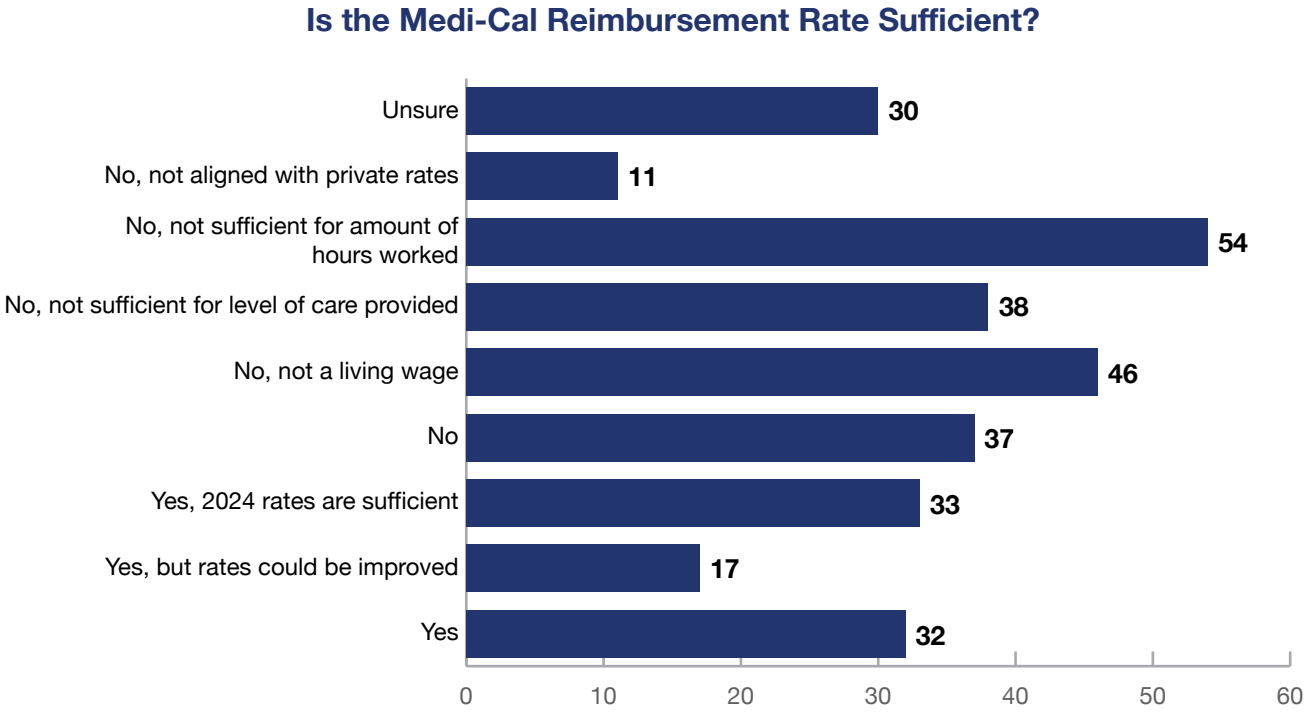
Doulas Enrolled in Managed Care Plans



The majority of doulas are unsure of which managed care plan they are contracted with, though this can also be interpreted as doulas having challenges with contracting. If doulas are not able to contract with managed care plans or do not know which managed care plans they are contracted with, this represents a clear breakdown in the process doulas must go through to work with Medi-Cal managed care enrollees or a breakdown in communication between doulas and managed care plans. Doulas who are stuck between completing the requirements through DHCS and completing contracting with managed care plans are unable to provide services to the majority of Medi-Cal enrollees as eighty-eight percent of Medi-Cal enrollees are in managed care plans and only twelve percent are in fee-for-service as their delivery system. Further, in 2019, **Medi-Cal** managed care covered about 140,164 births and fee-for-service covered about 72,231.

Reimbursement Rate

We asked doulas if they felt like the Medi-Cal reimbursement rate was sufficient. This survey question was open-ended and answers were coded into categories based on respondents' answers. Also, note that the doula Medi-Cal reimbursement rate increased considerably, from roughly $1500 to $3100 as of January 1, 2024. As the rate increase was still in the process of being rolled out over the first several months of 2024, the survey respondents may not yet have been aware of the increase in reimbursement rate at the time that they responded to the survey. The following graph represents their answers.



The most frequent response was that the Medi-Cal reimbursement rate is not sufficient for the amount of hours that a doula works. Many doulas also noted that the rate does not represent a living wage. This is especially relevant as **California ranks among the most expensive states** for residence. Others felt that the rate was insufficient for the level of care provided. Doulas highlighted the amount of time, energy, and resources they put into their work with each client. One doula's explanation on why the rate is not sufficient was:

"Not at all. As a Birth Doula, I am available 24/7 to my clients during the on-call period which usually is from 38-42 weeks gestation. During this on-call time, I am available 24/7 to assist them when they are in labor. This means I am never more than two hours away, I have to arrange on-call childcare and cancel anything I have going on at the moment. Birth is unpredictable and can be hours or days long. Most labors average 24 hours and when that is incorporated into the compensation received for birth support by Medi-Cal the hourly rate is inadequate. Long births may require me to call a backup Doula that I must pay out of pocket. The emotional toll that supporting those in birth with negative outcomes is also taxing on Doulas physically and mentally. The current compensation does not reflect the time and dedication we give to each client. I would like to be able to serve Medi-Cal families but can't do it at my expense."

Still, some doulas felt that the rate was sufficient and specifically noted the new 2024 rate as sufficient.

We asked doulas broadly if they had anything to tell us about the Medi-Cal benefit that we did not ask about. Doulas responded that they need assistance with enrolling as providers, a more streamlined enrollment and billing process, an easier process to contract with managed care plans, higher reimbursement rates, quicker rollout of the new 2024 reimbursement rates, and faster turnaround times for reimbursement. They shared ongoing frustration with billing and contracting with managed care plans and DHCS, especially from doulas who have been engaged in advocacy on the benefit design and implementation. One doula shared:

"It takes three times as long to contract with managed care providers than it did through straight MediCal. Most managed care providers don't have documents that relate specifically to doulas for enrollment which make the process even more confusing. Some MCP's [...] are now saying they aren't taking on new doulas. I didn't realize that there was a cap for doulas who were enrolled in providing free doula care for the community that is in need of more doulas."

In addition, another doula said:

"[...] Also billing is so so difficult — I've only gotten paid for one client out of the 10 I've supported. Processing takes forever, my claims keep getting denied for reasons I don't know, and it's so hard to actually connect with someone from the MCPs online or via phone that can do anything to help."

In terms of frustration with DHCS, doulas have shared that they need more resources and support from DHCS in subjects like enrolling and contracting with managed care plans. One doula responded:

"Last year when this enrollment started, doulas were promised an easy transition into Medi-Cal, we were promised comprehensive workshops to help us enroll and seminars and information to help us gather an NPI [National Provider Identifier] and an LLC [Limited Liability Company] and how to bill and get reimbursed and how to play ball with a medical insurance company. They have not done that, every single step I have made on my own with much push back from hospital staff up to individuals in Medi-Cal."[5]

Doulas underlined the need for funding for administrative support, particularly with the amount of time they spend navigating Medi-Cal billing processes. One doula shared:

"I personally want to serve the low-income community but I think that the system is not making it easy for me to make Medi-Cal doula a long term career as there is too much bureaucracy and as I am learning, how the health system is so messed up and broken. It has taken me a long time to complete the process of enrollment to the California program, and I am still in the process of enrolling in the local health care provider plan."

Another doula shared:

"The amount of administrative bureaucracy for tracking my service and billing is horrible especially given that the folks who are supposed to respond to your calls, emails never do. I would be curious to know how many [...] birthing people have received doula care services and if so, whether those doulas got paid."

Doulas also noted that they felt positively about the Medi-Cal program. They said that it was a great resource for families who could otherwise not afford a doula, that they were passionate about helping low-income families, and are optimistic about the Medi-Cal benefit allowing them to serve a wider population. One doula responded:

"I think this coverage is wonderful and I'm glad the rates are increasing and becoming more realistic compensation for the work."

Another doula shared:

"I am optimistic I will be able to serve a wider community."

Similarly, one doula shared:

"You're providing an amazing benefit. I serve a high population of financially insecure clients & all of my Medi-Cal clients are so grateful for no out of pocket fee for services."

5 Response edited for clarity.

Ultimately, doulas want to be recognized for their time and effort. One doula sums this up well:

"I don't think Medi-Cal realizes the scope of what we do and why reimbursement should be more, we travel to and from our client's locations for their prenatal appointments, we take time to build a deep relationship with them in person and through phone calls and texts, we are on-call 24/7 from week 37-42 of their pregnancy and have to drop everything we're doing to attend this birth and we can't tell our own children when we'll be home because we never know, it could be 6 hours or 3 days."

Another doula notes:

"If you want high quality doula programs, compensate people accordingly. Pay us what we're worth, draw in highly seasoned doulas, streamline the process, and watch the state's medical bills go down."

Training

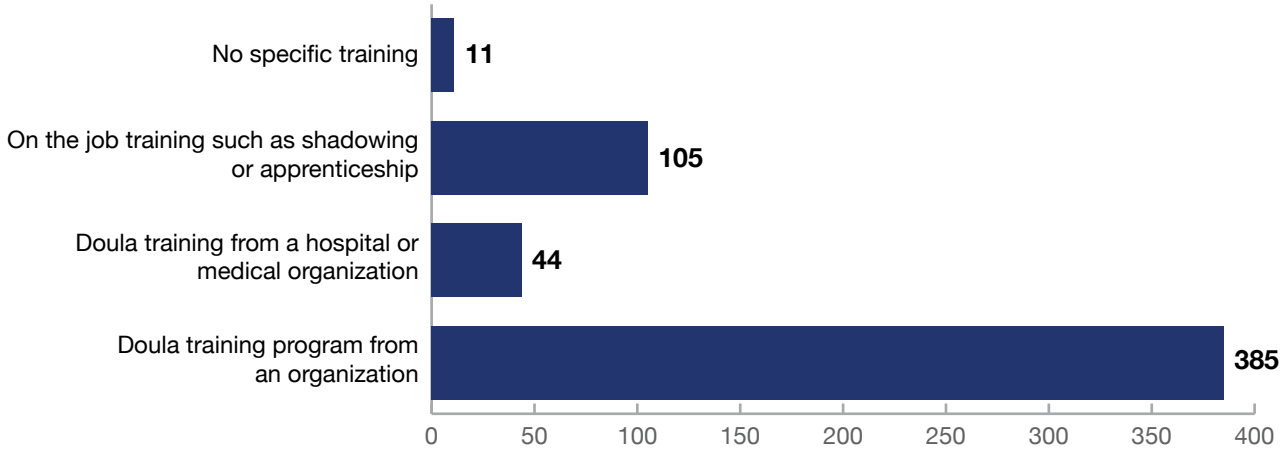
The penultimate section of our survey asked doulas about their experiences with training. This included what types of training they completed, if their training provided them with certification, if they felt like their training adequately prepared them for their doula work, and if they had plans to pursue midwifery.

A definition of **certificate of completion and certification** is not necessarily standard. Typically, a certificate of completion indicates the completion of a certain course or training while a certification is a verification of competency in certain skills or knowledge.

The following graph shows what type of doula training that respondents received.

Doulas overwhelmingly report that they received training from an organization. Second to training from an organization, doulas reported that they received on the job training through shadowing and apprenticeship.

Type of Doula Training Received



The next graph shows doulas' thoughts regarding whether their training adequately prepared them to work as a doula. This question was open-ended and the responses were coded into the following categories.

Most doulas felt that their training prepared them for their work as a doula. Many doulas felt that their training was a good starting point, but felt that they also needed continuing education, hands-on experience, or additional training in subjects like running a small business. Doulas who felt that their training did not prepare them for their work as a doula cited reasons like a lack of hands-on experience and a need for mentorship.

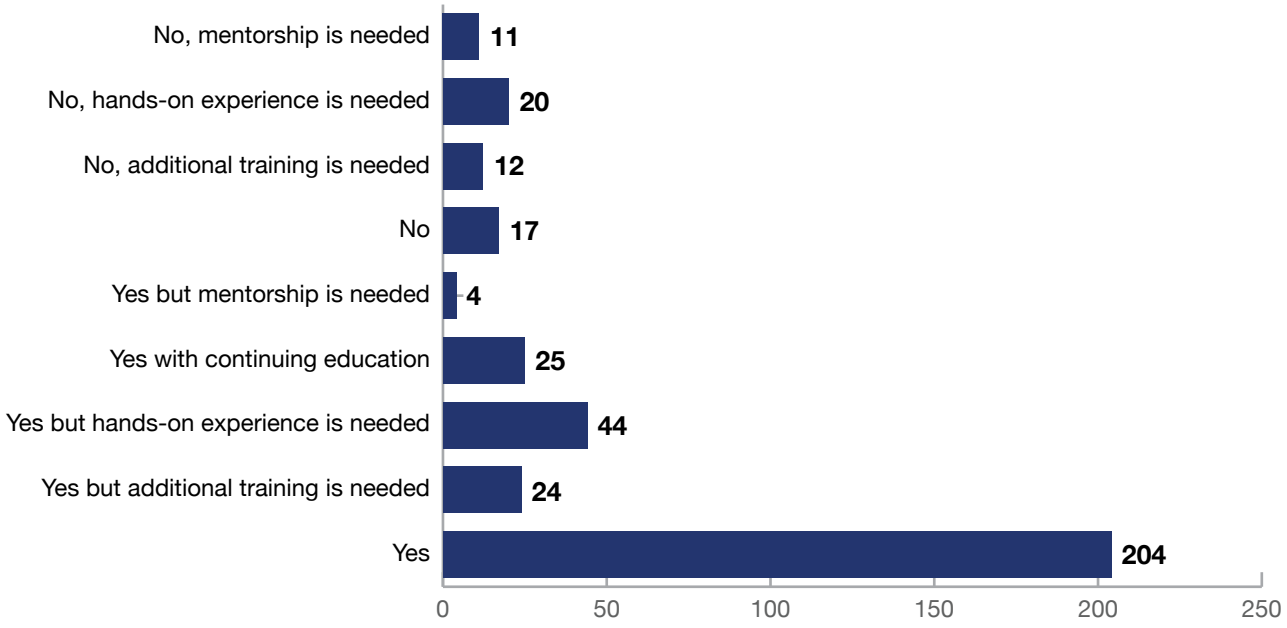
One doula discussed how their training was a good starting point but ultimately needed more:

"To get started yes, but hand on practice has taught me much more. Business practices for doulas are more of a trial and error learning experience and much of that is left for doulas to learn on their own or from others who have done it."

Another doula shared how their training did not prepare them and the importance of mentorship:

"No. I certified 12 years ago and there was no mentorship and no ongoing support. I was required to document 3 births, get feedback from the nurses and doctors and families. I attended a weekend long training on birth and breastfeeding. That's NOT enough. Apprentice-ship would have prepared me so much more. I read a lot of books but that's not enough either."

Did Training Adequately Prepare Respondents To Work As A Doula?



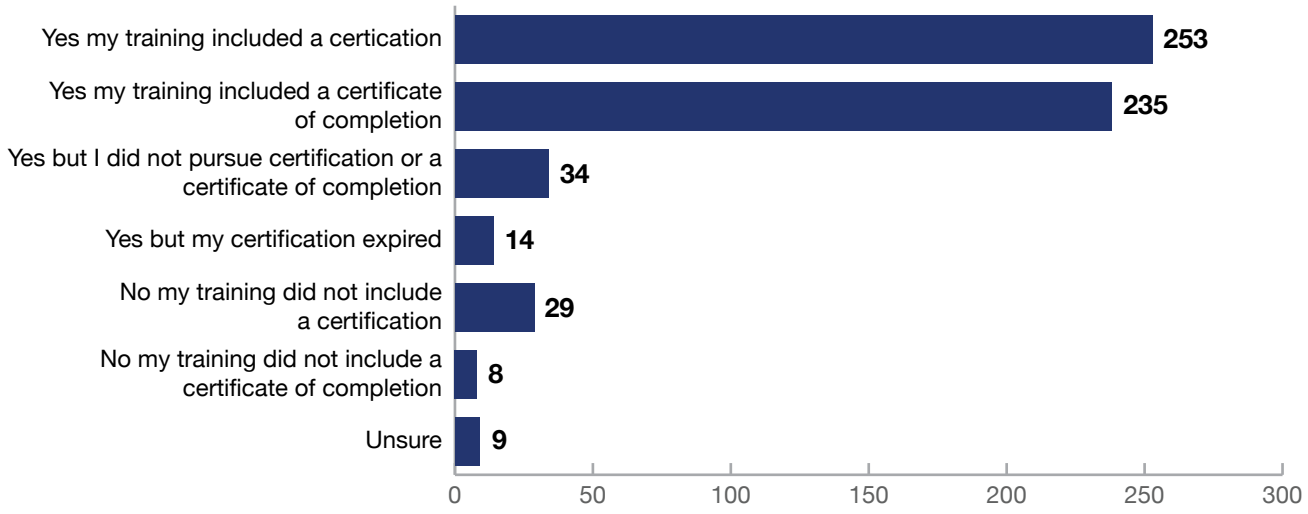
Others shared how their training prepared them for their work:

"Yes I do, we spent 10 weeks training, 4 hours once a week for those 10 weeks and I left the training feeling extremely prepared and even felt supported afterwards. I still keep in touch with my trainer and also stay connected with my Fellow Doula sisters. I felt extremely confident when I took on new clients because we covered preconception all the way to postpartum and infant care, lactation support."[6]

The next graph shows if doulas received a certification or a certificate of completion after their training. A certificate of completion indicates the completion of a training course and a certification indicates competency in a field as measured by a professional organization.

Most doulas responded that their training did include either a certification or a certificate of completion. Some decided not to pursue a certification or certificate of completion even though their training program did offer it. **California's Medi-Cal doula benefit** does not require that doulas have specific certification or a certificate of completion in a specific doula training program to enroll as Medi-Cal providers.

Availability of Certification or Certificate of Completion in Doula Training

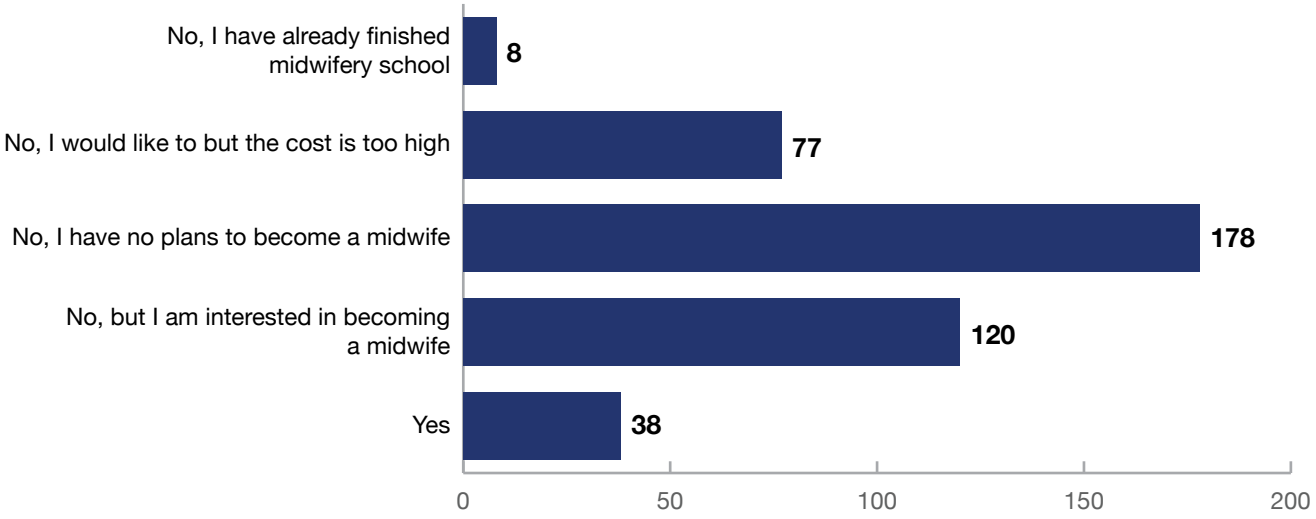


6 Response edited to remove identifying information.

Finally, we asked if respondents had plans to attend midwifery school. The following graph shows the responses.

Most doulas had no plans to become a midwife. The second most reported response was that doulas did not currently have plans to become a midwife but were interested in it. The third most popular response was that doulas did not currently have plans to become a midwife because the cost is too high. As this survey indicates that most respondents have no plans to become a midwife, doulas must be supported in growing their careers as doulas. For the success of the Medi-Cal doula benefit, doulas must be paid a living wage, have timely reimbursement, and support to succeed in their careers as doulas.

Respondents' Plan to Attend Midwifery School



Conclusion

This snapshot of the doula workforce in California demonstrates the diversity, strength, and engagement of doulas throughout the state. Doulas should be involved in any policy work regarding their work and they should be compensated for their advocacy in the policy space.

Several recommendations can be gleaned from this data. To ensure a successful doula workforce and the improved maternal health outcomes that research has indicated are possible we must provide more support to doulas across the state. Doulas must be encouraged and supported to work in maternity care deserts and rural areas. These areas are especially vulnerable and doulas can serve as both a key link to accessing maternity care and as advocates for these communities. To expand the doula workforce and ensure culturally congruent care, we must support doulas and prospective doulas from their communities. This can be done by providing fee waivers, free training, and scholarships for doulas of color, doulas proficient in languages other than English, and LGBTQIA+ doulas. More training and support should also be allocated to doulas who serve specific populations with diverse health care needs like doulas who work with incarcerated and formerly incarcerated people, people experiencing SUDs, survivors of intimate partner violence, people with disabilities, and others. Overall, doulas must be supported to stay in the doula profession. This can be done through paid mentorship programs, peer support, on-going education, vicarious trauma support, and through supporting doula groups or collectives.

Finally, to ensure that the Medi-Cal doula benefit is successful, Medi-Cal doula providers and prospective providers must be provided with enrollment support, as well as support in navigating, contracting, and billing with managed care plans. Further, Medi-Cal doulas need a more streamlined and quicker billing process, administrative support, and more outreach and education about the benefit.

This survey should be replicated in the future as the doula workforce and the Medi-Cal doula benefit evolves. Surveying this population can show if any workforce development efforts have been successful and can give us key information about the status of the doula workforce and its engagement with the Medi-Cal doula benefit.

Doulas provide an incredible opportunity to support pregnant and birthing people and improve maternal health outcomes, especially for reducing racial disparities, but they are not the only solution. Doulas alone cannot address the negative effects of racism within the health care institution nor can they

address the issues in our **entire health care system**. Doulas experience the same issues as their clients and we must acknowledge the emotional cost of this work. In championing doula care, we must also continue to advocate for policies that dismantle systemic racism in the medical system and improve health care access for all.

Appendix A

Survey Questions

SECTION 1 - CAPTCHA TYPE QUESTIONS

1. Please confirm you are a human and not a bot by writing in the answer to the following: what number do you get when you subtract eight from twelve?
   a. Open answer
2. What do you call someone who provides emotional and physical support before, during, and after childbirth?
   a. Open answer

SECTION 2 - LOCATION

1. In what county do you work in? If you work in more than one, please select your most worked in county.
   a. Drop down of 58 California Counties
2. If you work in multiple counties, please list all additional counties that you do doula work in.
   a. Open answer
3. Please list all cities you work in as a doula.
   a. Open answer

SECTION 3 - RACE AND ETHNICITY

1. What is your race or ethnicity? Choose all that apply to you.
   a. Multiple selection check box:
      i. American Indian or Alaska Native
      ii. Asian or Asian American
      iii. Black or African American
      iv. Latino/a/e/x
      v. Native Hawaiian and Pacific Islander
      vi. South West Asian and North African

vii. White or Caucasian
viii. Declined to state
ix. Other (write in)

2. What is the primary race/ethnicity of your clients? Choose all that apply.
    a. Multiple selection check box:
        i. American Indian or Alaska Native
        ii. Asian or Asian American
        iii. Black or African American
        iv. Latino/a/e/x
        v. Native Hawaiian and Pacific Islander
        vi. South West Asian and North African
        vii. White or Caucasian
        viii. Declined to state
        ix. Other (write in)

SECTION 4 - LANGUAGE

1. What language(s) do you speak? Choose all that apply.
    a. Multiple selection checkbox:
        i. Arabic
        ii. Armenian
        iii. Cambodian
        iv. Chinese
        v. English
        vi. Farsi
        vii. Hindi
        viii. Japanese
        ix. Korean
        x. Laotian
        xi. Mien
        xii. Punjabi
        xiii. Russian
        xiv. Spanish
        xv. Tagalog
        xvi. Thai
        xvii. Vietnamese
        xviii. Declined to state
        xix. Other (write in)

2. What language(s) do you provide services in? Choose all that apply.
    a. Multiple selection checkbox:
        i. Arabic
        ii. Armenian
        iii. Cambodian
        iv. Chinese
        v. English
        vi. Farsi
        vii. Hindi
        viii. Japanese
        ix. Korean
        x. Laotian
        xi. Mien
        xii. Punjabi
        xiii. Russian
        xiv. Spanish
        xv. Tagalog
        xvi. Thai
        xvii. Vietnamese
        xviii. Declined to state
        xix. Other (write in)

3. What language(s) do your clients speak? Choose all that apply.
    a. Multiple selection checkbox:
        i. Arabic
        ii. Armenian
        iii. Cambodian
        iv. Chinese
        v. English
        vi. Farsi
        vii. Hindi
        viii. Japanese
        ix. Korean
        x. Laotian
        xi. Mien
        xii. Punjabi
        xiii. Russian
        xiv. Spanish
        xv. Tagalog
        xvi. Thai
        xvii. Vietnamese
        xviii. Declined to state
        xix. Other (write in)

SECTION 5 - GENDER AND SEXUALITY

1. What gender do you identify as? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. Woman
        ii. Man
        iii. Transgender
        iv. Non-binary
        v. Declined to state
        vi. Other (write in)

2. Do you identify as a member of the LGBTQIA+ Community?
    a. Multiple choice single answer:
        i. Yes
        ii. No
        iii. Prefer not to answer
3. Do you serve clients that identify as members of the LGBTQIA+ Community?
    a. Multiple choice single answer:
        i. Yes, often
        ii. Yes, sometimes
        iii. Yes, rarely
        iv. No
        v. Not sure

SECTION 6 - DOULA PRACTICE

1. How long have you been practicing as a doula?
    a. Drop down:
        i. 1 year
        ii. 2 years
        iii. 3 years
        iv. 4 years
        v. 5 years
        vi. 6 to 10 years
        vii. 11 to 15 years
        viii. 16 to 20 years
        ix. 20+ years

2. What type of doula care do you provide? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. Prenatal care
        ii. Birth support

iii. Postpartum care
iv. Miscarriage or stillbirth care
v. Loss care
vi. Abortion care
vii. Lactation support
viii. Fertility support
ix. Other (write in)

3. Do you serve clients with any of the following? Choose all that apply to your work.
   a. Multiple selection checkbox:
      i. Teens of young people
      ii. Substance use disorder
      iii. Incarcerated or formerly incarcerated individuals
      iv. Domestic violence survivors
      v. Clients with disabilities
      vi. Immigrants
      vii. Limited English proficiency
      viii. I would like to but don't have the resources
      ix. Other (write in)

4. About how many births do you support in a year? (Please note if you do not do birth support.)
   a. Open answer

5. About how many births have you supported in your career as a doula?
   a. Drop down:
      i. None
      ii. 1
      iii. 2
      iv. 3
      v. 4
      vi. 5
      vii. 6
      viii. 7
      ix. 8
      x. 9
      xi. 10
      xii. 11 to 15
      xiii. 16 to 20
      xiv. 20+

6. About how many clients are you supporting in any given month?
    a. Open answer

7. Is doula work your only source of income?
    a. Multiple choice single answer:
        i. Yes
        ii. No
        iii. Other (write in)

8. What type of payment do you usually receive for your doula work? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. I am a Medi-Cal provider and get reimbursed by Medi-Cal
        ii. I am paid by a private insurance company
        iii. I am paid by clients directly out of pocket
        iv. I am paid by a hospital or clinic
        v. I am paid by a Health Savings Account (HSA) or Flexible Spending Account (FSA)
        vi. I am paid or reimbursed by TRICARE
        vii. I am paid by a doula program (pilot program, community program)
        viii. I do not receive payment because I volunteer or work on a pro bono basis
        ix. Other (write in)

9. If you are paid by a private insurance company, doula program, or by a hospital or clinic, please specify the organization here.
    a. Open answer

10. Are you part of a doula partnership, group, or collective?
    a. Multiple choice single answer:
        i. Yes
        ii. No
        iii. Other (write in)

11. If yes, which doula partnership, group, or collective are you a part of?
    a. Open answer
12. Are you enrolled as a Medi-Cal doula provider?
    a. Multiple choice single answer:
        i. Yes
        ii. No
        iii. In progress
        iv. Other (write in)

13. If you are a Medi-Cal doula provider, are you enrolled with any of the following Medi-Cal managed care plans? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. Unsure
        ii. Aetna Better Health
        iii. AIDS Healthcare Foundation dba PHC California
        iv. Alameda Alliance for Health
        v. Anthem Blue Cross Partnership Plan
        vi. Blue Shield of California Promise Health Plan
        vii. California Health & Wellness
        viii. CalOptima Health
        ix. CalViva Health
        x. CenCal Health
        xi. Central California Alliance for Health
        xii. Community Health Group Partnership Plan
        xiii. Contra Costa Health Plan
        xiv. Gold Coast Health Plan
        xv. Health Net
        xvi. Health Plan of San Joaquin
        xvii. Health Plan of San Mateo
        xviii. Inland Empire Health Plan
        xix. Kaiser Foundation Health Plan, Inc.
        xx. Kern Health Systems
        xxi. LA Care
        xxii. Molina Health Plan of California
        xxiii. Partnership Health Plan of California
        xxiv. San Francisco Health Plan
        xxv. Santa Clara Family Health Plan
        xxvi. Other (write in)

14. Have you experienced any barriers or challenges as a Medi-Cal enrolled doula provider? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. Enrollment challenges
        ii. Problems getting recommendation paperwork completed
        iii. Problems billing Medi-Cal
        iv. Problems getting actual reimbursements/problems getting paid
        v. Problems contracting with managed care plans
        vi. Problems billing managed care plans
        vii. Hospital access
        viii. Problems finding clients

ix. Challenges with medical providers
x. Lack of resources to complete enrollment
xi. None of the above
xii. Other (write in)

15. Do you think that the Medi-Cal reimbursement rate is sufficient? Why or why not?
    a. Open answer

16. In your opinion, what should the Medi-Cal reimbursement rate be?
    a. Open answer

17. If you are not a Medi-Cal enrolled doula provider, why not? Choose all that apply.
    a. Multiple selection checkbox:
        i. Not interested
        ii. Does not pay enough to be financially feasible
        iii. Too much work to enroll
        iv. Unaware of the benefit
        v. Other (write-in)

18. Do you have anything else you would like to tell us about your thoughts around Medi-Cal coverage for doula care?
    a. Open answer

SECTION 7 - TRAINING

1. What type of training did you receive to become a doula?
    a. Multiple selection checkbox:
        i. Doula training program from an organization
        ii. Doula training from a hospital or medical organization
        iii. On the job training such as shadowing or apprenticeship
        iv. No specific training
        v. Other (write in)

2. Did your training include a certification or a certificate of completion? Choose all that apply to you.
    a. Multiple selection checkbox:
        i. Yes my training included a certification
        ii. Yes my training included a certificate of completion
        iii. Yes but I did not pursue certification or a certificate of completion
        iv. Yes but my certification expired
        v. No my training did not include a certification
        vi. No my training did not include a certificate of completion
        vii. Unsure
        viii. Other (write in)

3. If you received training, please detail what type of training, and what organization(s) you received your training from.
    a. Open answer
4. If you received on the job 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 other training (for example, “other training was too expensive” or “I could not find a training program that fit my needs”).
    a. Open answer
5. If you received training, do you feel that your training adequately prepared you for your work as a doula? Please explain your answer.
    a. Open answer
6. Are you currently in school to become a midwife?
    a. Multiple choice single answer:
        i. Yes
        ii. No, but I am interested in becoming a midwife
        iii. No, I have no plans to become a midwife
        iv. No, I would like to but the cost is too high
        v. No, I have already finished midwifery school

SECTION 8 - ADDITIONAL QUESTIONS

1. Is there anything you would like us to know that we didn’t ask in this survey?
    a. Open answer
2. Are you willing to be contacted by us if we have any follow-up questions?
    a. Multiple choice single answer:
        i. Yes
        ii. No
3. Are you interested in joining our CA Coverage for Doula Care listserv? The purpose of this listserv is to share information, resources, and updates about Medicaid coverage for doula care in California and updates from the Doula Medicaid Project.
    a. Multiple choice single answer:
        i. Yes
        ii. No
4. Are you interested in being entered to win a $200 gift card?
    a. Multiple choice single answer:
        i. Yes
        ii. No
5. If you answered yes to any of the above, please provide your name and email address
    a. Open answer

Appendix B

Social Media Toolkit

Welcome to the California Doula Workforce Survey

The purpose of this survey is to understand the current doula workforce landscape in California. Our goal is to create a snapshot of the current size and demographics of the doula workforce in our state, which will hopefully help doulas, advocates, state agencies, and other stakeholders determine how best to make decisions on outreach, training, funding, and other implementation tasks. This survey should not take more than 15 minutes. At the end of the survey, you will be asked if you would like to opt-in to a raffle. After the close of the survey, we will be raffling off forty (40) $200 gift cards to those that opt-in and provide their email address.

Survey responses are anonymous. NHeLP staff will have access to your name and email address only for purposes of the gift card raffle and/or to add you to our listserv at your request. **This survey will close March 31, 2024.**

If you have any questions please contact Alexis Robles-Fradet at robles-fradet@healthlaw.org.

ABOUT US:

The National Health Law Program (NHeLP) is a non-profit health law organization that protects and advances 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 U.S. See more information about us here: https://healthlaw.org/about/

NHeLP's Doula Medicaid Project seeks to improve health outcomes for Medicaid enrollees by ensuring that all pregnant and postpartum people enrolled in Medicaid who want access to a doula will have one. At NHeLP, we are lawyers, researchers, and policy advocates. We are not doulas. As such, we seek to do all our work in partnership with and with the guidance of community doula groups, doula collectives, and individual doulas, especially Black doulas and Black-led doula groups, as well as doulas and doula groups serving low-income clients. See more information about our project here: https://healthlaw.org/doulamedicaidproject/

This project is supported by the California Health Care Foundation (CHCF).

👇**Below are sample social media posts and an array of graphics to help engage people**

Survey Details
Doula Landscape Survey: https://healthlaw.org/nhelp-doula-survey/

High-res versions of the below images, as well as ½ page fliers, can be found here:
https://drive.google.com/drive/folders/1YXaFlOnSwZxqqiJf0xRs2uxFpuHZzzyK?usp=sharing

Sample Social Media Text:

- We're advocating for better funding, resources, education, and outreach for doulas in California. Help us paint a clearer picture of the doula workforce in our advocacy by filling out our 15-min survey: https://healthlaw.org/nhelp-doula-survey/
- Doulas deserve resources and support for their work — to do this, we need to know more about the workforce. If you're a California-based doula, fill out NHeLP's doula survey for the chance to win a $200 gift card. https://healthlaw.org/nhelp-doula-survey/
- Attention California-based doulas! We want to hear from you. We're trying to get an accurate count of the doula workforce in CA to help state agencies and potential funders make informed decisions on where to focus resources and outreach. https://healthlaw.org/nhelp-doula-survey/
- Doulas deserve to be supported and recognized for the critical work that they do — but right now, there's not a formal count of the doula workforce in California. Help us advocate for more equitable resource allocation by filling out this 15-min survey: https://healthlaw.org/nhelp-doula-survey/
- Are you a doula working in CA? Do you want more resources for your work? If so, please take 15 minutes to fill out our anonymous doula workforce survey! At the end, you can enter to win one of forty $200 gift cards we're raffling. https://healthlaw.org/nhelp-doula-survey/
- Join us in shaping the future of doula care in California! Take our Doula Landscape Survey and contribute to understanding the size and demographics of the doula workforce. #CaliforniaDoulasCount https://healthlaw.org/nhelp-doula-survey/
- California Doulas, your insights matter! Participate in the California Doula Landscape Survey and contribute to building a comprehensive snapshot of our state's doula workforce. #CaliforniaDoulasCount https://healthlaw.org/nhelp-doula-survey

And many thanks to CA doulas who are supporting this survey @KhefriRiley @KhefriRiley @FrontlineDoulas @sabiawade @Doula_In_Heels @BlackWPCenter @sisterwebdoulas and many others!

Image	Alt-Text
	Half of the image is a pregnant person with a toddler and doula during an examination. The toddler's ear is pressed to the pregnant person's abdomen. Below that, text in blue reads: California Doula Workforce Survey. Help us advocate for better funding, resources, education, and outreach for doulas in California by filling out this 15-minute survey. To the left is a QR code that leads to the survey.

	Half of the image is a pregnant woman with her toddler sitting together in a home setting. The toddler holds her mother's stomach. They both appear happy and content. Below that, text in blue reads: California Doula Workforce Survey. Help us advocate for better funding, resources, education, and outreach for doulas in California by filling out this 15-minute survey. To the left is a QR code that leads to the survey.
	Half of the image is a pregnant person leaning on their partner on a couch. Below that, text in blue reads: California Doula Workforce Survey. Help us advocate for better funding, resources, education, and outreach for doulas in California by filling out this 15-minute survey. To the left is a QR code that leads to the survey.
	White, bold text over a blush pink background reads "Take the California Doula Workforce Survey" Around the text, there are stylized drawings of six people, as well as the NHeLP logo.

	Over a geometric white-and-pink background, three light blue speech bubbles read: “We want your feedback” Beneath the speech bubbles, dark blue text reads “California Doula Workforce Survey” beside the NHeLP logo.
	In the center, bold text reads “California Doula Workforce Survey. We want to hear from you!” Around the text, there are three drawings of a pregnant person working with a care provider.
	A brown and white text box on top of a beige background reads: “We want to hear from you. All pregnant and postpartum people deserve access to full spectrum doula care. California Doula Workforce Survey.” Decorative floral drawings are on the top right and bottom left corners.

	Dark blue text over a light blue background reads: “Are you a doula working in CA? Give us your feedback. Fill out our Doula Workforce Survey.” In the lower right corner, there is a drawing of a person with long hair wearing a mask and typing on a computer. In the lower left corner is the NHeLP logo.

Twitter (X) Thread (for initial launch)

(1/x) Doulas deserve to be supported and recognized for the critical work that they do — but right now, there’s not a formal count of the doula workforce in California.

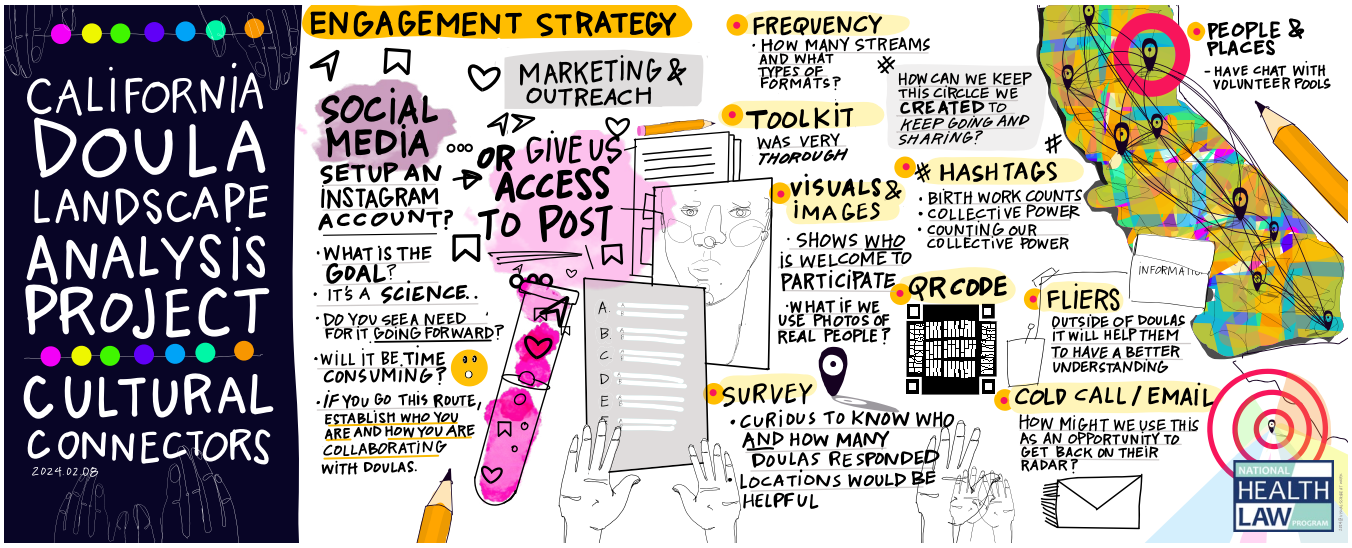
Help us advocate for more equitable resource allocation by filling out this 15-min survey: https://healthlaw.org/nhelp-doula-survey/

(2/x) Survey respondents will have the option to enter a raffle for one of forty $200 gift cards. All survey responses will be de-identified.

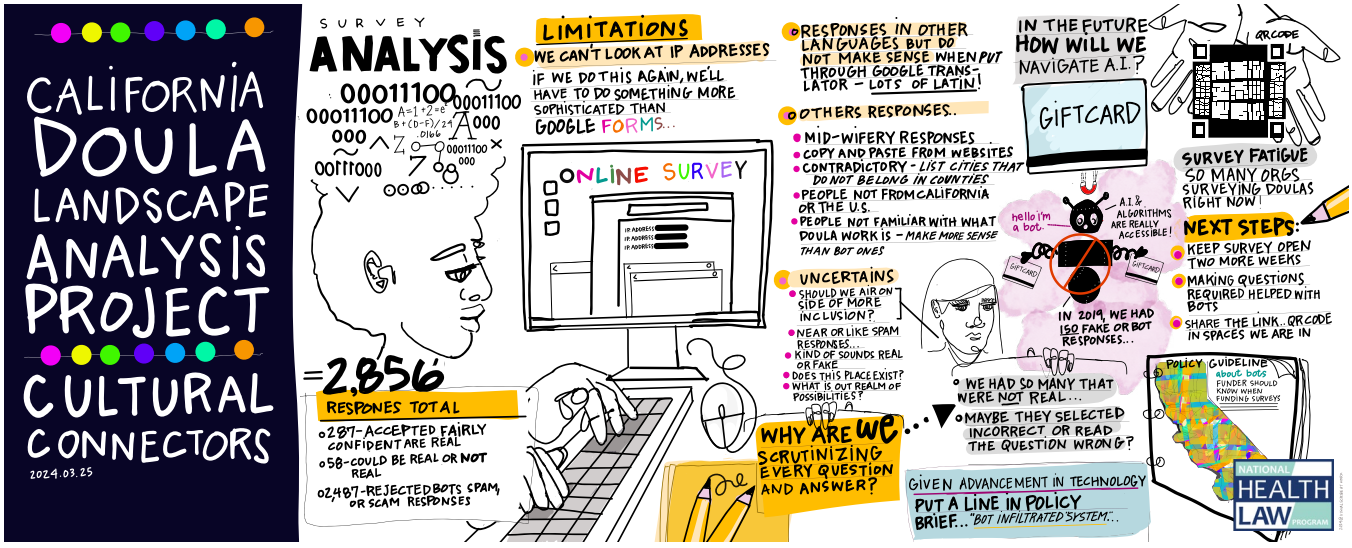
For more information about our work with doulas, please visit https://healthlaw.org/doulamedicaidproject/

Appendix C

Visual recordings by Ashanti Gardner from each of the meetings with the Cultural Connectors

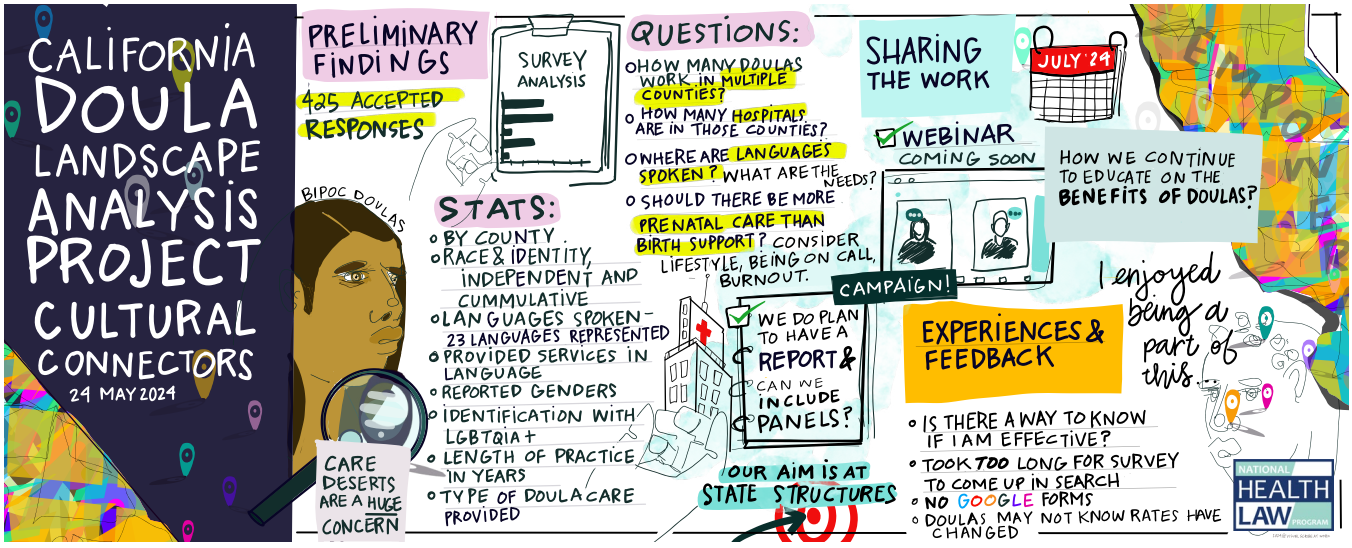


February 8, 2024
This meeting focused on engagement strategy, social media promotion strategies, and outreach plans.



March 25, 2024

This meeting focused on preliminary results, the representativeness of the data, additional outreach plans, and the deadline of the survey.

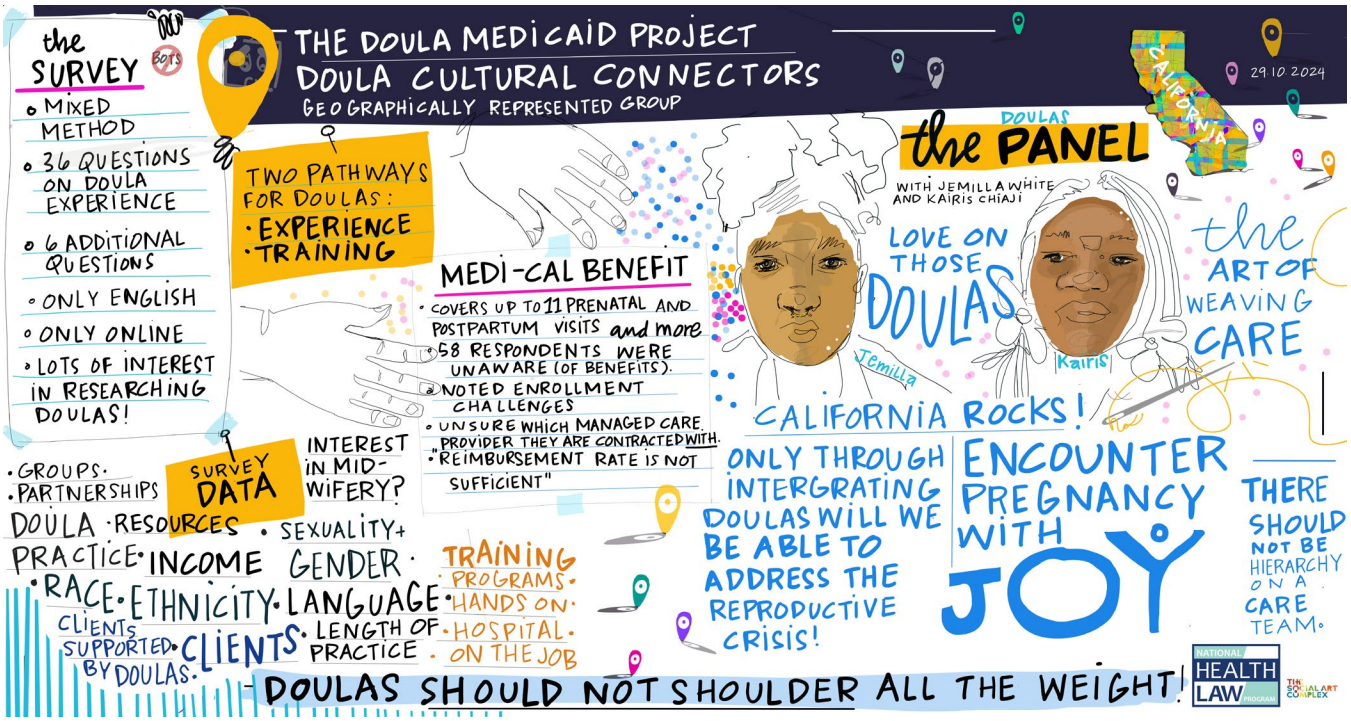


May 28, 2024

This meeting discussed the survey data results, planning the report, distribution of the results, and feedback about the experiences of the Cultural Connectors on this project.

Appendix D

Visual recording by Ashanti Gardner from the California Doula Workforce Analysis: Findings from the California Doula Workforce Survey Webinar



OCTOBER 29, 2024

This webinar discussed the findings from the California Doula Workforce survey.

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