How to identify and examine best practices for integrating doulas into New York's maternal healthcare system - Testimony from Denise Bolds, MSW Adv.CD(DONA),CLC,CBE March 1, 2023

Good afternoon my name is Denise Bolds. I am a native New Yorker born in Harlem Hospital. I live in NYC. I hold a Masters Degree in Medical Social Work. I'm also an Advanced Certified Birth Doula, and a Certified Lactation Counselor and Certified Childbirth Educator. I've been in the profession of Labor Doula for nine years and 259 births of experience. I'm known as the 'high-risk doula.' My niche is supporting families in hospitals as a result of my 40 years of being in hospitals, as an Allied Health Worker, Case Manager, and Medical Social Worker. I am familiar with all of the hospitals in New York City, and quite a few in northern New Jersey. I thank you all for listening to me today, and I thank Senator Brouk and the Senate Standing Committee on Health for inviting me to testify.

In nine years, I have supported births as far as Albany, New York, all the way down to south New Jersey. I'm here to share with you, some accounts of what I have witnessed and experienced in my capacity as a Labor Doula.

The topic for this hearing is: “How to identify and examine best practices for integrating doulas into New York’s maternal healthcare system.” I currently sit on the Doula Advisory Committee for New York City as well as the Doula-Friendly Committee for New York City. I'm also working with a major hospital system as a consultant on the topic of Doula's and Labor and Delivery Departments.

What I have witnessed is problematic: the fact while there was a mandate from the prior Governor of NYS, declaring Doula's are Essential Workers, hospitals here in New York City, and Long Island, chose when to allow Doula's in and went to shut Doula's out regardless of the mandate from the Governor.

How and why do hospitals have so much power? There is evidence provided in clinical journal articles, which confirm the benefit Doula's provide to hospitals and institutions: Doula's increased customer satisfaction, reduce C-section rates and interventions, and increase breast-feeding rates. Yet with this known evidence, Doula's are still fighting to have a seat at the table of Maternal Health.

There are many hospitals that are simply not ‘Doula friendly.’ There's no rest place for Doula's. There's no

inclusion of accommodation for Doula's and as I stated above, there's no consistency on having Doulas as part of the labor team in a professional and respectful way. Doula's are harassed by security, and by nurses and administrative staff on everything from verification of certification, and when can they come and do their job. So many times I have been told how to do my job by physicians, nurses and administration.

If you doubt the intensity of what I'm saying, I would like to remind you, of an app called Irth; was developed by Kimberly Seals Allers, where Doulas and families can actually write about their experiences at hospitals and the treatment by clinical staff in the institutions they work in in order to collect this data to show the existing problems in Labor and Delivery Departments across the nation. Unfortunately, this is just not a New York State situation but a national one. I'm sure you have all seen the 'Ick Video' by the nurses at Emory Hospital in Atlanta, Georgia. Those nurses are here in New York State as well. Some Labor and delivery Departments actually lock up their food pantries where the ice/water machine are making these resources inaccessible to Doulas and the families

For years, the conversation has been on the table about Doula reimbursement, yet hospital’s who benefit, so greatly from the presence of Doula's, always walk away from the table and feel they are not accountable to contribute to the solution. There are several hospitals here in New York City that actually have Doula's as part of their care team and they have noted the positive outcome of doing so both on Labor and Delivery and the Mother Baby Unit floors.

There have been questions about billing: CPT codes and ICD-9 codes for insurance. Why aren't Doulas allowed the designation of being Allied Health Workers? Why are Doulas treated like visitors?

During the pandemic, I made national news by providing one of the first cases of virtual doula support to my client. Her husband and I sat in the car in the hospital parking lot as she gave birth upstairs alone. During the pandemic, Doulas stepped up and developed virtual services in labor, support, childbirth education, and breast-feeding support. Doula's also volunteered on virtual hotlines, harvested breastmilk, when there was a formula shortage and helped families find resources in the community. Doula's are an intricate part of every existing community they serve in.

Another observation: There’s a growing trend with Obstetricians and Residence Physicians. Many New York City OB’s ban their patients from having Doula's because they don't like Doula’s. There are Resident physicians who want to practice on Black and brown laboring people with no regard to their respect or compassion.

New York City lost two major hospitals for Labor and Delivery Departments, as a result the remaining hospitals are flooded with conveyor-belt-like-services in the Labor and Delivery departments where families are waiting in the lobby for a bed like an airport on standby.

Columbia Presbyterian, 165th St. has a very different approach to their patient care: my client saw a group of physicians in her prenatal care for 10 months, only to go across the street to the hospital and encounter a completely different group of physicians where she gave birth with this second group, she has never met before, never had a rapport with, and therefore, her birth experience was greatly compromised. Not to mention many of the New York City hospitals are teaching hospitals, therefore they expect Black and brown patients to be very amenable to students

practicing on them without question or hesitation, and this is wrong. They also expect for Black and brown birthing people to allow spectators into their private birth experience to observe like it's a hockey game.

It is time for hospitals to own up and acknowledge they are for profit. In fact New York City hospitals, in the past five years has experienced several Black women who were pregnant die of childbirth or post partum complications.

It is time to hold hospitals accountable to contribute to having freestanding birth centers in ambulatory care, settings, adjacent to the hospitals as well as to contribute to the cost of having Doula's on payroll at hospitals. Doulas are not a luxury -they are a necessity for Black and brown births. Just ask the women who are no longer with us, and ask those women who have horrible traumatic stories of how they barely made it alive through the birth of their children. New York State has a moniker of being a dangerous place for black and brown women to give birth. I cannot tell you how many times per day I answer my phone on Doula inquiries where the person on the other end starts the conversation by saying: "I'm Black, I'm pregnant and I don't want to die."

Why can't New York City hospitals do billing for Doula's who accept Medicaid at those hospitals? It would alleviate so much bureaucracy and cost as the hospital already has an established billing system. If hospitals, accept Medicaid, and Doula's also accept Medicaid, the hospitals, should be ready and able to process the billing for Doula's that are providing support at those facilities.

It is time to have Doula's provide childbirth education as well as lactation support that will free up registered nurses to do their clinical tasks and responsibilities. I have never been able to understand why there is such a choke-hold on why registered nurses are to teach childbirth education and provide breast-feeding, education and support when there are trained Doulas who are more than capable. I myself am on track to become an IBCLC this year and I hope to work in a hospital.

It is time to also allow Doulas into operating rooms to support surgical births. I am really proud to be the owner and facilitator of a new organization: Black Women Do VBAC. I will be providing an intensive eight hour training to birthwork professionals who want to better support, Black and brown women who are facing surgical births, and facing a vaginal birth after C-section = VBAC. This training and successful

completion, the participants will be endorsed on the Black Women Do VBAC website's directory where families can find these trained professionals to support and empower their birth experience.

Doulas are the pulse of the community; we know where the bones are buried. We know the racist, physicians, nurses, and other staff members. We know the hospitals who say they're Baby Friendly, but they do not practice Baby Friendly competencies. We know the doctors who are dangerous and commit obstetric violence. We know the nurses that are not kind. Doulas know what hospitals, birth centers, and facilities are doing wrong and what they are doing right.

I am suggesting New York State host an annual Doula meeting of two days where Doula's from the entire state come together to learn, share, grow, and unify the Doula practice and profession, as opposed to remaining in the current silos. I propose New York State host this gathering to find out the most pressing issues, as well as the opportunity to learn and understand how to dismantle maternal health disparities, and to grow the Doula profession. I envision this two day event to be filled with workshops, committees and caucus. I also propose New York State Department of Corrections put Doula's on their

budget line for those who are pregnant and incarcerated.

I have also observed the inequities when it comes to race with New York City hospitals, and the physicians and clinical staff in the Labor and Delivery and Mother Baby Units. There has to be mandated trainings for all clinical staff to participate in to understand about racism and maternal health. As a Black Doula, I cannot tell you how much passive aggression and racist behavior I interface and literally block away from my clients who never know because of my skill in blocking these acts of racism, hostility and passive aggression. I also facilitator workshop on the history of black Maternal health that is clarifying and definitely educational on the Black contribution when it comes to gynecological and obstetrical health advances in this country in relation to slavery..

Lastly, I would like to share with you briefly my genetic inheritance. Unlike my white counterparts, my genetic inheritance it's not wealth, real estate or nepotism, goes like this: 58 years ago, my mother gave birth to me in Harlem Hospital. She had an unassisted birth in the hospital as she was then part of the pandemic of the time - tuberculosis, and no clinician wanted to come in and help her give birth to me, so she gave birth unassisted and reduce the cord that was

wrapped twice around my neck. Fast forward 26 years later I gave birth to my son at Columbia Presbyterian Allen Pavilion while on PCAP I had a very traumatic birth experience there being Black, and on Medicaid, I was treated with bias and indifference while a white midwife managed my care, the same bias, and indifference my mother was treated 26 years before. Not much is changed between my birth, my son's birth, and the many Black births I've supported these past nine years. That is my genetic inheritance. Not Wealth but indifference, danger, another hard story, another Black woman, traumatized.

If you want know about more racism, ask yourself about the midwifery programs here in New York and how racist they are towards Black and brown midwifery students.

It is my hope Harlem Hospital receives funding from the state of New York as the only Black hospital in the state and have a Doula program set up to do qualitative and quantifying services in a safe and respected environment for Black and brown women and to utilize those statistics for further funding, so that other hospitals may also have Doulas as part of their payroll.

The current mirror, Eric Adams has instituted a New York City Doula incentive program here that is riddled with challenges: Doula's, not being paid in a timely fashion. There was a lack of photo IDs for the Doulas, and more. I find it ironic Mayor Adams has not visited Harlem Hospital and started a Doula program there in an all Black hospital, instead he chose to stay in close proximity to his offices in Brooklyn.

Respectfully Submitted,
Denise Bolds
March 1, 2023.

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Evidence on: Doulas

By Rebecca Dekker, PhD, RN, APRN of EvidenceBasedBirth.com

Question: What is a doula?

Answer: A *birth doula* is a companion who provides people with continuous support during labor and birth.

Question: What does doula support look like?

Answer: *Physical support* from a doula includes the use of massage, pressure, and soothing touch. Doulas create a calm environment, assist with water therapy, and help keep you nourished with ice chips, food, and drinks.

Emotional support from doulas helps people feel a sense of pride and empowerment after the birth. Examples of emotional support include encouragement and praise, helping you see your situation more positively, keeping you company, showing that they care for you, and helping you debrief after the birth.

Doulas can also support you with *information* during pregnancy and birth. For example, they can guide you and your partner through labor and suggest techniques like breathing, relaxation, movement, and changing positions. Doulas help you find evidence-based information about your options, and they can help explain medical procedures.

As far as *advocacy* goes, most doulas will not speak on your behalf. However, doulas should support you in your right to make decisions about your body and your baby. They will also use advocacy techniques such as encouraging you to ask questions and speak up for what you want. Doulas can also enhance communication between parents and providers.

Question: What is the evidence on doulas?

Answer: There have been 26 randomized trials that tested the effects of continuous labor support on more than 15,000 people giving birth. Overall, people who receive continuous support are more likely to have a normal vaginal birth and less likely to have pain medication, negative feelings about childbirth, and Cesareans. In addition, their labors are shorter and their babies are less likely to have complications at birth. In these studies, the best results occurred when the continuous support was provided by a trained doula—someone who was not a staff member at the hospital and not part of the birthing person's social network.

Question: How can doulas work with partners?

Answer: Ideally, doulas and the birth partner (i.e. spouse, partner, family member) work together to improve the mother's birth. Studies have shown that the most positive birth experiences for fathers/partners are ones where they have continuous support from a doula or midwife. In one important randomized trial, adding a doula to a supportive partner reduced Cesarean rates from 25% down to 13%. These differences were even more apparent with a labor induction. When labor was induced, the Cesarean rate was 59% with a partner alone, and 13% when partners worked together with doulas.

Question: What's the bottom line?

Answer: Of all the ways birth outcomes could be improved, continuous labor support seems like one of the most important and basic needs for birthing people. Research has shown that labor support from doulas is both risk-free and highly effective.

> **"Doulas should be viewed as a valuable, evidence-based member of the birth care team."**

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Evidence on: Doulas

What is a doula?

According to Dr. Christine Morton, author of the book *Birth Ambassadors*, a *birth doula* is a companion who supports a birthing person during labor and birth. Birth doulas are trained to provide continuous, one-on-one care, as well as information, physical support, and emotional support to birthing persons and their partners.

Originally published on March 27, 2013 and last updated on May 4, 2019 by Rebecca Dekker, PhD, RN and Anna Bertone, MPH.

How many people use doulas?

In a 2012 survey that took place in the U.S., 6% of birthing people said they used a doula during childbirth (Declerq et al., 2013), up from 3% in a 2006 national survey (Declerq et al., 2007).Of those people who did not have a doula but understood what they were, 27% would have liked to have a doula.

What do doulas do?

Doulas nurture and support the birthing person throughout labor and birth. Their essential role is to provide continuous labor support to the mother, no matter what decisions the mother makes or how she gives birth. *Labor support* is defined as the therapeutic presence of another person, in which human-to-human interaction with caring behaviors is practiced (Jordan, 2013).

Importantly, the doula's role and agenda are tied solely to the birthing person's agenda. This is also known as *primacy of interest*. In other words, a doula's primarily responsibility is to the birthing person—not to a hospital administrator, nurse, midwife, or doctor.

Evidence On: Doulas

A doula can provide labor support via the four pillars of labor support. In the textbook *Best Practices in Midwifery*, the author describes three pillars of labor support as emotional support, physical support, and advocacy. In the book *Optimal Care in Childbirth*, informational support is also listed as a pillar of support.

Physical support is important because it helps the birthing person maintain a sense of control, comfort, and confidence. Aspects of physical support provided by a doula may include:

- Soothing with touch through the use of massage, counter pressure, or a rebozo
- Helping to create a calm environment, like dimming lights and arranging curtains
- Assisting with water therapy (shower, tub)
- Applying warmth or cold
- Assisting the birthing person in walking to and from the bathroom
- Giving ice chips, food, and drinks

Emotional support helps the birthing person feel cared for and feel a sense of pride and empowerment after birth. One of the doula's primary goals is to care for the mother's emotional health and enhance her ability to have positive birth memories (Gilland, 2010b). Doulas may provide the following types of emotional support to the birthing person and their partner:

- Continuous presence
- Reassurance
- Encouragement
- Praise
- Helping the birthing person see themselves or their situation more positively
- Keeping company
- Showing a caring attitude
- Mirroring—calmly describing what the birthing person is experiencing and echoing back the same feelings and intensity
- Accepting what the birthing person wants
- Helping the birthing person and partner work through fears and self-doubt
- Debriefing after the birth—listening to the mother with empathy

Informational support helps keep the birthing person and their partner informed about what's going on with the course of labor, as well as provides them with access to evidence-based information about birth options. Aspects of informational support include:

- Guiding the birthing person and their partner through labor
- Suggesting techniques in labor, such as breathing, relaxation techniques, movement, and positioning (positioning is important both with and without epidurals)
- Helping them find evidence-based information about different options in pregnancy and childbirth
- Helping explain medical procedures before or as they occur
- Helping the partner understand what's going on with their loved one's labor (for example, interpreting the different sounds the birthing person makes)

Advocacy is a pillar of support that is considered controversial by some for two reasons: first, the word advocacy has several meanings and definitions, and second, doulas differ on their beliefs about whether or not advocacy is part of their role.

In an important paper about the concept of advocacy in the nurse's role, Kalaitzidis and Jewell (2015) compiled all of the existing definitions of patient advocacy. They found that in the past, the most common definitions of advocacy were "pleading the cause of someone" or "speaking on behalf of someone." Advocacy can also be defined as "supporting an individual or group to gain what they need from the system" or supporting a person in their right to self-determination.

Advocacy has long been considered an essential component of the nurse's role. However, while some dome doulas believe that advocacy is a part of their role, others have been specifically trained that advocacy is not part of their role at all. For many years, DONA International, the first doula training and certification organization, has stated in their standards of practice that advocacy is part of the doula's role, as long as the doula does not speak on behalf of the client (DONA Code of Ethics, 2015).

Advocacy can take many forms—most of which do not include speaking on behalf of the client. Some examples of advocacy that doulas have described include:

- Encouraging the birthing person or their partner to ask questions and verbalize their preferences
- Asking the birthing person what they want
- Supporting the birthing person's decision
- Amplifying the mother's voice if she is being dismissed, ignored, or not heard, " Excuse me, she's trying to tell you something. I wasn't sure if you heard her or not."
- Creating space and time for the birthing family so that they can ask questions, gather evidence-based information, and make decisions without feeling pressured
- Facilitating communication between the parents and care providers
- Teaching the birthing person and partner positive communication techniques
- If a birthing person is not aware that a provider is about to perform an intervention, the doula could point out what it appears the nurse or physician is about to do, and ask the birthing person if they have any questions about what is about to happen. For example, if it looks like the provider is about to perform an episiotomy without the person's consent: "Dr. Smith has scissors in his hand. Do you have any questions about what he is wanting to do with the scissors?"

Taking into account the past definitions of advocacy for nurses, and the desire of many doulas to support the birthing person but not speak in place of them, I'd like to propose a new definition of advocacy in the context of doula care:

Advocacy is defined as supporting the birthing person
in their right to make decisions about their own body and baby.

What is NOT included in doula support?

Doulas are not medical professionals, and the following tasks are not performed by doulas:

- They do not perform clinical tasks such as vaginal exams or fetal heart monitoring
- They do not give medical advice or diagnose conditions
- They do not make decisions for the client (medical or otherwise)
- They do not pressure the birthing person into certain choices just because that's what they prefer
- They do not take over the role of the partner
- They do not catch the baby
- They do not change shifts (although some doulas may call in their back-up after 12-24 hours)

What is the evidence on doulas?

In 2017, Bohren et al. published an updated Cochrane review on the use of continuous support for women during childbirth. They combined the results of 26 trials that included more than 15,000 people. The birthing people in these studies were randomized to either receive continuous, one-on-one support during labor or "usual care." The Cochrane reviewers stated that the overall quality of the evidence is low-quality, according to the GRADE systems for assessing evidence. In the GRADE system, the quality of evidence for each outcome is graded as one of four levels: high, moderate, low, or very low. A rating of high would be considered great evidence, where the authors are very confident that the true effect of doulas is very close to the effect seen in the study results. On the other hand, a rating of very low means that they have very little confidence in the findings, and that the true effect of doulas is likely to be very different than what was seen in the study results. The middle ratings aren't great, but they aren't weak either. Since it is not possible to blind participants or care providers to continuous labor support, the quality of the evidence for doulas received a lower grade.

Continuous support was provided either by a member of the hospital staff, such as a midwife or nurse (nine studies), women who were not part of the birthing person's social network and not part of hospital staff (doula, eight studies; childbirth educators, one study, retired nurses, one study), or a companion from the birthing person's social network such as a female relative or the woman's partner (seven studies). In 15 studies, the husband/partner was not allowed to be present at birth, and so continuous support was compared to no support at all. In all the other 11 studies, the husband or partner was allowed to be present in addition to the person providing continuous labor support.

Overall, people who received continuous support were more likely to have spontaneous vaginal births and less likely to have any pain medication, epidurals, negative feelings about childbirth, vacuum or forceps-assisted births, and Cesareans. In addition, their labors were shorter by about 40 minutes and their babies were less likely to have low Apgar scores at birth. There is a smaller amount of evidence that doula support in labor can lower postpartum depression in mothers. There is *no* evidence for negative consequences to continuous labor support.

The results of this study mean that if a birthing person has continuous labor support (that is, someone who never leaves their side), both mothers and babies are statistically more likely to have better outcomes!

How did doulas compare to the other types of continuous support?

The researchers also looked to see if the type of support made a difference. They wanted to know—does it matter who birthing persons choose for continuous support? Does it matter if they choose a midwife, doula, or partner for continuous support? The researchers were able to look at this question for six outcomes: use of any pain medication, use of Pitocin during labor, spontaneous vaginal birth, Cesarean, admission to special care nursery after birth, and negative birth experiences.

For two of these outcomes (designated with asterisks*), the best results occurred when a birthing person had continuous labor support from a doula– someone who was NOT a staff member at the hospital and who was NOT part of their social network. The researchers found that overall, people who have continuous support during childbirth experience a:

- 25% decrease in the risk of Cesarean; the largest effect was seen with a doula (39% decrease)*
- 8% increase in the likelihood of a spontaneous vaginal birth; the largest effect was seen with a doula (15% increase)*

- 10% decrease in the use of any medications for pain relief; the type of person providing continuous support did not make a difference
- Shorter labors by 41 minutes on average; there is no data on if the type of person providing continuous support makes a difference
- 38% decrease in the baby's risk of a low five minute Apgar score; there is no data on if the type of person providing continuous support makes a difference
- 31% decrease in the risk of being dissatisfied with the birth experience; mothers' risk of being dissatisfied with the birth experience was reduced with continuous support provided by a doula or someone in their social network (family or friend), but not hospital staff

The rate of special care nursery admissions was no different between people who received continuous support and those who received usual care. The rate of Pitocin was also no different but there was a trend towards more Pitocin with continuous support from hospital staff and less Pitocin with continuous support from a doula.

It's important to note that these decreases in risk are *relative* risk reductions—which requires you to carry out a math formula to understand the true reduction in risk. Relative risk is the risk of something happening to you in *comparison to someone else*. Absolute risk is the actual, or true risk of something happening to you.

To understand the true (absolute) reduction in risk, you would have to carry out this math formula:

Relative risk reduction X your baseline risk = actual reduction in risk

then

Baseline risk – actual reduction in risk = new absolute risk

For example, if having a doula decreases your risk of Cesarean by 39% (relative risk), and your baseline risk of having a Cesarean was 32% (about 32% of people giving birth in your hospital have a Cesarean), then 0.39 x 0.32 = 0.12 or 12%.

So if your baseline risk of a Cesarean is 32% without a doula, then with a doula that risk would be lowered by 12% down to an actual risk of 20%. This is still a substantial decrease in risk—your risk went from about 1 in 3, to 1 in 5.

Why are doulas so effective?

There are several reasons why we think doulas are so effective. The first reason is the "harsh environment" theory. In most developed countries, ever since birth moved out of the home and into the hospital, laboring people are frequently submitted to institutional routines, high intervention rates, staff who are strangers, lack of privacy, bright lighting, and needles.

Most of us would have a hard time dealing with these conditions when we're feeling our best. But people in labor have to deal with these harsh conditions when they are in a very vulnerable state. These harsh conditions may slow down a person's labor and their self-confidence. It is thought that a doula "buffers"

this harsh environment by providing continuous support and companionship which promotes the mother's self-esteem (Hofmeyr, Nikodem et al. 1991).

A second reason that doulas are effective is because doulas are a form of pain relief in themselves (Hofmeyr, 1991). With continuous support, laboring people are less likely to request epidurals or pain medication. It is thought that there is fewer use of medications because birthing people feel less pain when a doula is present. An additional benefit to the avoidance of epidural anesthesia is that women may avoid many medical interventions that often go along with an epidural, including Pitocin augmentation and continuous electronic fetal monitoring (Caton, Corry et al. 2002).

This finding—that people with doulas are less likely to have an epidural—is not due to the fact that clients with doulas in these studies were more likely to want these things up front and were more motivated to achieve them. In fact, randomized trials account for these differences—this is why they are called randomized, controlled trials. The people assigned to have a doula, and those assigned to not have a doula, are *randomly* assigned, meaning that the same percentage in each group would have a desire for an unmedicated birth.

A third reason why doulas are effective has to do with the attachment between the birthing person and doula which can lead to an increase in oxytocin, the hormone that promotes labor contractions. This theory was proposed by Dr. Amy Gilliland in her 2010a study about effective labor support. In personal correspondence with Dr. Gilliland, she wrote, "I believe the Doula Effect is related to attachment. When the mother feels vulnerable in labor, she directs attachment behaviors to suitable figures around her, who may or may not be her attachment figures (parent, mate). When the mother directs attachment seeking behaviors to the doula, the experienced doula (25 births or more) responds in a unique manner. She is able to respond as a secure base, thereby soothing the mother's attachment system. The accompanying diminishment in stress hormones allows for a surge in oxytocin in both the mother and the doula... theoretically, oxytocin is the hormone of attachment, and it is released during soothing touch and extended eye contact, which are habitual behaviors of birth doulas." (Personal communication, Dr. Amy Gilliland, July 2015).

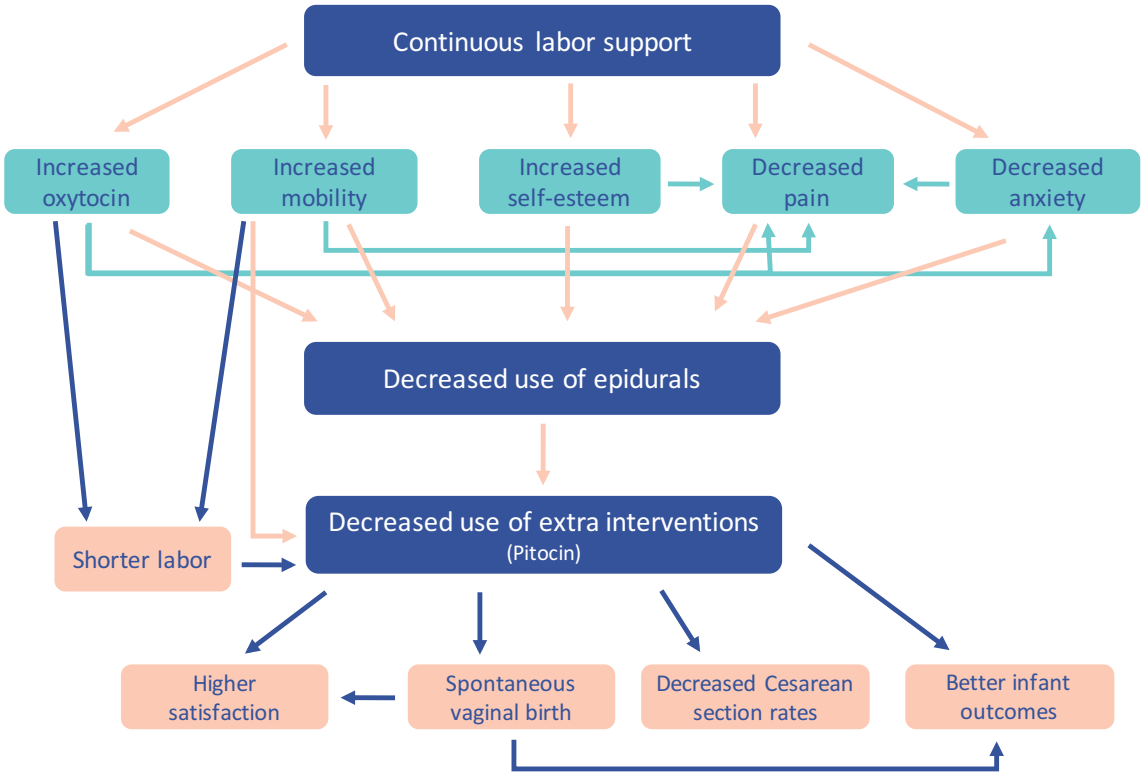
Swedish oxytocin researcher Kristin Uvnas Moberg writes that the doula enhances oxytocin release which decreases stress reactions, fear, and anxiety, and increases contraction strength and effectiveness. In addition, the calming effect of the doula's presence increases the mother's own natural pain coping hormones (beta-endorphins), making labor feel less painful (Uvnas Moberg, 2014).

A recent study in Iran compared first-time mothers' anxiety and pain levels with doula support to those without doula support (Ravangard et al., 2017). They randomly assigned 150 first-time mothers to doula support or no doula support and used standard questionnaires to measure anxiety and pain levels. They found that on average, the mothers who received doula support had less anxiety and lower average pain scores during labor. The authors concluded that the doula's presence has a clinically meaningful impact on anxiety and pain levels in first-time mothers giving birth. They recommend that all hospitals and maternity care centers in Iran provide access to doulas since having a safe and calm delivery is considered a human right.

Based on the evidence, I have come up with a conceptual model of how doula support influences outcomes.

A *conceptual model* is what researchers use to try and understand how a phenomenon works. Here is my conceptual model on the phenomenon of doula support.

Conceptual Model for Continuous Labor Support (revised 2017)



How is a doula different from a labor and delivery nurse?

Nurses provide support when they can, but research has shown that labor and delivery nurses can only spend a limited amount of time in each client's room. In one research study that took place in the U.S., nurses spent about 31% of a person's labor in the room with them. The majority of the time that nurses were in the laboring person's room, they were doing direct clinical care (such as administering medications or performing interventions), maintaining equipment, applying and assessing the electronic fetal monitor, or documenting at the computer. For 12% of each person's labor, the nurse provided labor support including emotional, physical, or informational support, or advocacy. More experienced nurses were more likely to spend time providing emotional support (Barnett et al. 2008).

Three other studies in Canada have found similar findings—that nurses spend about 50-75% of their time outside the birthing person's room. In addition to caring for their assigned client, nurses have many other responsibilities, like communicating with care providers, taking care of other clients, covering for other nurses' breaks, documenting care, and assisting on the labor unit as necessary (Gagnon & Waghorn, 1996; McNiven et al., 1992; Gale et al. 2001).

Nurses may also touch the birthing person in a variety of ways, some of which may be unpleasant, like having an IV put in or a cervical check done. Although all of these procedures are optional, they may not be presented as such. When and how a doula touches is up to the person giving birth, so the laboring brain probably anticipates and responds to the doula more positively over time (Personal communication, A. Gilliland, 2017). Nurses may also go off shift, at which point their support ends. Most doulas, on the other hand, remain with the birthing person through birth. Also, nurses are employed by

the hospital and while they see themselves as patient advocates, they also have an interest in satisfying their employer, while an the primary responsibility of an *independent doula* (one not employed by the hospital) is to their client—the person giving birth.

How is a doula different from having your partner/spouse there?

Some people think that they do not need a doula because their partner will be with them continuously throughout labor. It is true that the birth partner is an essential support person for a birthing person to have by their side. However, the birth partner will need to eat and use the bathroom at times, and they are having their own emotional journey that requires support. Also, many partners have limited knowledge about birth, medical procedures, or what goes on in a hospital, while doulas have knowledge and experience about all of these things that they can use to inform and support both the partner and birthing person. Ideally, doulas and partners can work *together* to make up a labor support team.

In one landmark study that evaluated the effects of doulas and fathers working together, researchers found that combining a supportive partner and a doula significantly lowered the mother's risk of Cesarean compared to just having a supportive partner alone. In 2008, McGrath and Kennell randomly assigned 420 first-time mothers to have routine care (including a supportive partner) or care that also included a professional doula whom they met for the first time during labor. All of the women in the study were classified as having middle- to upper-class financial income levels, having supportive partners, and in the care of obstetricians.

During labor, doulas provided continuous support, including encouragement, reassurance, and physical support. They helped the partner support the laboring person, and were careful not to take over the partner's role.

The results showed a substantial improvement in outcomes for women who had both a birth partner and a doula, compared to having a birth partner alone. The Cesarean rate for these first-time mothers was 25% in the group with a partner only, and 13.4% in the group with a partner and doula. The women who had their labor medically induced experienced an even more striking decrease in the Cesarean rate with a doula—the Cesarean rate with labor inductions was 58.8% in the group without a doula, and 12.5% in the group with a doula. Also, fewer women in the doula group required an epidural (64.7%) compared to those without a doula (76%).

Research has shown that the most positive birth experiences for fathers were ones where they had continuous support by a doula or a midwife. In the McGrath and Kennell study, the women and their partners who had a doula overwhelmingly rated the support of their doula as positive—with 93% rating their experience with the doula as very positive, and 7% as positive. In other studies, fathers have said that when they had labor support from a midwife or doula, things were explained to them, their questions were answered, their labor support efforts were guided and effective, and they could take breaks from the emotional intensity of the labor without abandoning their laboring partner (Johansson, 2015).

Doula care has a positive impact on birthing people of color

Access to continuous labor support from a doula is especially vital for birthing people of color. Black women experience higher rates of poor birth outcomes, including higher rates of Cesarean, preterm birth, low birth weight, and infant death (Thomas et al., 2017). Studies show that significant racial disparities (differences) in birth outcomes continue to exist even after accounting for factors like the

pregnant person's income, education, marital status, tobacco/ alcohol use, and insurance coverage. In other words, health and social factors alone can't explain the higher rates of poor birth outcomes among Black people. Then what does explain the health inequity? Researchers have proposed that African Americans are subjected to individual, institutional, and other forms of racism throughout their lives; these experiences build on each other and are uniquely stressful; and the increased stress can negatively impact pregnancy outcomes (Giscombé and Lobel, 2005).

In public health, racism (https://bit.ly/2OL9hu6) influences *social determinants* of health, which include housing, education, and employment. Researchers have conducted interviews with racially/ethnically diverse, low-income pregnant women to try and understand how doula support may help disrupt negative social determinants of health (Kozhimannil et al., 2016).

The researchers analyzed the women's responses around five main themes:

- First, they found that doulas play an important role in *Agency*. Agency is defined as the capacity of individuals to act or to make their own choices. Doulas helped their clients to understand their options and they facilitated communications with care providers, so that clients felt a sense of empowerment or ownership over their care.
- Doulas also contributed to feelings of *personal security*. When women felt scared by their care providers, they were comforted and reassured by their doulas.
- There was a consensus in the interviews that a doula's presence facilitated greater *respect* and autonomy in decision-making.
- Doulas also played a critical role in transferring *knowledge* about the pregnancy and birth process. They connected clients with resources and "translated" information received from care providers during clinic visits.
- Finally, doulas helped women with *connectedness* so that they would not feel socially isolated. Many of the participants described stressful life situations and desired a doula with similar life experiences, someone who shared their culture and background.

Doula care offers many benefits including better birth outcomes, but people of color often face barriers in accessing doula support. To address this critical need, we need more programs like the By My Side program through Healthy Start Brooklyn (https://on.nyc.gov/2p1yqmX) in New York that offers free doula services to low-income people in Black and Latino neighborhoods (Thomas et al., 2017). The idea for the By My Side program came about when Gabriela Ammann, a local doula and Lamaze instructor, noticed that many of the women attending her free childbirth-education series did not have reliable support for their labor and birth. Some women's partners were not able to take time off work for the birth; other women needed their partner or mother to take care of older children instead of providing continuous labor support. To address this need, she matched birthing people with volunteer doula care.

In 2010, the process of pairing these women with free doula support was formalized when Healthy Start Brooklyn hired certified doulas to provide support during pregnancy, childbirth, and the postpartum period. The program focused on non-Latina Black women, since this was the group with the highest infant-mortality rate in the program area. The doula and educator with the idea for this initiative is now the director of the By My Side program. Between 2010 and 2015, nearly 500 infants were born to women enrolled in the program. Compared to similar births in the area, program participants had significantly lower rates of preterm birth and low birth weight. In addition, participant feedback showed that doula support was highly valued:

"She showed me she believed in me"

"I would've had no one there; it was just me and her. If it wasn't for her, maybe I wouldn't even get through it, because she really helped a lot"

Those who could most benefit from doula care frequently have the least access to it. To address the existing unjust health disparities, it is imperative that continuous labor support be accessible to everyone and provided by a culturally diverse doula workforce.

How do I find a doula?

If you're at all on the fence about hiring a doula, you may want to interview several doulas with your partner. Childbirth Connection has a great list of interview questions for a doula. The website DoulaMatch.net has a great search function for finding birth doulas.

So what is the bottom line?

Of all the ways birth outcomes could be improved, continuous labor support seems like one of the most important and basic needs for birthing people. Providing labor support to birthing people is both risk-free and highly effective. Evidence shows that continuous support can decrease the risk of Cesarean, the use of medications for pain relief, and the risk of a low five minute Apgar score. Labor support also increases satisfaction and the chance of a spontaneous vaginal birth. Continuous support may also shorten labor and decrease the use of Pitocin. Although continuous support can also be offered by birth partners, midwives, nurses, or even some physicians, research has shown that with some outcomes, doulas have a stronger effect than other types of support persons. As such, doulas should be viewed by both parents and providers as a valuable, evidence-based member of the birth care team.

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NATIONAL ASSOCIATION TO ADVANCE BLACK BIRTH

Black Birthing Bill of Rights

At NAABB we believe that all Black women and persons are entitled to equitable, comprehensive, and quality pre - and postpartum care in order to achieve their full birthing potential and thrive during the childbearing years. The Black Birthing Bill of Rights serves as a resource for individuals to become knowledgeable of their rights as a Black person in need of maternal care. It also serves as guidance to engage hospitals, health providers, government health agencies and others to change/improve their ethic, policies, and delivery approach to serving Black women and persons throughout the birthing process.

I have the right to be listened to and heard.

I have the right to have my humanity recognized and acknowledged.

I have the right to be respected and to receive respectful care.

I have the right to be believed and acknowledged that my experiences are valid.

I have the right to be informed of all available options for pain relief.

I have the right to choose how I want to nourish my child and to have my choice be supported.

I have the right to early postpartum visits and individualized postpartum care.

I have the right to restorative justice and mediation to address obstetric violence, neglect, or other injustices.

I have the right to choose the family and friends that are present during my pregnancy, birth and postpartum care.

I have the right to receive accurate information that will allow me to give informed consent or refusal.

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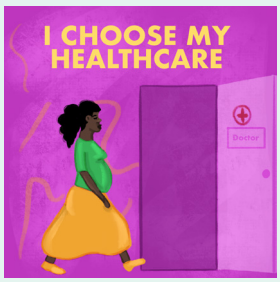
I have the right to receive affordable care.

I have the right to receive care from providers that share my cultural background.

I have the right to a doula or other professional support person.

I have the right to a perinatal advocate to address my concerns.



I have the right to change providers or birth facilities.

I have the right to receive care that acknowledges my strengths.

I have the right to incorporate traditional beliefs and cultural practices into my care.

I have the right to anti-racist maternity care.

I have the right to make medical decisions for my baby.

I have the right to uninterrupted time with my baby.

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