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Name: Sydney Comstock Date

"I live in a doula desert":

Doula Experiences in Rural Georgia

By

Sydney Comstock, MPH

Behavioral, Social, and Health Education Sciences

Committee Chair: Dr. Jessica Sales

Committee Member: Dr. Elizabeth Mosley

Department Chair: Dr. Don Operario

"I live in a doula desert":
Doula Experiences in Rural Georgia

By:
Sydney Comstock

Bachelor of Arts
Wake Forest University
2020
Thesis Committee Chair: Dr. Jessica Sales, PhD, MA

An abstract of
a thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral, Social, and Health Education Sciences
2023

Abstract

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Background: Rural maternal and child health outcomes in Georgia are dismal, and there are fewer rural hospitals and providers every year. Doula care (or non-clinical perinatal support) can improve birth experiences and outcomes and reduce infant and maternal morbidity.

Methods: The community-engaged Georgia Doula Study, co-led by a university doula-researcher and a community-based doula organization, surveyed, and interviewed 22 doulas across the state. Descriptive analyses were conducted in Stata v. 14, and the interview transcripts were analyzed using coding, memo-ing, and diagramming in Dedoose.

Results: Of the 22 doulas interviewed,16 served rural populations. Five themes emerged: at baseline, 1) Rual childbirth education disparities, knowledge gaps, and opportunities, 2) Poor access to full spectrum of childbirth options in rural areas, 3) Insufficient perinatal support and social service gaps, 4) Far distances between doulas, rural clients, and healthcare settings, and 5) Rural poverty impedes doula access through long travel times and economic barriers. These findings emphasize the facilitators and barriers to doulas providing care to people in rural Georgia. The protective factors of education, knowledge, advocacy that doulas implement into their practice are essential to providing care.

Conclusion: Doulas face challenges in their work with rural communities, and their rural clients also face numerous barriers to doula and other holistic perinatal care. However, doulas carry numerous benefits and opportunities for rural communities including perinatal education, empowerment and advocacy, and connection to care.

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Chapter I: Introduction and Statement of the Problem and Purpose

Background

Maternal health in the United States is a major public health crisis. Individuals giving birth in this country face much more dangerous outcomes compared to other countries with similar gross domestic products (GDPs) (Small et al., 2017). Especially after the COVID-19 pandemic, more people have died annually from pregnancy-related causes, specifically 1,205 in 2021 compared to 861 in 2020 (Hoyert, 2023). The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, which is significantly higher than 23.8 in 2020 (Hoyert, 2023). However, the United States is a huge country, with vastly different outcomes across geography and race/ethnicity.

The state of Georgia consistently has some of this country's worst maternal health outcomes (Kramer et al., 2023). In particular, in rural areas of Georgia access to health and social services is already an issue, and the barriers for people in the perinatal stage of life are rampant. Due to care shortages, hospital closures, and fewer obstetric providers, services in rural areas have become less available, which contributes increased maternal mortality rates overall and to rural-urban disparities (Daymude et al., 2022). More than 5 million women live in maternity care deserts, or areas where there are no hospitals that offer obstetric care (March of Dimes, 2020). Additionally, Black pregnant people have a mortality rate that is three times higher than the rate for White women and for American Indian/Alaska Native People the rate is two times higher (Hill et. al. 2022). In the face of all of these barriers, doulas, who are non-clinical labor support professionals, can be a service to bridge this divide and be a solution to these obstacles. This thesis will attempt to understand the experiences of doulas who provide perinatal support to rural communities in Georgia and the barriers and facilitators they face in their work.

Doulas are labor professionals that provide physical, informational, and emotional support for individuals during and after pregnancy (Guenther et al., 2022). While doulas are receiving greater recognition among the general population and are becoming more widely used, many people still do not have access to this service or are unaware about the benefits of doula care. Individuals who have continuous support during childbirth have better health outcomes including increased likelihood to have a vaginal birth, shorter labors, less likely to have a cesarean section, less likely to have a low-birth-weight baby, and less adverse birth outcomes overall (Gruber et al., 2013; Hodnett et al., 2012). Doulas have been typically used by individuals who have a higher income, and these services are not usually included in reimbursement policies for Medicaid, which covers a large proportion of U.S. births, about 42% of pregnant people (Knocke et al., 2022; Peristats, 2020). As of 2013, when the last data was available, about 6% of births in the United States utilized doula services, but this number is most likely an under report since there is no national collection of doula data (Guenther et al., 2022; Knocke et al., 2022). As people begin to explore using this labor support professional in their pregnancy journey and recognize the benefits that this type of advocate can have for their experience, some states have begun to explore covering this service through Medicaid. Even groups in the state of Georgia—namely Healthy Mother's Healthy Babies Coalition of Georgia—have put together doula training programs and Medicaid doula reimbursement pilots to look into this possibility.

Rural communities in Georgia deserve to have the same access to doula care, but the extent to which doulas serve women in rural communities has not been well examined in the literature in Georgia or elsewhere. Doulas are a key connector in the community, who understand the obstacles people face when accessing healthcare, gather information about individual's access to their services, and connect them with health and social services in their area. There is need for

more research around doula support for rural communities, especially in states like Georgia, where there are high maternal mortality and morbidity rates.

Theoretical Frameworks

There are multiple theoretical frameworks that have informed the approach to this research. Reproductive Justice is Black feminist social justice movement and human rights framework that emphasizes intersectionality (ex: how race, class, gender, and sexuality intersect) and the spectrum of reproductive freedom (Luna & Luker, 2013; Morison, 2021). The tents of Reproductive Justice are that people deserve bodily autonomy free from coercion and the ability to not have children, to have children, and to raise one's child(ren) in a space that is safe from violence, has available schooling, access to medical resources, and other basic needs (Morison, 2021). According to Reproductive Justice, rural communities deserve access to the full spectrum of perinatal services that can optimize reproductive outcomes, including doula care (Basile, 2012).

The Good Birth Framework also informs the current doula study, and it emphasizes the role doulas have in mitigating the negative effects that poor social determinants of health can have on the perinatal period, namely access to health care and one's social and community context (Kozhimannil et al., 2016). Doulas can alleviate stressors during pregnancy, birth, and postpartum by supporting their clients through knowledge, respect, connectedness, agency, and security. Finally, given this thesis focuses on rural barriers to healthcare, the Health Access Framework also informed the current study by focusing on the dimensions of accessibility, approachability, acceptability, availability, affordability, and appropriateness (Levesque et al., 2013).

Purpose and Research Questions

This thesis aims to explore obstacles rural populations face when accessing doula care, and also focuses on how to potentially address doula shortages, improve access to doula services, and expand their work in rural communities. The primary research question is:

- What is the perception that rural doulas in the state of GA have of their geographic location affecting their ability to perform their role as a labor support individual?

A secondary research question is:

- What are the facilitators and barriers for rural doulas to provide care to their clients in rural Georgia?

To do this, this study used qualitative interviews and quantitative surveys of doulas in the state of Georgia, purposively sampling for doulas serving rural areas, to understand their experiences providing doula services to rural clients. This research will help researchers to better understand the birthing situation in rural Georgia from the perspective of doulas as well as how to better support these labor professionals. By learning about the realities in these areas, the findings of this work will be used to increase access to doulas and facilitate better pregnancy outcomes in the state of Georgia.

Doulas are a potential solution to the high rates of and wide disparities within maternal mortality and morbidity in Georgia and the United States, as they have been proven to improve birth outcomes and prevent the precursors of maternal morbidity and mortality (Safon et al., 2021). The broader field of maternal and child health will benefit from learning more about the rural communities and their access to doulas care during and after pregnancy. This knowledge will inform doula practice and policies, including training and capacity building for doula care in

rural communities and for policies governing doula reimbursement (ex: Medicaid coverage or other mechanisms for making doula care broadly accessible).

Chapter II: Literature Review

In the rural United States, the socioeconomic and healthcare situation has been getting significantly worse over time especially for pregnant individuals. For example, rural communities in Georgia (17% of the population) are dealing with high rates of poverty: 18.8% compared to 13.1% in urban areas (Rural Health Information Hub, 2021). Due to care shortages, hospital closures, and fewer obstetric providers, services in rural areas are less available and accessibly, which contributes to the urban-rural disparities in U.S. maternal mortality (Daymude et al., 2022). One study found that 9 percent of rural counties experienced the loss of all hospital obstetric services from 2002 to 2014, and now more than half of all rural counties in the United States are without obstetric services (Hung et al., 2017). Additionally, more than 5 million women live in maternity care deserts—areas where there are no hospitals that offer obstetric care (March of Dimes, 2020). There are many factors that contribute to this issue of rural health care for pregnant people. This research focuses on the role of doulas in providing perinatal care to rural communities and the obstacles they face in Georgia.

Maternal Mortality

Maternal mortality is a significant public health issue in the United States. This country has the highest maternal mortality rate among high-income countries and the rates have been increasing although rates are declining elsewhere globally (MacDorman et. al., 2016). Specifically, from the years 1987 to 2011 the rates have increased from 7.2 to 17.8 deaths per 100,000 live births (Milder et al., 2017). Currently, there are an estimated 19.9 maternal deaths per 100,000 live births, which is very high for a country that is considered to be one with a robust health care system (Milder et al., 2017). These numbers indicate a serious issue happening, and one that is getting worse.

In 2010 to 2012 the pregnancy related mortality ratio for Georgia was 26.5 per 100,000 live births (Platner et al., 2016). Additionally in some more recent studies the maternal mortality rate is 6.8 times higher in Georgia (39.3 deaths per 100,000 live births) than in Massachusetts (5.8 deaths per 100,000 live births) (Milder et al., 2017). These numbers indicate severe maternal health issues in this state. Comparing the south-eastern state of Georgia to other states is important in understanding the context, however gaining more information about this situation through talking to individuals who are at these births is essential. Additionally, the rural hospital closures add another layer to this problem in the state.

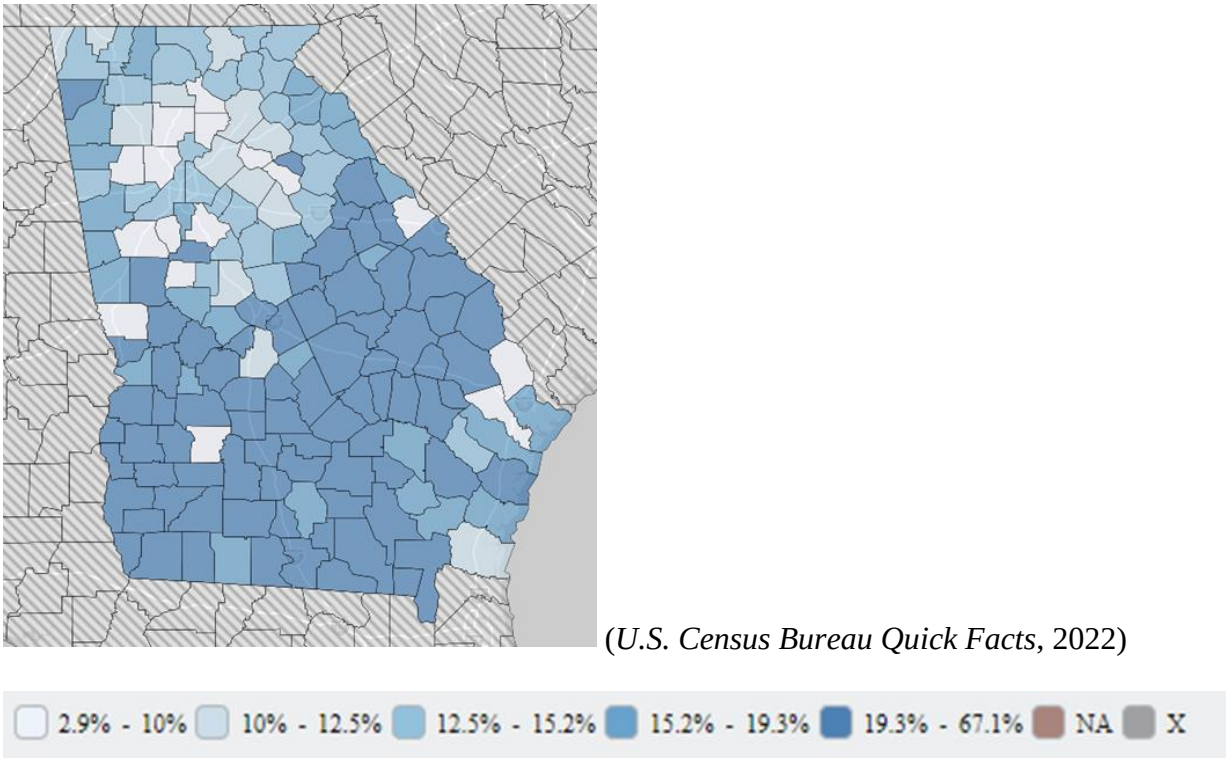
Multiple studies have only looked at the numbers of deaths, it is time to turn to looking to solutions. In terms of maternal mortality surveillance in the United States there are multiple methods being used currently, the National Vital Statistics System, the Pregnancy Mortality Surveillance System, and maternal mortality review committees (Pierre et al., 2018). These systems inform the numbers of maternal health in the U.S. and influence the public health responses or policy responses. While these numbers are important, to understand the specific picture in rural Georgia, these need to be funneled down to create solutions tailored to specific states and communities. Qualitative research looking at different aspects of the United States geographically is essential to giving context to these numbers in places that can be focused on.

Rural Disparities

The lack of health and social services in rural areas contribute to the maternal mortality issue in the United States as evidenced by rural residents having a 9 percent greater probability of severe maternal morbidity and mortality, compared to urban residents (Kozhimannil et al., 2019). Specifically, rural residents have higher maternal mortality rates, increased risk of postpartum hemorrhage, and non-indicated cesarean sections (Gregg, 2022). Finally, rural obstetric unit

closures typically happen in smaller hospitals and places where there are already few obstetric professionals (Hung et al., 2016). These rural disparities are an important and urgent problem, and the perspectives of doulas can be analyzed for possibly solutions. Rural areas of the United States have been left behind by the healthcare system and they need to be an explicit focus in research to be able to find suitable solutions for these communities, especially during the highly vulnerable and impactful perinatal period.

Image I: Percent of Persons in Poverty by County in Georgia



(*U.S. Census Bureau Quick Facts*, 2022)

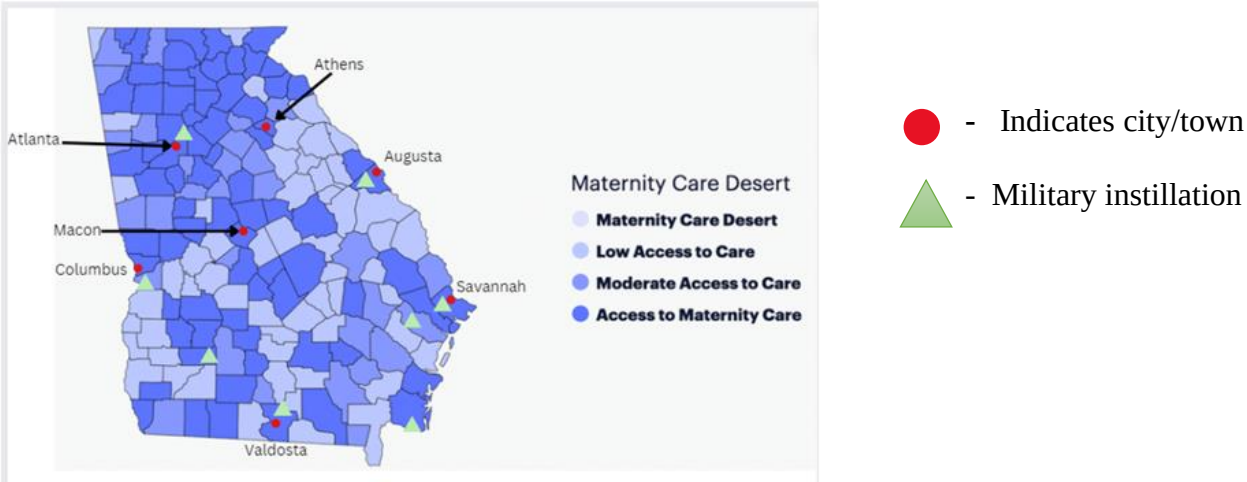
Once the maternal death checkbox on death certificates was implemented throughout the United States, there was an increase of 7.5 maternal deaths per 100,000 live births and 16.6 in rural areas— a 107% increase (Kozhimannil et al., 2019). Additional studies are needed to better understand the context, factors driving rural maternal mortality, and possible solutions. Even when it comes to prenatal care in rural areas, which can improve maternal health outcomes, there has been qualitative research to identify the barriers with shortage or non-shortage obstetric care

service areas, yet doulas were not talked to (Meyer et al., 2016). These qualitative interviews are immensely important in painting a picture of birthing situations in rural counties and places where there are few obstetric providers. This methodology can be used and applied to birth professionals to better understand what they see in their work as well.

Birthing Situation in Rural Georgia

The rural disparities in the state of Georgia are very present, along with closures of maternity wards in hospitals. The context of rural hospital and maternity ward closures continuously exacerbate this maternal mortality crisis. In Georgia, nine labor and delivery hospitals in rural areas closed from 2012 to 2016, leading the areas outside of the city of Atlanta with no obstetric providers rise from 37 to 44% (Daymude et al., 2022). In the year 2017, 75 out of the 159 Georgia counties did not have any OB/GYN physician (Georgia Board for Physician Workforce, 2017). This absence of providers leads to individuals in rural communities consistently have to travel much farther for OB/GYN services and prenatal care ("ACOG Committee Opinion No. 586," 2014; Hung et al., 2016). These sources outline the severe issues the Georgia is facing but they do not offer solutions. Missing from this discussion of hospital closures and lack of obstetric care are doulas, which create maternity care deserts, are individuals who provide birthing women with support during the prenatal period as well as during birth, such as doulas.

Image II: Georgia Maternity Care Desert Breakdown by County, 2020



(March of Dimes, 2020)

Doula Care

Doulas are one portion of the birthing team that see and provide support for these births happening in rural Georgia. Doulas are non-clinical pregnancy support professionals who give physical, emotional, and informational support and help pregnant people advocate for their needs and desires (March of Dimes, 2020). In the third national U.S. survey of women's childbearing experiences in 2013, 6% of women used doulas and more than a quarter (27%) of those who did not have a doula indicated they would have liked to have had doula care (Declercq et al., 2014).

The evidence on benefits of doulas for maternal and infant health is extremely strong and clear. One meta-analysis that looked at studies describing the work of doulas from 1980 to 2013 identified that the focus of the research is on patient's experiences and the clinical outcomes doula care, but some more recent studies have begun looking at the perspectives of doulas and their role in the clinical care team (Steel et. al, 2015). This analysis groups research on doulas from an international perspective and breaks them down into workforce and professional issues, trained doula's role and skills, medical outcomes of trained doula care, and social outcomes of

trained doula care (Steel et. al., 2015). Another large study analyzed the benefits of continuous support during labor by reviewing 22 trials over 16 countries and identified that with this assistance people are more likely to have spontaneous vaginal birth, less likely to have intrapartum analgesia, and less likely to report any dissatisfaction (Hodnett et. al., 2012). This analysis also found that people were less likely to have a cesarean section or a baby with low five-minute Apgar scores (Hodnett et. al., 2012). These meta-analyses have been immensely beneficial to the understanding of the work of doulas but there is still more work to be done, especially to better understand rural areas, which these studies do not focus on.

According to one study preterm birth rates were 6.1% among doula-supported birth compared to 7.1% among Medicaid beneficiaries (Kozhimannil et al., 2013). Additionally, the rates of cesarean delivery were 40.9% lower for doula-supported births (Kozhimannil et al., 2013). Individuals who gave birth with the support of a doula were 4 times less likely to have a low-birth-weight baby, 2 times less likely to experience a birth complication, and more likely to initiate breastfeeding because nearly 90.4% of the individuals in this study assisted by a doula chose to initiate breastfeeding (Gruber et al., 2013). All of these benefits of a patient advocate of a doula indicate possible solutions for maternal health in the United States, making it essential for these professionals to be included in any research that goes on around birth in this country.

Through the five simple strategies of reassurance, encouragement, praise, explaining and mirroring, doulas are able to improve patient experiences (Gilliland, 2011). These studies illustrate the benefits of doulas on patient experience and overall maternal health outcomes, but they have not applied this potential solution to rural areas, especially in the state of Georgia. Even less studies have focused on the perspective doulas have or the scenarios they have seen in these rural areas as individuals who are caring for people giving birth. By looking at these

techniques and other situations that doulas encounter can paint a bigger picture for researchers looking at context around improving labor outcomes.

Rural Doula Programs

When combining the impact of doulas and looking at the condition of obstetric issues, there are very few studies looking at the potential situation or perspective of doulas. There are shortages of doulas in rural areas of Georgia which is in addition to the issues of clinical care being located far away (Safon et al., 2021). Doulas who are on the ground doing this work can be essential to understanding the situation that people are facing. There is one study that looks at the patient experience in a rural community supported doula program, called the Washington County Mental Health Doula Project, where doula services are offered to at risk patients during their pregnancy, through the birth process and the post-partum period, as well as up to one year after the delivery (Gregory-Davis, 2021). However, this study focuses on one program in rural Vermont, not Georgia as well as only looking at the perspective of patients not the doulas themselves. The stories of doulas could be a very helpful and insightful resource as the state of Georgia looks to solve the issue of the lack of clinical birthing facilities and the lack of doulas through potentially expanding Medicaid coverage to these birth support professionals.

Additionally, as states including Georgia begin to look at including doulas in health care coverage, understanding the services they provide in rural areas where birth support is needed, research including doulas is essential. Many rural individuals are on Medicaid and states are considering incorporating doula care into the coverage for their expansion plan (Medicaid and CHIP Payment Access Commission, 2021). As states begin to understand the benefits of doulas and start looking to include them in Medicaid expansion waivers and state plan agreements, it is essential to study the doulas perspectives on working in rural areas throughout the United States

(Mehra et al., 2019). Oregan is one state that allows for Medicaid reimbursement for doula services, which began in 2012, and has a category for community health workers, but these rates are very low compared to the cost doulas usually provide services at (Kozhimannil & Hardeman, 2016). By researching doula work in Georgia, especially rural areas of the state, these services can be appropriately paid for. Finally, to be able to solve the maternal health issues going on in Georgia, doulas could be a valuable resource, so understanding the problem from their perspective is essential.

Previous Georgia Doula Study Work

This thesis on rural doula care is part of a larger community-engaged project called the Georgia Doula Study, co-led by researchers at Emory University and by Healthy Mothers Healthy Babies Coalition of Georgia. To date, the Georgia Doula Study has assessed barriers and facilitators of doula care in Georgia (Mosley et al., Under Review). The team also reported on changes in doula practice during COVID-19 (Turner et al., 2022). Additionally, the study team investigated racism and discrimination of doulas and their clients (Sayyad et al., Under Review), as well as interprofessional dynamics between doulas, doctors, and nurses (Williamson, 2022). Finally, the team interviewed full spectrum doulas who provide abortion support services (Lindsey et al., 2022, 2023).

There is not much research specifically looking at the experiences of rural doulas in the United States. While there is clear evidence of hospital closures, maternity care deserts, and the benefits of doulas, there is an absence of work studying doulas in rural areas. This current research study aims to understand the doula care situation in rural areas, through the eyes of doulas working in these places. The aim of this study is to understand the perspectives of rural doulas through qualitative and survey methodologies, which can inform future practice and

policy to improve maternal health equity in Georgia. Notably, this study uses community-based participatory research methods, which are essential for understanding groups and communities who have been marginalized by society and by traditional research.

Benefits of Community-Based Participatory Research

This scholarly work will use community-based participatory research to be able to include individuals from the local professionals who are doing the work on the ground. This enables the research to gain first-person stories and perspectives on the situation affecting individuals in rural Georgia. This type of research builds on the strengths and the resources within the community and creates a collaborative relationship with doulas in rural areas (Israel, 2005). Community-based participatory research focuses on finding solutions to public health concerns that matter to the groups involved (Israel, 2005). Creating trust and seeking out human-interest stories of the people who are facing the public health problems of maternal health in rural Georgia, is essential to this research endeavor.

Including the core structures of research partnership such as power sharing, shared values, and community involvement have been shown to be connected with positive health outcomes (Duran et al., 2019). This project wants to be able to use this basis to influence the methodology, which enables this work to influence other studies. Community-based participatory research has been used in previous doula studies, especially for this specific Georgia Doula Study work. However, in terms of rural doula work, this has not been applied yet. More geographically rural communities in this state could greatly benefit from this type of research because these places can be tightly knit and building trust is essential.

This thesis will investigate the perceptions that rural doulas have on their ability to perform their job and support their clients. This study will do this through the use of qualitative

interviews with rural-serving doulas in Georgia to evaluate how rural geography affects doula care and the facilitators and barriers of providing doula care to rural communities. This research will help researchers to better understand the birthing situation in rural Georgia from the perspective of doulas as well as how to better support these labor professionals.

Chapter III: Methodology

This thesis is both qualitative works, using interviews to gain insight into and context around doulas' work, and quantitative work, using a survey to measure demographics and doula services. Qualitative methodology is ideally suited for the research questions explored in this study as the intention is to better understand the context and lived experiences of doulas, particularly as it relates to their work in rural communities in Georgia. Additionally, community-based qualitative methods enabled this study to create trust and reach different doulas who may not normally be accessible to research. Study design, recruitment, sample, data collection methods, and analysis methods will be discussed in this section of the thesis.

Community-Engaged and Mixed Methods Study Design

The Georgia Doula Study is a community based, mixed-methods study which includes surveys and in-depth interviews. The work is co-led by Healthy Mother's Healthy Babies Coalition of Georgia (HMHBGA), a community non-profit organization—namely Executive Director Ky Lindberg and Research and Policy Director Madison Scott— and Dr. Elizabeth Mosley, an academic researcher who is also a full spectrum doula located at Emory University. This study originally began through the Georgia Doula Access Working Group, which first met in 2019, with the goal of improving access to doula care for more Georgians. Dr. Mosley is a member of this group and updates them every quarterly meeting about the study's progress, this is a key opportunity for the working group to provide feedback and ask questions. This working group continued to be on the Community Advisory Board for this study and consists of doulas, health professionals, researchers, and community leaders. The focus on rural doulas came from a priority identified by the Georgia Doula Access Working Group as well as HMHBGA. Community-based participatory research is critical to connecting with local communities and

including them in research by making them an integral partner in all steps (Israel et al., 2010). The goal of using this approach is to create buy-in from the community and learn from the people this research is working to find solutions concerning health equity for (Israel et al., 2010). Additionally, HMHBGA team members attended all study meetings and had equal decision-making power as Dr. Mosley.

This study and the procedures have been reviewed by the Emory University Institutional Review Board (IRB) and were given an exemption from IRB oversight, because the human subjects' identities were not easily identified, and any disclosures would not place the subjects at risk of damages. The study originally planned to interview 20 doulas, 5 for each of the 4 major interview sections: training and certification, practice/clientele, discrimination, and rural challenges. For the inclusion criteria, participants needed to be over 18 years of age, self-identify as a doula, worked in Georgia for at least 6 months, and speak/understand English. Additionally, for this iteration of the Georgia Doula study, the doulas who were targeted were those that served clients in rural areas of the state.

Recruitment and Eligibility

These individuals were recruited with help from the study's partner's Healthy Mothers Healthy Babies and their doula contacts who are working with them on their Medicaid Doula Pilot List. This list was the first round of individuals who were connected and then snowball sampling was used and each participant was asked if they knew anyone else who would want to participate. Doulas were additionally recruited through the Healthy Mother's Healthy Babies conference and using cold emailing using search engines on the HMHBGA website for doulas and through DoulaMatch.net. To determine if an individual qualified for the study they were asked to fill out a short questionnaire, the screener, asking their age, how long they have been a

doula, type of clientele served, the type of doula they are, which county they serve in Georgia, and collects their contact information (Appendix II). Once an individual was identified as eligible, then a graduate research assistant reached out to them to schedule an interview. If a potential participant was unresponsive, then the research assistant would attempt to contact them three more times. All participants who completed the survey and interview were given a physical or virtual $100 gift card.

Survey Measures

Quantitative data were collected using two online surveys on Qualtrics. In addition to the eligibility screener, there was a main survey that asked about demographic information, specifically gender, race/ethnicity, age, economic status, level of education, current employment, and sexual orientation. Gender was measured through a check all that apply question with the options of female/women, male/man, transgender, genderqueer, nonbinary, or self-identify. Race/ethnicity was measured in a similar way with the participant asked to check all that apply for the options of Black/African American, Hispanic/Latinx, Asian/Pacific Islander, American Indian/Alaska Native/Native Hawaiian, Biracial/multiracial, White, Other (specify), or prefer not to answer. For age, the groups were broken down into under 25, 25-35, 36-45, 46-55 and over 55. To understand the participants economic status, the question was focused on the difficulty of the individual to afford necessities, such as education costs, food, clothing, transportation, housing, and medical care. The response categories included yes, currently; yes, in the recent past (within 3 years); yes, in the past for a limited period of time; yes, historically throughout my life; no; or prefer not to answer. Education was broken down into the answer categories of high school or less, some college, graduated college, graduate degree, clinical professional degree, non-clinical professional degree, or others. Current employment was measured as full-time, part-

time, not employed, and not looking, and not employed and looking. Sexual orientation was measured through a check all that apply that included the options of lesbian, gay, bisexual, queer, straight/heterosexual, don't know/questioning, self-describe, or prefer not to answer.

After these demographic questions, the survey moved onto the length of time the participant has been a doula, what training and certifications they completed, and what type of doula services they provide. For trainings/certifications, participants could select any of the options including Doulas of North America (DONA) International, CAPPA Childbirth and Postpartum Professional Association, ALACE Association of Labor Assistants and Childbirth Educators, Birth Works International, HypnoBirthing, N/A, or Other (specify). Participants could check all that apply for the doula services that include preconception/fertility, prenatal, birth, postpartum, abortion, full spectrum, radical/justice, death/grief/loss/bereavement, prison, or other (specify).

The participants were also asked about their family planning attitudes. These questions included if they offered contraceptive counseling, if they had been trained in contraceptive counseling, if they would be interested in offering this service, when they offer contraceptive counseling, and abortion stigma items. The questions that focus on abortion stigma were measured through a revised version of the Stigmatizing Attitudes, Beliefs, and Actions Scale (SABAS), which originally has 37 items (Shellenberg et al., 2014). The 24 questions that were kept included a statement about abortion and then had the participant select an answer from strongly disagree to strongly agree with a neutral/don't know option. Additionally, the participants were asked about 7 situations around abortion and had the options of choosing between if abortion "always wrong", "sometimes wrong", "Neutral/don't know", "wrong only sometimes", and "not wrong at all" in each situation. Before each interview the participant was

asked to fill out this demographic survey to better understand their work as a doula and to tailor the interview questions to the specific individual (Appendix III).

In-Depth Interview Guide

All of the interviews took place over zoom using an Emory University Zoom account, with each conversation being recorded and saved to the password protected, private study Share Point folder. All participants were asked if they were comfortable with being recorded during their interview and were reacquainted with the goals of the study at the start of each interview. These conversations usually lasted from 45 minutes through an hour and 15 minutes. Starting over the summer of 2022 in June, the recruitment and interviews began and continued through November of the same year. Analysis of the data started in January of 2023. Each interview was recorded and transcribed verbatim.

Data Analysis Methodology

The survey data were cleaned and analyzed using Stata v. 14. Descriptive statistics (means, variance, proportions) were analyzed for all variables. Existing scales for workplace discrimination, family planning attitudes, and abortion stigma were constructed using previously validated methods. Bivariate statistics (t-tests, chi-square) were calculated to compare rural-serving doulas to exclusively urban-serving doulas.

Qualitative analysis began in October of 2022 and used Dedoose as the coding software. The two graduate research assistants (Ileana Medrano-Lopez and I) met three separate times to compare the coding each had done on three different interviews. After discussing the codes that were given to different sections and agreeing on how best the codebook should be used, the remaining transcripts were divided between the two GRAs.

We employed a codebook already developed from previous iteration of the Georgia Doula study to begin our coding (Appendix IV). We used this codebook and revised when necessary to make this more specific to rural doulas. There is a combination of deductive and inductive codes within this analysis. After each interview there was a debrief form that was filled out by the interviewer, which highlighted the main information and new topics that came out in the interview. Through the use of these forms and a large analysis memo for each interview, the main topics of this thesis arose, which include lack of alternative birthing services, barriers of transportation for doulas and clients, and knowledge gaps around childbirth and different services useful for clients.

Positionality

I am a Jewish, white cis-gendered woman from a town in Maryland close to D.C. I am in a Master of Public Health program at Emory University. I also volunteer as a labor support professional at Emory Decatur hospital, which serves mostly urban patients but also some rural patients. Coming from a suburban living experience allowed me to approach this study with an eagerness to learn about individual's rural experiences. I am genuinely passionate about doula work and improving the health outcomes of all people who decide to have children. I have done previous undergraduate research on doulas as a solution and have looked into social determinants of health as well as reproductive justice in my graduate career. My future career goals are focused on rural populations and serving their health care needs, specifically in terms of maternal health and for individuals in the perinatal phase of life.

Chapter IV: Results

The study interviewed 22 doulas overall, with 14 who reported serving rural individuals in any context and 7 who specifically reported that 20% of their clientele or more live in rural areas. All participants self-identified as doulas and referred to themselves as such, many held other jobs including lactation consultant, student, or business owner. Table 1 details the demographic breakdown of the participants who were interviewed by the graduate research assistants in this study. Race/ethnicity, Doula Scope of Work, and Gender Identity were questions that the participants could check all apply. The top two race/ethnicities that people identified as were Back or African American and white. Most of the respondents had the gender identity of cis-gendered female, but there was one participant that identified as non-binary and one who marked female and non-binary. Most of the participants marked that they were in the age range of 25-35. Most participants had graduated from college and finally, all different types of doula work were represented, prenatal, birth, postpartum, abortion, and full-spectrum practice.

Table 1: Demographics of the Doula Sample (n=22)

Variable	Frequency	Percent
Race/Ethnicity		
Black or African American	8	36.36%
White	9	40.9%
Hispanic or Latinx	1	4.54%
Biracial or Multiracial	2	9.09%
Asian or Pacific Islander	1	4.54%
Other	1	4.54%
Gender Identity		
Female/woman	20	90.9%
Nonbinary or Genderqueer	1	4.6%
Female/woman and Nonbinary	1	4.6%
Age		
Under 25	1	4.6%
25-35	12	54.6%
36-45	7	31.8%
46-55	1	4.6%
Over 55	1	4.6%

Education		
High School	1	4.6%
Some college/technical degree	4	18.2%
Graduated college	12	54.6%
Clinical professional degree	2	9.1%
Graduate degree	2	9.1%
Missing	1	4.6%
Employment		
Yes, full-time	11	50.0%
Yes, part-time	6	27.3%
No, not looking for employment	5	22.7%
Doula Scope of Work		
Prenatal	14	63.6%
Birth/Labor	19	86.4%
Postpartum	12	54.6%
Full Spectrum or Abortion	5	22.7%

*Race/Ethnicity, Doula Scope of Work, and Gender Identity were check all apply

Through the mixed methods of this work, there were several themes that were identified, these include 1) Rual childbirth education disparities, knowledge gaps, and opportunities, 2) Poor access to full spectrum of childbirth options in rural areas, 3) Insufficient perinatal support and social service gaps, 4) Far distances between doulas, rural clients, and healthcare settings, and 5) Rural poverty impedes doula to alternative birthing options through long travel times, and economic barriers. These findings emphasize the facilitators and barriers to doulas providing care to people in rural Georgia. The protective factors of education, knowledge, advocacy that doulas implement into their practice are essential to providing care. Additionally, word of mouth and building positive relationships also enable doulas to do their work in these tight-knit rural communities, who may not know very much about the work they do and the benefits they have. These findings have huge implications for public health and can help impact maternal health outcomes in rural Georgia, as well as other counties throughout the United States.

Rural Childbirth Education Disparities, Knowledge Gaps, and Opportunities

Participants described how there is poor access to childbirth education which contributes to poor knowledge about child birthing options in rural areas, but rural-serving doulas can and

are filling that gap. There are education gaps around childbirth and understanding what will happen during delivery and postpartum, however many doulas are delivering this education in rural populations. A few doulas in this sample mentioned taking on the education piece of childbirth, whether it was informal where they just explained information to their clients, or where they lead childbirth classes themselves. Amber, a white, over 55-year-old participant described she was "*less and less happy with the way I saw people being coerced, I felt, into things that were not necessarily needed. After a while, I became a childbirth educator because I saw a need for people to have more education about what was going on and what to expect, and what they could and couldn't do."*

This doula saw a need in these rural communities, specifically where they served outside of Athens, and became a childbirth educator and helped to close this education gap. One of the main roles of a doula is as an educator in letting their clients know what to expect, many doulas require that whoever they take on must also attend childbirth classes with them or with a group they trust. When entering communities where people may not have a clear understanding of birth and what to expect during this experience, doulas are a key link.

When individuals do not have the knowledge around what they want or what could happen during this situation, they have less confidence in advocating for themselves. In these kinds of situations, knowledge can be power and having an advocate such as a doula to remind their clients of their wants and how to communicate that in a clear way to their provider. In the face of knowledge barriers, the focus on education that doulas can provide is important. Amber mentions that *"At the same time, a lot of our people that live around here [coastal Georgia] are not very well educated. They go to a doctor who is notorious for, shall we say coercing patients*

into things that they don't need. Oh, the stories I could tell you…The five o'clock C-sections that would just magically be needed because this particular doctor liked to be home with her family eating dinner…but because people around here aren't so well educated, a lot of them, they don't know what they need to know. You don't miss what you don't know about. All your friends went to this doctor and in spite of what he does, they think he hung the moon and the stars."

Participants in this study discussed the lack of education in rural communities and how people in rural Georgia do not have access to a lot of different childbirth options such as waterbirths, birth centers, or know to ask for different options during birth. Doulas are important in filling this knowledge gap through teaching their clients advocacy and about other options available to their clients that they may not know to ask for. Charlotte, a white, aged 25-35 participant explains that *"I think the education gap is huge. I think there's just a lack of options here. I'm trying to figure out why that is and still but, no hospitals here offer waterbirth, so no one knows to ask about it. Or they don't offer things like sterile water injections. People look at me when I have three heads. When I say, "Can we do some sterile water injections?"*

In these rural areas, doulas consistently run into gaps around child birthing options in these areas. Doulas are in the space to provide education around their work and the alternative options individuals can have in terms of their birthing experience. There are many different techniques to build into a birth plan, including laboring at home or different options to advocate for in the hospital, which this doula discusses. However, the barriers are made clear when there is a lack of knowledge around the work of doulas, the options individuals can include in their birth plan, and advocating for their wants or needs. The support and education that doulas can provide to their clientele is essential in overcoming the barriers to an individual's alternative wants during birth.

The medicalization of childbirth and the disconnection of an individual's body from their experience contributes to the issues around people's lack of breastfeeding or having a birth they need to work through afterwards. People do not necessarily know about the other options that connect their birth to their body and they can have a positive birth experience. Logan, a Black participant, aged 36-45 explained that *"Even just the breastfeeding rates are dismal, so anything that's connected to the body is so disembodied. It's something I think that is intergenerational. I think there's definitely a move where it's just like, well, what if I don't have to be in pain, why would I be in pain? Give me the epidural. [laughs] I don't want to stretch my vagina. Go ahead and let's do the C section, and so I think there's a lot of people who are totally okay and their OBs aren't giving them any other options. I think it's also the same thing with folks who are looking for a VBAC. There's nobody who really is open to that. Do you even know what that looks like? Because your first one was an emergency, although you actually talked to a doctor, they won't say it's an emergency because it wasn't. I think they saved my life. Did they really? No, they didn't."*

People may not know about the potential outcomes from interventions that seem like the obvious decision to make. Doulas are an important resource to educate individuals on all the options, guide their clients through interventions they choose, and advocate on their behalf. This doula also touches on an important point about VBACs, which stands for a vaginal birth after a cesarean section. Some providers will not participate in a VBAC, despite the knowledge that for many individuals this is a possibility for a second birth.

Logan noted that some of the rural people only know the medicalized birth when they are making decisions about their own experience. They mentioned that for rural populations "*There's*

also this like, "Oh, I'm going to go, I'm going to get epidural. I'm going to get the C section." It's very medicalized because people haven't seen it any other way."

Doulas can be a part of this process to support individuals in the decisions they make within the delivery space, whether they choose more interventions or not, but people should be given the full spectrum of options. Additionally, a c-section is a very serious abdominal surgery that has a very different recovery and could lead to other potential medical issues. Doulas would be able to educate birthing people around the different intervention options and the current standard in delivery that they should expect from their provider.

Lack of Knowledge about Doula Care

In addition to different childbirth options being unavailable, many participants in this study indicated that people do not always know about the possibility of having a doula. This is on the part of clients and providers not understanding the role of a doula and the benefits they can have. However, as doulas begin to work with more rural populations, they can build connections with clients who spread their experiences through word of mouth. These relationships that these labor support professionals build is a huge facilitator for their work in rural populations because building trust is important.

One participant points out that in rural areas people do not always know about doula services and this birthing professional is being reintroduced in these areas after birth has been so medicalized in the United States. Mia, a Black doula aged 25-35 explained that they *"feel like, in the rural areas, its people are still trying to I guess accept doulas and understand the role that they play in sense as far as the medical team. I think people are still trying to adapt and adjust to*

that when it comes to rural areas. You see less people-- I don't know, it is different, I will say. It is different. People are still trying to adjust. I think that's my answer, I think. They're still trying to accept because they want to, but again, when you live in certain parts, it's always hard, but I do like it though, and then they're the ones that they would end up putting on somebody else. "Oh, this is my doula." A neighbor or somebody gets pregnant and they're going to call me, "Oh, this person's pregnant, I think you should be their doula." They sometimes provide a connection, but it's a little bit different."

This participant also touches on the importance of word of mouth. Once someone experiences the benefits of this labor support, they recommend this service to their friends and family. Doulas can be of great service in these areas, there still needs to be work done around educating hospitals and professionals in these areas about the role that doulas can play and the benefit they can have for their patients.

Poor Access to Full Spectrum of Childbirth Options in Rural Areas

Many participants described how rural pregnant people cannot access the full range of childbirth options including doulas, birth centers, and water birth because of a dearth of these services in rural communities. The reason that rural people may have a lack of knowledge around doulas and other birthing options, is potentially due to the issues around how many doulas, midwives, birth centers, and other options are available. If these services and professionals are not available to people, then they may not know about them at all. The participant Amber mentioned that they *"never found anybody that was anywhere closer than Jacksonville, Florida. For somebody living in Brunswick, yes, it could be possible. It was definitely not the best*

situation to have your doula that far away. I was thinking when I was filling out your survey, I thought of a doula desert. I live in a doula desert."

Rural areas in the state of Georgia are doula deserts. This labor support professional is not common outside of large cities, such as Atlanta. People have to go over state lines to obtain the labor support that they want in their experience. Birthing people who want to have doulas, midwives, or give birth in a birthing center have to leave their counties in rural Georgia to get the services they want.

Doulas in this study explained they have a hard time because they see the differences in access to labor support when they have moved away around the state. One participant, Logan, who identified as female and non-binary stated, "*Before I moved to Savannah at the end of 2020, I lived in Brunswick on a farm. I actually lived on a farm. … [Doulas and midwives are] still not there yet. Again, there's so much that was lost, and that people just automatically assume they're going to go to the hospital. There's not even a-- There may be-- No, because again, for the coast specifically, this is different. Atlanta is so different from Savannah."*

The workforce issue in terms of labor support professionals can really affect how many people have access to doulas or know about their role in birth. If there is only one home midwife, then there are people who would like this service and will not be able to get it. People who may be in a higher socioeconomic status, they may be able to afford to take more time off work, travel out of state, and pay for specific services outside of Georgia. However, this option is not open to everyone who may want this experience.

Lack of access is a barrier that will continue to affect people living in rural areas until there is a focus on bringing more of these options to people who live there. A participant described how they have experienced services in different geographic areas. Charlotte, a white doula aged 25-35 discussed how they and their family *"were living in Minnesota, where birth is much more ahead. I don't know a better way to say that. There's birth centers everywhere. There were five birth centers within 10 minutes of my house. All of the hospitals offer water births, and everyone knows what a doula is, and majority the of people use midwives. I did internships pretty quickly through the birth center and things like that. That kind of grew my love for birth work, and then we moved to Atlanta. We were in Atlanta for a little while, and I did work there. Now we're in Augusta. I've just decreasingly gone with how many options are available."*

This doula discusses the lack of alternative options such as birth centers, offers for water births, and the use of midwives. This quote offers an important comparison for rural areas in Georgia compared to other states and the large metropolitan city of Atlanta. In other places, there are these many options for people looking to choose different birth experiences. Additionally, the norm in other places is different with the use of midwives and number of doulas available to individuals who want them.

The lack of options in rural Georgia has the potential to be detrimental to maternal health outcomes given the benefits that midwives, doulas, and individuals have more options and control over their experience can have on this experience. Amber, who identified as a woman emphasized how they "*live in coastal Georgia and mostly Florida. There are no other doulas. There are maybe beginning to be several times I have known of people who would like to become a doula are actively working on certification. One of the biggest impediments to my career as a doula is that I'm solo. I do not have a backup and that really limits what you can do."*

This quote captures the ever-present issue in rural Georgia when it comes to labor support, there are very few doulas in these areas providing services to people. Additionally, if a doula needs another job to support themselves, they have even less time to be able to support more clients than they can take on. People who do not work for a coalition or a doula business, which there are few in rural Georgia because of the overall lack of numbers of this professional, have a much harder time providing needed services. Midwives have also had issues with providing services. The participants in this study explained that for people who choose a homebirth, there are less professionals who are able to accommodate that. Charlotte, who identified as a woman explained *"That continuity of care I think is really important for women, knowing who's going to be at your birth. Where I live…, there's only one home-birth midwife. Yes, within two hours, there's one. Women need options and I don't think that home birth is the answer for everyone, but I think that we've seen incredible rates of-- The research would show that midwifery carries lead to higher rates of life, [laughs] and so that's my desire is to give more access, especially in this area."*

Many participants noted this same theme around doulas being available and allowed into hospitals. Charlotte continued to explain that "*In [city], there's pretty much three hospitals that you can birth at. [Hospital] is the only one that's allowing doulas 24 hours. The other two hospitals are allowing doulas during visiting hours. If you happen to give birth during the day, your doula can be there, but if you birth at night, doula cannot be there."* In addition to the issue around the absence of midwives, this doula gives another quote to support the absence of acceptance of doulas in these areas. Even when a person can get into a hospital that is potentially on diversion or overcrowded, they may not be able to bring their labor support person. People

want to be able to have control over their birthing experience and include the support during what can be a tumultuous time.

In addition to doulas and midwives, participants explained that rural populations did not have access to birth centers as well. Amelia, a white doula, aged 36-45 discussed how in the rural area she works that, "*They tried to open a birth center here, which would've been awesome, incredibly awesome because everybody where I am, has to travel a minimum of two and a half hours in any direction to access a birth center. There are lots of people who travel for that. [The birth center was] declined because they couldn't get any of the hospitals to agree to a transfer agreement. [The hospital] never actually cited a reason, but behind closed doors, it's because they deemed it as financial competition. It's not that the birth center would've taken a massive number of patients away. In fact, we would've been able to refer a lot of patients back to that hospital because we would've had patients come in that didn't meet the criteria for a center birth*."

People giving birth should be able to make any of the safe decisions they need to regarding their experience. Birth centers can be a great alternative to the medicalization that can happen in hospitals, however there is a lack of these in rural areas. Clients in these geographic areas are at a disadvantage if they want to use alternative options for their birthing experience. Birthing centers can be very helpful to hospitals they have a transfer agreement with. People who have specific diagnoses in their pregnancy may need more interventions to keep them safe, so they would not be candidates for a birth center. In this situation the birth center would refer these clients to the hospital they have an agreement with, bringing in more clients for the hospital.

Another participant in the study touched on the issues around having less birth centers in rural areas. Victoria, a Black doula, aged 25-35 explained that *"Being out in the rural area, like I*

said, the lack of access to the birth center. Then it's not even that we can't have the birth center, it's that the hospitals, the doctors aren't willing to work with the providers that are looking to put together a birthing center. In [city], they've actually denied access to opening up the birthing center that they were trying to get going here because the doctors in the hospital don't want to agree to be back up in case a client has to be transferred to the hospital from the birthing center…They're blatantly limiting access and honestly, it boils down to money. In their wording… they felt a birthing center was competition to have to the hospital."

This doula also discusses the same issue between the hospital and the birth center that people tried to open. This news can be very demoralizing for professionals who are trying to bring new birthing options to different areas of Georgia. Multiple doulas have pointed out that their clients would want the option of a birthing center and that they would feel more accepted in the work that they do there.

Participants discussed the lack of a birth centers affecting the decision making of their clients, which in turn can impact the work of the doula. One doula expressed how they have a client who would have liked to give birth outside of a hospital at a birth center, but the distance and availability of services influenced her ability to obtain the birth she wanted. Victoria, who identified as a woman, described that *"For her to deliver, she had to make a choice. Do I drive to Augusta to go to a hospital? Do I drive to Savannah to go to a birth center and have access to a better quality of care than what I would get in this little community that I'm in? She chose to go to Savannah, but even with me being able to support her, that's almost a three-hour or so drive to be able to get to her and be able to provide assistance. It was one of those things where it put into perspective what people that are further out from the more established cities have to truly deal with."*

The absence of options forces people to make choices that could take them hours away from where they live. People in rural communities have to make tough decisions around their birthing experience and need to be prepared for every outcome, especially when many options have been closed off to them because of their geographic location. Doulas are willing to work with these clients, but this situation can be very hard for them to assist when they are not located in these areas.

Insufficient Perinatal Support and Social Service Gaps

Multiple participants in this work mentioned continuously that rural families have little to no access to mental health, economic, and other perinatal resources. Doulas explained that they are being creative to provide rural care, however rural geography leads to service gaps in perinatal services, especially postpartum. These barriers to care are made worse when rural hospitals are forced to close, leaving many people without care. Doulas in this study see these problems consistently, but they can be a protective factor helping rural people get connected to services that are available to them, as well as being a service themselves when it comes to support after birth.

One doula, Amelia, explained that the services they see clients receive, "*...I suppose at any point in their pregnancy, but mostly postpartum, there's a lack of resources locally. They usually have to travel more significantly to get to those services. However, lots of the services within this area are mobile and can come to them. There definitely could be more available. I think there's enough demand for it but it's hard."*

Many doulas in this study said that when looking at the postpartum services, specifically mental health services, available for new parents that there are not many that rural communities have access to, and they may not know about those that are available to them. This doula brings

up an important potential solution, which is mobile clinics. However, there needs to be reliable and consistent services for any postpartum needs people may have. Postpartum doulas who work in this space are critical to connecting individuals to what services there are and providing help in the transition to parenthood. Rural geography can be a hard barrier to overcome, but doulas are a potential solution.

A few doulas in this work touched on the closing of hospitals in rural areas, which just exacerbated access to services. The doula Amelia continued and explained that *"Yes, we had one facility closed. I can't believe I forgot about that. Seems like a lifetime ago. Yes, every hospital is regularly at capacity here. This is typically up until about right now, August is usually a very quiet time…I don't know if it's because of the proximity to [Military Base], which moves a lot of people. I've had people hire me from out of state because they're not here yet, but they know there, say I've had at least two come in from [out of state] and hire me ahead of time. Even recently, two of the hospitals this year I've had to go on diversion. For one of them, it was the first time in something like 20 years. For the other one, I think the nurse told me they've only done it twice in the last 30 years. They're converting triage rooms to [labor and delivery] rooms."*

In addition to rural hospitals having to close, this doula explains the impacts of hospitals having to go on diversion. Diversion is a term used for ambulance transporting patients to let them know that the hospital is close to capacity and to take people they have in their truck to other local places if possible (*Georgia Hospitals on Diversion*, 2021). Individuals coming in to deliver or who are transferring into the hospital to give birth need to have accessibility these services desperately, especially if there is an emergency. Multiple doulas in this work have

pointed out the impact that closing hospitals in rural areas and these hospitals having to go on diversion can have on the populations they are serving.

Another doula, Amber, explains that even before the pandemic, which put a strain on medical services, rural hospitals were closing and impacting their clientele. This participant stated that *"I know that there are a lot of the people that deliver there are on WIC, so they must be figuring out how and it's the only hospital in [city]. The closest hospital. We've had some rural hospitals that have closed even, before COVID… but the closest hospitals are in Savannah and well, the one in [town], which is a small hospital, and beyond that Jacksonville. If you are in this area, you're going to deliver at Brunswick unless you choose to have a different kind of birth, go down to [town]."*

This quote illuminates several aspects of perinatal service gaps. The closure of hospitals forces people to make decisions about where they can or want to give birth. Jacksonville is in northern Florida, which indicates that some clients feel they have so few options here in Georgia that they have to leave the state. When this doula discusses having a different kind of birth, they are pointing out the fact that people who would like a less medicalized birth, they choose to go to different hospitals that are more accepting of those decisions.

Far Distances between Doulas, Rural Clients, and Healthcare Settings

Multiple participants in this work touched on how they must travel far distances to serve rural clients, and how their clientele must travel far to access care leading to long travel times. This theme is further complicated by maternity care deserts and sparse population of rural healthcare clinics and hospitals. Birth can be unpredictable, and birth can be fast, doulas in this study explained that travel times can prevent clients from getting to the hospital or the doula

from getting to their client. Mia, who identified as a woman, told a story about one of their own clients who P033 "*almost didn't even make it to the hospital. By the time she got there, she had the baby in the wheelchair. Literally, I would say, wow, five minutes later, you would've had the baby in this car…These ones weren't really home birth. Because if it was at home where the midwife is, you know what, that's fine, but these are ones that I had to go to the hospital with and it was just a bit far, cell service has not been great, … Before I even take a client on, I make sure I check to see the distance because again, some people labor longer, but birth is unpredictable. So, I try not to play that game, next thing you know, the way she gave birth in the wheelchair".* This doula details how before they even take a client on, they check the distance from their house to their client or to the hospital they plan to deliver to. This is critical because people who live farther out may not have as many doulas willing to take them on.

This doula emphasizes how they consider multiple pieces when taking on a new client, including the distance of their home to their client or the distance the client is to the hospital. Many doulas support their clients in hospitals and work as advocates, but when their clients are very far from these places they may not be able to provide the services their client is paying them for. Additionally, this quote touches on how cell service was not great. Broadband issues in rural areas are still a problem and can interfere with people reaching the hospital or for their support to get to them. Doulas have to factor in the distance when taking on clients, which may present some people from accessing these services due to the willingness of professionals to take on rural people.

Mia goes on to explain that it's *"a challenge, not having as much access to a hospital or facility. If you're in an urban area, you can visit more every 5, 15, at least 20 minutes away. These ones can go 45 to an hour…that has just been my challenge and my worry, whenever I*

think about having to service clients in those kinds of areas". This doula compares the differences in access to hospital services in rural areas versus urban areas of Georgia. If someone plans to have their child in a hospital then they should be able to, but these services can be far in rural areas according to what these doulas see as they are doing work in this state.

Another participant discussed the considerations for their own health when driving to support clients in rural areas. Hannah, a doula who is white and was under the age of 24, explained that *"I don't like to do more than an hour because if I'm somewhere else, if there's bad weather then it starts to take a long time for me to get there. Then also for my own safety, when you're at a long birth and you're driving home, you don't want to be driving home for too long. Whenever I've done 45 minutes to an hour drive, that is enough for me to be trying to blast music and stay awake just to get [home]"*. After being on call with a client and being awake throughout the labor process, the doula may live far from the hospital as well and now has to travel home. These are all considerations that the participants in this work reflected on when providing support to clientele in rural areas of Georgia.

Doulas want to provide their client with a positive birthing experience, with whatever may happen during labor, but when this process happens very quickly it can be hard for the doula to get there and for them to debrief with their client. Emily, a Black doula, aged 25-35 described that "*In rural spaces, [the birth] is probably going to be [a] hospital birth, but the issue with those comes commuting. They have to commute to the next biggest city with the hospital unit that has the OB-GYN. A lot of rural areas, family doctors are the ones who deliver babies. That just provides another barrier to access of care. Then also too, there are a lot of midwives in the state, but because of the laws for midwifery here, not recognizing certified professional midwives as midwives in the state, that also produces another barrier to care as well."* This doula continues

the discussion around access to hospital services as well as midwife services. With the issues around regulation for certified professional midwives in the state of Georgia, clients are faced with traveling long distances to hospitals with OB-GYNS. Doulas are a part of this commute when they take on a client, if they meet them to labor at home for a bit or if they meet them at the hospital; birth can happen very quickly and the long distances to services can be detrimental.

Multiple participants discussed the long travel distances for them to assist their clients in rural areas but another layer doulas talked about were the distances to general care. In addition to just driving somewhere to give birth, people are also dealing with driving long distances for prenatal care. Victoria stated that *"There's driving hours on end. [My client] was literally driving an hour and a half to appointments and as you get further along the appointments get closer together. Once a month, in the beginning, wasn't so bad, but when she got down to every other week, once a week as she got closer to delivery, that becomes stressful. Then you've got this massive belly, everything is uncomfortable, and you're forcing women to drive just to have a better-quality experience for delivery. That's really all it was. She desired to birth at a birthing center, and she had to go out of her area an hour or so out in order to gain somewhat of a normal birth experience."* The long driving distances for prenatal care impact the clients these doulas are serving because they may not be able to get to every appointment, which can affect their overall prenatal care if they are farther along in their gestational age and need additional checks.

Birthkeepers

Birthkeepers are individuals in rural Georgia who are attending births and supporting people, usually without training. These are people who are living in the rural area, they do not have long distances to their clients. Birth-keepers are not interacting with the healthcare system

and the medical model because they seem to be attending home births. However, for patients and providers there can be risks of attending home births without the necessary training, such as medical safety or legal repercussions. The work illustrates that research needs to understand why these people have felt pushed away from the healthcare system.

Only one doula in this study mentioned birthkeepers and explained the role these individuals have during birth and why they have potentially made a resurgence in rural Georgia. Charlotte stated that *"Then there is something called-- they call themself birth workers I don't know if you're familiar with that term or not-- or birthkeepers, sorry. …You see it a lot more commonly within the Black community going back to, they would say, ancestral roots. They're attending births as a doula, attending births as a midwife, but they don't necessarily have any sort of training. That's becoming more common in this area… It's hard because they don't carry things. Home birth can be safe, but if you're not carrying things for hemorrhage postpartum, you can't do anything about that at home, or if a baby is born and you don't know how to resuscitate a baby. I understand the push for it, and I understand why we've gotten there, but it's really hard to-- again, we just need more options. We really do."*

In these rural communities there has been a movement for specifically Black birth workers to take the power back from the medical system that continues to hurt racially marginalized community members. The systematic racism that is ever present in the medical system and specifically in terms of pregnancy and birth, has created a pushback from these communities. While these individuals may not have the necessary training, which can prove dangerous when providing care to clients in rural areas, one must understand the generational

trauma that have caused this shift and work to connect with birth keepers to ultimately protect the patient while attempting to give them the experience they would want.

This doula believes that home birth can be safe, as long as people are prepared and trained to make decisions about when to go to the hospital and have the medical supplies to intervene when necessary. The power dynamics at play here between race, medicine, and culture are critical to understanding how people have built up a distrust of the medical system and traditional providers. Doulas can potentially be a bridge to between the clients who choose this and birth keepers who are providing this service. Given that many doulas work in the hospital and work to provide an individual the birthing experience as close to their birth plan as safety allows, they are an important birth support that can connect with different shareholders, while prioritizing the client.

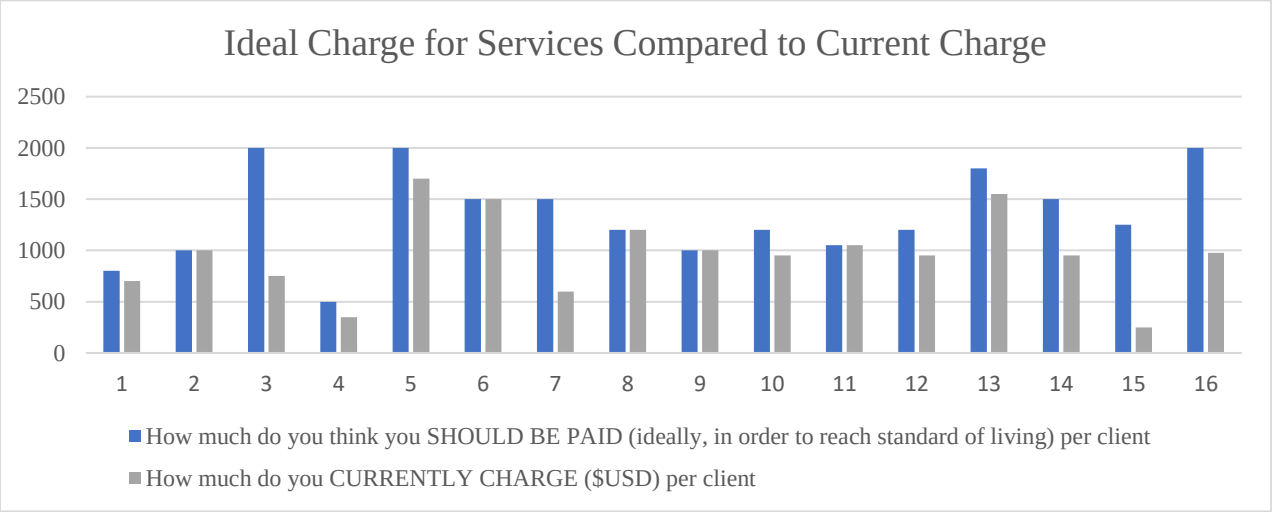
Rural Poverty Impedes Doula Access

Rural clients are impoverished and cannot afford doula care, while doulas want to serve low-income rural clients but also struggle economically themselves. Doulas and birth centers are still perceived as a luxury item for people of lower socioeconomic status, especially in rural Georgia where clients may be less likely to afford them. When people cannot afford to pay for specific services, this limits the birthing experience they will have. Doulas will offer sliding scales and pro bono work, but walking the line between helping people and being able to cover their own costs can make it hard for them to be as helpful as they would like.

In the demographic survey, the doulas in this study were asked about how much they currently charge for their services compared to what they believe they should be paid for ideally, specifically, to be able to reach a standard of living. This was not a required question in the

survey and some participants did not answer. Participants were asked to answer this question in U.S. dollar amounts, which are the numbers on the y axis. The numbers on the x axis are for each participant and they are in no specific order for this graph.

Graph 1: Ideal Charge for Birth Services compared to Current Charge



Most of the doulas who answered this question indicated that for their birth services specifically they would prefer to charge more. 11 out of the 16 participants serving rural clients answered that their ideal total for birth services is higher than what they currently charge when they filled out this survey. These quantitative findings potentially points to doulas in this work attempting to be more accessible for their clientele because they know people may not be able to afford this service.

Multiple participants discussed the impact of a client's socioeconomic status on their ability to obtain the birth they would like. Victoria explained that, *"I would say the one major experience, like I said, is the lack of the access to a birthing center because I feel it limits the options that families have. Here it's literally either you go to the hospital, or you deliver at home. The majority of the time for home births, it's an out-of-pocket expense because that's not necessarily something that's covered by insurance. Then when you're thinking of communities of*

color and stuff, it's like you're pretty much telling a particular community that they have to go to a hospital setting because more than likely financially they can't necessarily afford the home birth option. A lot of them, they build up a level of anxiety just at even the thought of delivering in the hospital." This illustrates an intersection between race, insurance coverage, and socioeconomic status. At this point, many different birthing options are not covered by insurance, which makes them a luxury item for many people who do not have the money to spend on a high price like that immediately.

Mia disclosed a client story where they were working for free and how this potentially impacted the experience of the birth. Mis went on to say that *"[their client] was another pro bono case as well…When I got there, she was in active labor and they kept trying to push Pitocin and she said, "No, I don't want Pitocin. I don't want Pitocin." [The providers] were just not listening…I went outside to use the bathroom, and then by the time I came back to my client, she started saying, "Oh, I think whatever the nurse gave me, I think it's Pitocin, because this is how I'm feeling." I'm looking at the bag now because I used to be in nursing school. So, I'm looking at the bag and I'm like, "Why is this Pitocin?" Then when they came back, I said, "She specifically said she didn't want Pitocin. Why did you guys even in a sense, lie to her and told it was just some pain meds IV?" That was a potential because for her to even sue the hospital. That was just when the doctor came and he was like, "You know what, you want get there fast enough," and he was just really mean, and I was like-- He didn't really have any respect for me as a doula because he didn't see the need for doula."* This is an extreme case of medicalization; the provider wanted the patient to process faster than they were and lied to them because of it. Additionally, this client was being supported by the doula for free because this person did not have the means to pay for their services.

The doula Charlotte explained that they take on a number of clients every year who may not be able to regularly afford a doula. She described that "*I would say every year I have a handful of clients who genuinely can't afford my services. I charge the fee that I do so that I can take clients who can't. I've done payment plans. I've found that there is something helpful in-- I feel like my clients that can't pay the full amount still want to pay something, and I think there's a lot of dignity in paying something versus like a free handout. I do a lot of in that initial phase, like, "Hey, I know that my fees are a lot. I honestly couldn't afford them a couple years ago. That's okay. Tell me what you honestly can afford, and I want to work with you." I give them a range, anywhere from here to here is good. Help me understand where you can come up with that and we can pay that off over months. I've had some people pay me 200, which is fine, and I can do that a couple of times a year."* This doula described how they also have struggled financially in the past and have a distinct understanding of the luxury of these services. The quote explains how this participant charges the fees they do for people who can afford them so that they can support clients who may not be able to pay.

Logan describes the difference between people who have money and can drive somewhere to access a birth center. This doula stated that, *"If folks had money, they may be like, "Oh, I'll go to the birthing center in Savannah or I'll go to the Women's Center in Jacksonville," because Brunswick is like right smack dab in the middle of Savannah and Jacksonville"*. This quote emphasizes how people want these options, but cost is a barrier for them to get the experience they would like. Logan went on to describe the poverty situation in some parts of rural Georgia, they explained that *"If you were just a regular person, because also Brunswick has, I think it's something more than-- maybe it's like 42% of the population is below the poverty*

line". This participant's discussion indicates how cost is a barrier for people to improve their birth experience and hire the professionals they would prefer to have.

Doulas are trying to bridge this gap by offering their services at discounted rates when they can and at times doing work for free. Taking a pay cut can be a hard decision for doulas because they also have to pay their bills. These other birthing options can be seen as a luxury item for people and unavailable to many who want them, making cost a barrier to care. Economics and socioeconomic status factor heavily into the birthing space and effect doulas in rural Georgia.

Chapter V: Conclusion, Implications, and Recommendations

The findings from this current study are useful for increasing the understanding of doulas services and their benefits for rural Georgia and, by extension, other rural communities in the United States. Education, knowledge, access to childbirth options, perinatal support service gaps, distances between care and support, and rural poverty all impact the answer to the overall research question about how doulas in rural Georgia are facing issues and overcoming them. Doulas who are serving rural communities in the state of Georgia see their geographic location as a barrier for them to successfully complete their job at times, but still feel pulled to support clients in these areas. The facilitators of the focus that doulas have on advocacy and education for their clients can improve their ability to complete their jobs. The role of geography in the work of doulas in this state can be a hinderance for them when providing service to their clients.

There are not many studies that explore and analyze the facilitators and barriers of doulas in rural areas of the United States from the perspective of these professionals. This thesis is unique in investigating rural birthing experiences from the perspective of doulas, who are supporting pregnant people and attempting to overcome the perinatal challenges they face. Previous studies that focus on the strategies of doulas such as explaining, encouragement, and reassurance, do not necessarily consider the educational or advocacy aspect of their work (Gilliland, 2011). By understanding doulas' barriers and facilitators, then solutions can be tailored to these rural areas in Georgia and then potentially applied to other places in the country. There are few studies looking at rural birthing situations from a doula perspective and those that do only focus on specific programs in states that are not Georgia (Gregory-Davis, 2021). Doulas

are known to have positive outcomes for the people they support, and this study helps us understand the facilitators and barriers that influence care in rural Georgia.

Regarding the rural childbirth education disparities and knowledge gaps, doulas are stepping in as educators. Some doula training and certification groups, such as Birthworks International, offer dual certification doulas and childbirth educators (Dual-Certification - Childbirth Educator & Birth Doula Workshops, n.d.). Rural clients deserve to be able to ask for the experience that they would like and to understand the options that are available to them for their birth. Pregnant people in rural communities want to be able to trust the healthcare providers, who have delivered a healthy baby for their other loved ones or neighbors. However, if someone does not know accurate information and options around birth or if they have not completed childbirth education classes, they may not have the knowledge and tools to advocate for themselves to receive the highest quality of care. The training that doulas get around being educators and advocates is a facilitator to be able to reinforce the needs of their rural clients.

Rural doulas are recognizing that their clients do not have access to childbirth options, and they are stepping in and promoting the options people may not know about. Currently there is a study that Northwestern is working on that will look at the work of doulas as health navigators and connecting people to services in the United States (Simon, 2023). Rural geography limits the options people have because of the smaller number of people who provide these options in these areas. With fewer providers, there are fewer people who will be accepting of different options that people potentially may want or need for their birth experience. Even if people do not always want a home birth, there should be more midwives if individuals want this kind of professional. The comparison of the situation in Georgia to other states illustrate the

barriers people giving birth in this state are dealing with, specifically the absence of alternative birthing options. All choices should be made available to all birthing people so they can make the necessary decisions about their own experience.

Rural geography affects the social services that are available for people, with individuals often encountering barriers such as the means to access services, trust in their provider or the medical system, and workforce shortages making it hard to obtain appointments or get services (Rural Health Information Hub, 2022). Prenatal and postpartum needs are essential to a healthy and positive pregnancy but have been impacted by the closures of hospitals and workforce shortages affecting the number of providers, making these necessary services hard to obtain (Garcia & Hunter, 2022). Mobile clinics can be a great solution to reaching rural populations, sending services directly to communities in need, and can be flexible in their offerings to match the community's needs, but people may not always know about them, and they may not be able to be consistent due to financial issues (Yu et al., 2017). Doulas as health navigators and connecting people to different social services can bridge the gap between clients and their needs (Kozhimannil et al., 2016; Safon et. al., 2021).

Due to rural geography in rural Georgia, there is a distance between perinatal and postpartum services on top of a dearth of services overall. Pregnant people in rural Georgia do not have access to childbirth education and less access to healthcare facilities. All of these barriers put pregnant people in rural areas at multiple disadvantages. Long distances from rural pregnant people and the healthcare they need is an ever-present issue in rural Georgia, and this is no different for doula care. At baseline, access to birthing facilities and childbirth education is poor. Moreover, doulas—at least those identified by HMHBGA and this study—are more likely

to live in urban areas and then drive out to clients living in rural areas. This doubling of travel times make it very hard for doulas to reach rural-dwelling clients to provide services. This limits the number of doulas who are willing to take on rural clients. This underscores the imperative of identifying existing and training new birth workers, who already live in rural communities. Less knowledge about pregnancy and childbirth can lead to higher risk of poor health outcomes, and the traditional power differential between doctors and their rural patients can cause harm. Rural doulas would be well-positioned to address knowledge gaps and advocate for patient autonomy.

Widespread rural poverty (Rural Health Information Hub, 2021) is a major barrier for pregnant clients needing to access and pay for doula services. While doulas try to provide pro bono or sliding scale work, many of them are also living on low incomes and need to pay their own bills. This tension between doulas wanting to serve low-income clients while also needing to make a living has been documented in the overall Georgia Doula Study (Mosley et al., Under Review), but the tension is amplified by rural-based poverty and lack of educational and economic opportunities. Clients living in these areas who would benefit from having support from doulas may not be able to pay for them.

While there are many barriers, there are multiple facilitators for doulas to do their work in rural Georgia. First, these innovative professionals are providing childbirth education for their clients in addition to labor support, thus addressing a major educational gap identified by this study. Second, the training and education doulas go through to support, advocate, and empower their patients, are critical facilitators for both perinatal support *and* childbirth education. By teaching their clients these necessary techniques, doulas improve birth experiences and build relationships with everyone in the process. Third, positive relationships with providers and

clients help to spread the word of the work these professionals do. In fact, in the Georgia Doula Study's investigation of interprofessional relationships they noted that collaboration between doctors, nurses, and doulas was mutually beneficial (Williamson, 2022). At the basis of this work, connecting with people and supporting their clients are the key strengths of a doula and will assist them in their work.

Limitations and Strengths

This work has limitations, which can be improved upon in further research, but the current study also carries a number of notable strengths. One limitation was that while doulas who were interviewed serve people in rural areas, most do not all live in rural areas. In the future, the study should connect with labor support people, who may not even call themselves doulas but live and serve in these rural communities. For example, future studies could include birthkeepers to understand their work better. Additionally, understanding why people felt disconnected from the hospital system would be beneficial to incorporate into solutions. Finally, this study was community-engaged and co-led by a Georgia-focused non-profit, Healthy Mothers Healthy Babies of Georgia. As such we cannot generalize these findings beyond Georgia. Future studies could similarly explore barriers and facilitators of rural doula care in other settings.

Implications and Recommendations

This work has critical implications for public health, specifically maternal health equity, and can inform policies, programs, and future research around doula care. Improving maternal health outcomes and reducing disparities are essential to upgrading overall community health and have far-reaching opportunities by bettering the lives of children from a young age. Through

supporting doulas in rural populations, public health can positively affect multiple generations at once.

One of the first recommendations based on this work is the need for doulas to be affordable by the most socioeconomically disadvantaged community members—whether by covering and reimbursing doula care by Medicaid or another mechanism. By covering doula care for pregnant people living on low incomes, doulas will be able to sustainably serve those communities and their clients at highest risk of poor maternal and child health outcomes will have access to these health-protective services.

For future research, the public health community could investigate the benefits rural-serving doulas can have in other states. By doing rural research in different states, more information will be understood about how doulas serving these populations are resilient in supporting their clients to the best of their ability. Additionally, further work can look at birth-keepers, by doing qualitative work around their experiences with the medical system and then their experiences with home birth in rural situations. Other states may have these individuals who have removed themselves from the medical system for different reasons and understanding their thinking around home birth can be beneficial to creating positive birthing experiences.

There are multiple opportunities for improving public health practice, both in the community and in hospitals. Rural-serving doulas could potentially benefit from cross-training in childbirth education, to better serve their clients. Additionally, extending training and mentorship opportunities to doulas who live in rural areas is essential to the labor support workforce. Future training for all doulas should include more information about the special needs and challenges of serving rural clients. Hospitals can be more supportive of birth centers, as well as training their

own volunteer doulas, which will give the hospital the opportunity to see how helpful these people can be for their nurses and their patient outcomes. Providers can benefit from the work that doulas do, but if they do not know about them then they will never be able to take advantage of how these professionals can impact their patient outcomes. Hospitals who have adjoining birth centers will be able to give their patients multiple opportunities for their experiences while keeping them safe. Additionally, having doulas that the hospital trusts and knows will create a positive bond between the providers and labor support professionals. Through the improvement between providers and doulas, more people will have access to the service of labor support professionals. Through programmatic improvements in doula training, connecting with doulas currently in these areas, and building relationships with hospitals, there will be more labor support professionals who are able to successfully work in rural communities.

These recommendations will take collaboration, determination, and understanding on behalf of many different shareholders. However, all individuals involved in birth should have the same goal of improving the outcomes of people giving birth and empowering them to have the most positive experience they can, no matter what happens during labor and delivery. By remembering this shared objective, labor professionals can communicate to enact these evidence-based recommendations.

Conclusion

Doulas are doing their best to provide services to clients in rural areas of Georgia and public health professionals can be doing more to support them in these efforts. The training that doulas have around advocacy, empowerment, and education are critical for improving rural maternal health outcomes. Doulas are already working across this country with pregnant people, improving their ability to do their job can alleviate barriers for other health professionals and

enhance patient outcomes. Rural pregnancy-related health indicators can be improved by making doula care easily accessible and affordable for rural communities. Research has repeatedly illustrated that doulas are beneficial for maternal and child health, now the doula workforce needs to be scaled up, especially in rural areas. Public health must advocate for the implementation of policies, resources, and practices to support doulas to positively affect the health of rural communities for generations to come.

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Appendices

Appendix I: *In-Depth Interview Guide for Doulas*

Introduction:

Thank you for taking the time to speak with me today. Again, my name is _____ and for this conversation, I would like to talk to you about your experiences as a doula in Georgia. As you already know, this interview is being conducted as part of a study by Healthy Mothers Healthy Babies Coalition of Georgia with Emory and Georgia State Universities. This research will be used for doula program development and policy change to improve access to doula care. If you feel uncomfortable at any time during the interview and would like to take a moment to pause or stop the interview, please let me know. I would like to record this conversation, with your permission. Would it be alright with you if I recorded this interview? Do you have any questions?

I. Opening

1. Why did you become a doula?

II. Training and Certification

2. On the survey you mentioned you received X, Y, Z training. Tell me more about your training experiences in X...in Y...in Z.
    a. Probe:
        i. If abortion training is listed: Where did you complete abortion doula training?
        ii. If abortion training is not listed but the doula provides abortion services: Without specific training in abortion doula care, how have you developed the skills needed to support abortion clients?

3. What training, if any, have you received about culturally appropriate care— care specific to the needs of specific racial/ethnic groups?
    a. Required probes:
        i. What culturally significant pregnancy/birth practices and rituals have your clients requested?
        ii. What culturally significant pregnancy/birth practices and rituals have you learned for your clients?
        iii. What additional training would you like to receive?

4. [If the doula provides services in rural areas]: How does doula training differ in rural areas versus in cities?
    a. Possible probe: Do doulas in rural areas get formal training?
    b. Possible probe: Aside from formal training, how do doulas in rural areas gain skills and experience?
5. [If the doula provides services in rural areas]: How does doula Certification differ in rural areas versus in cities?
    a. Possible probe: Do doulas in rural areas get certified? Why or why not?

III. Practice and Clientele

6. On the survey you mentioned you provided X, Y,Z doula services (prenatal, birth, post-partum, abortion). What do those services typically involve?
    a. Possible probe: Can you walk me through your typical services with X clients?
    b. Possible probe: Can you walk me through your typical services with Y clients?
    c. Possible probe: Can you walk me through your typical services with Z clients?

7. [If the doula provides services to immigrant/refugee communities]: What specific challenges have you faced in providing doula care for immigrant/refugee communities?
    a. Required probe: Interpretation services
    b. Required probe: Culturally sensitive care and providers
    c. Required probe: What is the availability of bi/tri/multilingual doulas?

8. How did you build your doula practice?
    a. Possible probe: How did you develop your client base? (social media, word of mouth, website, doula practices/programs, physician, or midwife referrals)
    b. Possible probe: What relationships (mentors, MCH organizations, physician practices, doula organizations) helped you start your practice?

9. Where do you provide services for X, Y, and Z?
    a. Required probe: Are you affiliated with a clinic, hospital, or organization?
    b. Required probe: Do you go to where the client is receiving care?
    c. Required probe: Rural areas? Cities?
    d. Required probe: In person? Virtual?

10. [If the doula provides services in rural areas]: What specific challenges have you faced in providing doula care for rural communities?
    a. Required probe: What is the availability of doulas / obstetric care providers in your rural area?
    b. Required probe: Thinking of the resources in your local area, how have they impacted comprehensive care for all of your clients' medical, social, and emotional needs?
    c. Required probe: We know there have been closures of hospitals and maternity wards across the state. How has that impacted your work in caring for clients?

11. A: [Non-volunteer doulas]: On the survey you said you do not volunteer. In general, how do you work with clients to ensure they can afford doula services—if at all?

a. Possible probe: Do you use a sliding scale?
b. Possible probe: Do you make referrals to other doulas?

B: [Volunteer doulas]: On the survey you said you are a volunteer doula. Why did you decide to volunteer your doula services as opposed to charge for them?

VII. Racism and Discrimination Qs for all doulas

12. Can you tell me about a time when you witnessed or experienced racial/ethnic discrimination as a doula?

13. Can you tell me about a time when you witnessed or experienced language discrimination as a doula?

14. How does your race/ethnicity influence the interactions you have with the medical team?
    a. Possible probe: Can you provide examples of when you felt your race/ethnicity was a factor in how the medical team treated you?

15. How does the race/ethnicity of your client influence the interactions they have with the medical team?
    a. Required probe: How does language influence their interactions with the medical team?
    b. Possible probe: Can you tell me a story about one of your clients [who are Black] [who are immigrants/refugees] [who are Latinx]?

16. How does your race/ethnicity influence the interactions you have with your clients?
    a. Possible probe: For clients of your race/ethnicity?
    b. Possible probe: For clients of a different race/ethnicity?

V. Doula Roles in Family Planning

17. What birth control needs do your clients have, if any?
    a. Possible probe: Do they need more information?
    b. Possible probe: Can they not afford birth control?
    c. Possible probe: Do they feel pressured to use it?

18. A: [If they answered yes, I provide services on the survey]: Please tell me more about the services you provide your clients about contraception and birth control?
    a. Possible probe: Can you tell me a story about one time?

B: [If they answered no I do not provide services on the survey]: On your survey, you indicated you do not provide contraceptive counseling. Can you tell me more about why you do not?

19. A: [If they answered Yes, I have received FP training on the survey]: Can you tell me more about the training you have received in contraceptive counseling?
    a. Possible probe: What additional training would you need or want—for example how to counsel on postpartum birth control?

B: [If they answered No I have not received FP training]: What kind of family planning training do you want, if any—for example how to counsel on postpartum birth control?

Abortion Doulas Only:

20. Why did you become an abortion doula?
    a. Possible probe: What are the benefits of abortion doula care?

21. Where do you provide abortion services?
    a. Possible probes: Rural areas? Cities? In person? Virtual?

22. How do you feel you are perceived because you are an abortion doula?
    a. Probe: How about by the larger doula community?
    b. Probe: How about by abortion providers?

23. What challenges do you face in providing abortion doula care?
    a. Possible probe: What are some challenges to building a sustainable business?
    b. Possible probe: How is your dynamic with the medical care team?
    c. Possible probe: What supports do you have from the doula community? (mentorship opportunities, networking, etc.)

VI. Conclusion

24. Can you tell me a story about a time when you had a lot of impact on a client's pregnancy experience?
    a. Possible probe: For example, a life-changing or empowering story?
    b. Possible probe: For example, a story highlighting the value of doulas for emotional or physical wellbeing around pregnancy and delivery

25. How can we improve doula services in Georgia?
    a. Possible probes:
        i. For people living in rural areas
        ii. For immigrant (Latinx, Asian) and refugee communities
        iii. For low income
        iv. For Black communities

26. Do you know any other doulas who would be interested in participating in this study?

That concludes our interview for today. Thank you very much for taking the time to share your expertise. We will be in touch soon with your gift card. You also have our contact information, so please do not hesitate to reach out if you have any questions. We also ask that you share our contact information with other doulas in Georgia, because we would be happy to speak with them for an interview.

Appendix II: Screener for Participants

Q1 The Georgia Doula Study looks at barriers and facilitators of doula care in Georgia with the goal of improving access to doula care for all Georgians. The study is co-led by Healthy Mothers Healthy Babies Coalition of Georgia and Emory University. First, we have to see if you are eligible for the study by asking a few questions. If you do not qualify for this particular study, we will save your contact information in case you are eligible for future studies. If you have any questions you can always email Dr. Elizabeth Mosley at eamosle@emory.edu.

Q1, Do you speak English?
o Yes
o No

Q2 What kind of doula do you identify as? (please check all the apply)
▢ Birth doula
▢ Postpartum doula
▢ Prenatal doula
▢ Abortion doula
▢ Radical/Justice doula
▢ Death/Grief/Loss/Bereavement doula
▢ Prison doula

Q3 What type of doula practice are you a part of? (check all that apply)
▢ Private
▢ Hospital
▢ Community based

Q4 Have you been practicing as a doula in Georgia for at least 6 months?
o Yes
o No

Q5 Are you over 18 years of age?
o Yes
o No

Q6 In which Georgia county do you reside?
_____

Q7, Do you provide doula services in rural areas?
o Yes
o No

Q8, Do you provide doula services to immigrant communities?
o Yes
o No

Q9 Do you provide doula services to refugee communities?
o Yes
o No

Q10 Do you provide doula services to Black communities?
o Yes
o No

Q11 Do you provide doula services to Latina/Hispanic communities?
o Yes
o No

Q12 With which of the following races/ethnicities do you identify?
▢ Black or African American
▢ Hispanic or Latinx
▢ Asian or Pacific Islander
▢ American Indian, Alaskan Native, or Native Hawaiian
▢ Biracial or Multiracial
▢ White
▢ Other (Specify) _____
▢ Prefer not to answer

Q13 Name:
_____

Q14 Email Address:
_____

Thank you for completing the Georgia Doula Study screening form. A member of the team will contact you soon letting you know if you are eligible to participate or not. If you have any questions, you can email Dr. Elizabeth Mosley at eamosle@emory.edu.

Appendix III: Survey for Participants

1. Follow-up Survey Sections

Study ID: _____

Survey Introduction

1. Please enter your name (First and Last)

2. What kind of doula do you identify as? Check all that apply
☐ Birth doula
☐ Postpartum doula
☐ Prenatal doula

☐ Abortion doula
☐ Full Spectrum doula
☐ Radical/Justice doula
☐ Death/Grief/Loss/Bereavement doula
☐ Prison doula
☐ Other (Specify): _____

Racism/Discrimination Questions
Here are some situations that can arise at work. Please tell me how often you have experienced them during the LAST 12 MONTHS.

3. How often are you UNFAIRLY given the jobs that no one else wants to do?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
4. At work, when different opinions would be helpful, how often is your opinion not asked for?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5

5. How often are you watched more closely than other doulas?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
6. How often does the medical team use racial or ethnic slurs or jokes?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
7. How often do members of the medical team direct racial or ethnic slurs at you?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
8. How often do other doulas use racial slurs or ethnic jokes?
   - Once a week or more……1
   - A few times a month……2

- A few times a year……3
- Less than once a year……4
- Never……5

9. How often do other doulas direct racial or ethnic slurs or jokes at you?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
10. How often do you feel that you have to work twice as hard as others work?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
11. How often do you feel that you are ignored or not taken seriously by the medical team?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
12. How often do others assume that you work in a lower status job than you do and treat you as such?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
13. How often has a doula with less experience and fewer qualifications gotten more clients than you?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5
14. How often have you been unfairly humiliated in front of others at work?
   - Once a week or more……1
   - A few times a month……2
   - A few times a year……3
   - Less than once a year……4
   - Never……5

Family Planning Attitudes

15. Please read each of the following statements and indicate how much you disagree or agree:

a. People behave differently toward a teen whom they know has used modern family-planning methods
b. Young women who use modern family planning are promiscuous
c. Teens who use modern family planning are viewed as bad girls
d. Modern family planning is not acceptable for unmarried women
e. Modern family-planning methods have bad effects on a woman's health

- Agree (1)
- Neutral (0)
- Disagree (0)

16. Please tell me whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if...

a. If there is a strong chance of serious defect in the baby?
b. If she is married and does not want any more children?
c. If the woman's own health is seriously endangered by the pregnancy?
d. If the family has a very low income and cannot afford any more children?
e. If she became pregnant as a result of rape?
f. If she is not married and does not want to marry the man?
g. The woman wants it for any reason

- Yes (1)
- No (2)
- Don't Know (3)

17. Do you personally think it is wrong or not wrong for a woman to have an abortion...

a. If there is a strong chance of serious defect in the baby?
b. If she is married and does not want any more children?
c. If the woman's own health is seriously endangered by the pregnancy?
d. If the family has a very low income and cannot afford any more children?
e. If she became pregnant as a result of rape?
f. If she is not married and does not want to marry the man?
g. The woman wants it for any reason

- Always Wrong (1)
- Sometimes Wrong (2)
- Neutral/Don't Know (3)
- Wrong Only Sometimes (4)
- Not Wrong At All (5)

18. Please read each of the following statements and indicate how much you disagree or agree:

a. A woman who has an abortion is committing a sin
b. Once a woman has one abortion, she will make it a habit

c. A woman who has had an abortion cannot be trusted
d. A woman who has an abortion brings shame to her family
e. The health of a woman who has an abortion is never as good as it was before the abortion
f. A woman who has had an abortion might encourage other women to get abortions
g. A woman who has an abortion is a bad mother
h. A woman who has an abortion brings shame to her community
i. A woman who has had an abortion should be prohibited from going to religious services
j. I would tease a woman who has had an abortion so that she will be ashamed about her decision
k. I would try to disgrace a woman in my community if I found out she'd had an abortion
l. A man should not marry a woman who has had an abortion because she may not be able to bear children
m. I would stop being friends with someone if I found out that she had an abortion
n. I would point my fingers at a woman who had an abortion so that other people would know what she has done
o. A woman who has an abortion should be treated the same as everyone else.
p. A woman who has an abortion can make other people fall ill or get sick
q. A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion.
r. If a man has sex with a woman who has had an abortion, he will become infected with a disease.

- o Strongly Disagree (1)
- o Disagree (2)
- o Neutral/Don't Know (3)
- o Agree (4)
- o Strongly Agree (5)

Family Planning Doula Services

19. Do you counsel your clients on family planning?

- o Yes (1)
- o No (2)

If yes, Explain and give an example (open answer)

_____

If no, would you be interested in counseling your patients?

- o Yes (1)
- o No (2)

20. Have you received any training in family planning?

- o Yes (1)

- No (2)

If yes, describe
_____

21. When do you think is best for doulas to provide family planning counseling? (ex: prenatal, postpartum, immediately after delivery)
_____

Skip Pattern: Continue to Abortion Doula questions if YES to providing abortion doula care, skip to end if non-abortion doula

Abortion Doula Questions

Please consider your experiences as someone who works in abortion services. Indicate how often you have felt or experienced the following:

22. People's reactions to my being an abortion worker make me keep to myself

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

23. I feel marginalized by other health workers because of my decision to work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

24. I feel like if I tell people about my work they will only see me as an abortion worker

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

25. I worry about telling people I work in abortion care

- All of the time [1]
- Often [2]

- Sometimes [3]
- Rarely [4]
- Never [5]

26. It bothers me if people in my community know that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

27. I avoid telling people what abortion care I do for a living

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

28. I am afraid that if I tell people I work in abortion care I could put myself or my loved ones at risk for violence

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

29. I am proud that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

30. I feel connected to others who do this abortion care work

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

31. By providing abortion doula care I am making a positive contribution to society

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

32. I find it important to share with people that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

33. Newspapers/television take a balanced view about abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

34. I feel that patients use me as an emotional punching bag

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

New Participant Survey Instrument
Study ID: _____

Demographics

1. With which of the following races/ethnicities do you identify? Check all that apply:

☐ Black or African American (1)
☐ Hispanic or Latinx (2)
☐ Asian or Pacific Islander (3)
☐ American Indian, Alaskan Native, or Native Hawaiian (4)
☐ Biracial or Multiracial (5)
☐ White (6)
☐ Other (specify) (7) _____

☐ Prefer not to answer (8)

2. How old are you in years?

☐ Under 25 (1)
☐ 25-35 (2)
☐ 36-45 (3)
☐ 46-55 (4)
☐ Over 55 (5)

3. Have you had difficulty affording necessities such as education costs, food, clothing, transportation, housing, and medical care? Check all that apply

☐ Yes, currently (1)
☐ Yes, in the recent past (within 3 years) (2)
☐ Yes, in the past for a limited period of time (for example, while I was a student) (3)
☐ Yes, historically throughout my life (4)
☐ No (5)
☐ Prefer not to answer (6)

4. Are you currently employed? Check all that apply

☐ Yes, full-time (1)
☐ Yes, part-time (2)
☐ No, not looking for employment (3)
☐ No, looking for employment (4)

5. What is the highest level of education you have completed?

☐ High School (1)
☐ Some college (2)
☐ Graduated college (3)
☐ Graduate degree (e.g., MPH, PhD) (4)
☐ Clinical professional degree (e.g., RN, LPN, MD, PA) (5)
☐ Non-clinical professional degree (e.g., GED) (6)
☐ Other (specify) (7) _____

6. With which of the following genders do you identify? Check all that apply:

☐ Female/woman (1)
☐ Male/man (2)
☐ Transgender (3)

☐ Genderqueer (4)
☐ Nonbinary (5)
☐ Self-identify (please specify) (6): _____
☐ Prefer not to answer (7)

7. What is your sexual orientation? Check all that apply:

☐ Lesbian (1)
☐ Gay (2)
☐ Bisexual (3)
☐ Queer (4)
☐ Straight or heterosexual (5)
☐ Don't know/questioning (6)
☐ Prefer to self-describe (7) _____
☐ Prefer not to answer (8)

8. What language do you primarily speak at home? Check all that apply:

☐ Arabic (1)
☐ Chinese (Cantonese, Mandarin, others) (2)
☐ English (3)
☐ French or French Creole (4)
☐ German (5)
☐ Hindi (6)
☐ Korean (7)
☐ Spanish (8)
☐ Tagalog (9)
☐ Vietnamese (10)
☐ Other (Specify) (11): _____

9. What is your immigration generation status? Check all that apply

☐ My parents and grandparents were born in the United States (1)
☐ One or more of my grandparents were born in the United States (2)
☐ One or more of my parents were born in the United States (3)
☐ I was born in the United States (4)
☐ Prefer not to answer (5)

10. In which Georgia county do you reside? _____

Pregnancy Information

11. Have you ever been pregnant?

☐ No (1) → Go to introduction to doula work and training
☐ Yes (2) → Go to 11.1

11.1. How many times have you been pregnant?

☐ 1 (1)
☐ 2 (2)
☐ 3 (3)
☐ 4 (4)
☐ 5 or more (5)

11.2 How many live children do you have? _____

11.3 For any of the pregnancies you mentioned above, did you have a doula?
☐ No (1) → Go to introduction to doula work and training
☐ Yes (2) → Go to personal experiences with doulas section

Personal Experience with Doulas

For these questions, consider the last time you had a doula:

12. What type of doula services did you receive? Check all that apply

☐ Birth doula (1)
☐ Postpartum doula (2)
☐ Prenatal doula (3)
☐ Abortion doula (4)
☐ Full Spectrum doula (5)
☐ Radical/Justice doula (6)
☐ Death/Grief/Loss/Bereavement doula (7)
☐ Prison doula (8)

13. How satisfied were you with those doula services?

☐ Very unsatisfied (1)
☐ Unsatisfied (2)
☐ Neutral (3)
☐ Satisfied (4)
☐ Very satisfied (5)
☐ Mixed feelings (6) (Explain: _____)

14. How valuable were their services?

☐ Not valuable at all (1)
☐ Mostly not valuable (2)
☐ Neutral (3)
☐ Somewhat valuable (4)
☐ Very valuable (5)

15. How did the doula affect your anxiety about the pregnancy?

☐ Negatively affected, increased anxiety (1)
☐ No effect (2)
☐ Positively affected, decreased anxiety (3)

16. How did the doula affect your pain during childbirth?

☐ Negatively affected, increased pain (1)
☐ No effect (2)
☐ Positively affected, decreased pain (3)

17. How did the doula affect your empowerment during the pregnancy?

☐ Negatively affected, decreased empowerment (1)
☐ No effect (2)
☐ Positively affected, increased empowerment (3)

18. Did you have any negative experiences with your doula?

☐ No (1)
☐ Yes (2): Please explain _____

19. Would you want a doula again?

☐ No (1)
☐ Yes (2)

Introduction to Doula Work and Training

20. How long have you been a doula? (Check all and type amount)
- _____ Years (1)
- _____Months (2)

21. What kind of doula do you identify as? Check all that apply

☐ Birth doula (1)
☐ Postpartum doula (2)
☐ Prenatal doula (3)
☐ Abortion doula (4)
☐ Full Spectrum doula (5)
☐ Radical/Justice doula (6)
☐ Death/Grief/Loss/Bereavement doula (7)
☐ Prison doula (8)
☐ Other (Specify): _____

22. How many clients (of each kind) have you been a doula for? (Check all and type amount)

☐ Birth doula (1) _____
☐ Postpartum doula (2) _____
☐ Prenatal doula (3) _____
☐ Abortion doula (4) _____
☐ Full Spectrum doula (5) _____
☐ Radical/Justice doula (6) _____
☐ Death/Grief/Loss/Bereavement doula (7) _____
☐ Prison doula (8) _____
☐ Other (Specify) (9): _____

22. What, if any, doula training have you completed?

☐ Doulas of North America (DONA) International (1)
☐ CAPPA Childbirth and Postpartum Professional Association (2)
☐ ALACE – Association of Labor Assistants and Childbirth Educators (3)
☐ BirthWorks International (4)
☐ Childbirth International (5)
☐ HypnoBirthing (6)
☐ N/A (7)
☐ Other (Specify) (8): _____

23. What, if any, doula certification have you completed?

☐ Doulas of North America (DONA) International (1)
☐ CAPPA Childbirth and Postpartum Professional Association (2)
☐ ALACE – Association of Labor Assistants and Childbirth Educators (3)
☐ BirthWorks International (4)
☐ Childbirth International (5)

☐ HypnoBirthing (6)
☐ N/A (7)
☐ Other (Specify) (8): _____

Family Planning Attitudes

24. Please read each of the following statements and indicate how much you disagree or agree:

f. People behave differently toward a teen whom they know has used modern family-planning methods
g. Young women who use modern family planning are promiscuous
h. Teens who use modern family planning are viewed as bad girls
i. Modern family planning is not acceptable for unmarried women
j. Modern family-planning methods have bad effects on a woman's health

- Agree (1)
- Neutral (0)
- Disagree (0)

25. Please tell me whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if...

a. If there is a strong chance of serious defect in the baby?
b. If she is married and does not want any more children?
c. If the woman's own health is seriously endangered by the pregnancy?
d. If the family has a very low income and cannot afford any more children?
e. If she became pregnant as a result of rape?
f. If she is not married and does not want to marry the man?
g. The woman wants it for any reason

- Yes (1)
- No (2)
- Don't Know (3)

26. Do you personally think it is wrong or not wrong for a woman to have an abortion...

a. If there is a strong chance of serious defect in the baby?
b. If she is married and does not want any more children?
c. If the woman's own health is seriously endangered by the pregnancy?
d. If the family has a very low income and cannot afford any more children?
e. If she became pregnant as a result of rape?
f. If she is not married and does not want to marry the man?
g. The woman wants it for any reason

- Always Wrong (1)
- Sometimes Wrong (2)

- Neutral/Don't Know (3)
- Wrong Only Sometimes (4)
- Not Wrong At All (5)

27. Please read each of the following statements and indicate how much you disagree or agree:

s. A woman who has an abortion is committing a sin
t. Once a woman has one abortion, she will make it a habit
u. A woman who has had an abortion cannot be trusted
v. A woman who has an abortion brings shame to her family
w. The health of a woman who has an abortion is never as good as it was before the abortion
x. A woman who has had an abortion might encourage other women to get abortions
y. A woman who has an abortion is a bad mother
z. A woman who has an abortion brings shame to her community
aa. A woman who has had an abortion should be prohibited from going to religious services
bb. I would tease a woman who has had an abortion so that she will be ashamed about her decision
cc. I would try to disgrace a woman in my community if I found out she'd had an abortion
dd. A man should not marry a woman who has had an abortion because she may not be able to bear children
ee. I would stop being friends with someone if I found out that she had an abortion
ff. I would point my fingers at a woman who had an abortion so that other people would know what she has done
gg. A woman who has an abortion should be treated the same as everyone else.
hh. A woman who has an abortion can make other people fall ill or get sick
ii. A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion.
jj. If a man has sex with a woman who has had an abortion, he will become infected with a disease.

- Strongly Disagree (1)
- Disagree (2)
- Neutral/Don't Know (3)
- Agree (4)
- Strongly Agree (5)

Family Planning Doula Services

28. Do you counsel your clients on family planning?

- Yes (1)
- No (2)

If yes, Explain and give an example (open answer)

_____

If no, would you be interested in counseling your patients?

- Yes (1)
- No (2)

29. Have you received any training in family planning?

- Yes (1)
- No (2)

If yes, describe

_____

30. When do you think is best for doulas to provide family planning counseling? (ex: prenatal, postpartum, immediately after delivery)

_____

Skip Pattern: Continue to Abortion Doula questions if YES to providing abortion doula care, skip to client demographics if non-abortion doula

Abortion Doula Questions

Please consider your experiences as someone who works in abortion services. Indicate how often you have felt or experienced the following:

31. People's reactions to my being an abortion worker make me keep to myself

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

32. I feel marginalized by other health workers because of my decision to work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

33. I feel like if I tell people about my work they will only see me as an abortion worker

- All of the time [1]
- Often [2]

- Sometimes [3]
- Rarely [4]
- Never [5]

34. I worry about telling people I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

35. It bothers me if people in my community know that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

36. I avoid telling people what abortion care I do for a living

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

37. I am afraid that if I tell people I work in abortion care I could put myself or my loved ones at risk for violence

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

38. I am proud that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

39. I feel connected to others who do this abortion care work

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

40. By providing abortion doula care I am making a positive contribution to society

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

41. I find it important to share with people that I work in abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

42. Newspapers/television take a balanced view about abortion care

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

43. I feel that patients use me as an emotional punching bag

- All of the time [1]
- Often [2]
- Sometimes [3]
- Rarely [4]
- Never [5]

Client Demographics: For the answers to each of these questions please estimate a percent for each demographic group (scroll over for 100% option)

44. Estimate the racial/ethnic breakdown (in percentage) of your clients (total in column should add up to 100)

	10	20	30	40	50	60	70	80	90	100

Black or African American										
Hispanic or Latinx										
Asian or Pacific Islander										
American Indian, Alaskan Native, or Native Hawaiian										
Biracial or Multiracial										
White										
Other										

45. Estimate the age breakdown (in percentage) of your clients (total in column should add up to 100)

	10	20	30	40	50	60	70	80	90	100
Under 25										
25-35										
36-45										
Over 45										

46. Estimate the socioeconomic status breakdown (in percentage) of your clients (total in column should add up to 100)

	10	20	30	40	50	60	70	80	90	100
Upper										
Upper Middle										
Middle										
Lower Middle										
Lower										

47. Estimate the highest level of education breakdown (in percentage) of your clients (total in column should add up to 100)

	10	20	30	40	50	60	70	80	90	100
High School										
Some college										
Graduated college										
Graduate degree (e.g., MPH, PhD)										
Clinical professional degree										

(e.g., RN, LPN, MD, PA)										
Non-clinical professional degree (e.g., GED)										
Other										

48. Estimate the number of pregnancies breakdown (in percentage) of your clients (total in column should add up to 100)

	10	20	30	40	50	60	70	80	90	100
1										
2										
3										
4										
5										
Over 5										

Racism/Discrimination Questions

Here are some situations that can arise at work. Please tell me how often you have experienced them during the LAST 12 MONTHS.

49. How often are you UNFAIRLY given the jobs that no one else wants to do?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
50. At work, when different opinions would be helpful, how often is your opinion not asked for?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
51. How often are you watched more closely than other doulas?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
52. How often does the medical team use racial or ethnic slurs or jokes?
    - Once a week or more (1)
    - A few times a month (2)

- A few times a year (3)
- Less than once a year (4)
- Never (6)

53. How often do members of the medical team direct racial or ethnic slurs at you?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
54. How often do other doulas use racial slurs or ethnic jokes?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
55. How often do other doulas direct racial or ethnic slurs or jokes at you?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
56. How often do you feel that you have to work twice as hard as others work?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
57. How often do you feel that you are ignored or not taken seriously by the medical team?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
58. How often do others assume that you work in a lower status job than you do and treat you as such?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)
59. How often has a doula with less experience and fewer qualifications gotten more clients than you?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)

- Never (5)

60. How often have you been unfairly humiliated in front of others at work?
    - Once a week or more (1)
    - A few times a month (2)
    - A few times a year (3)
    - Less than once a year (4)
    - Never (5)

Clients, Cost, and Other Logistics

61. How do you primarily find your doula clients? Check all that apply:

    - Fewer than preferred (1)
    - Actual number preferred (2)
    - More than preferred (3)
    - Don't know (4)

62. How do you primarily find your doula clients? Check all that apply:

☐ Personal website (1)
☐ Professional doula organization website/registry (2)
☐ Word-of-mouth (3)
☐ Other online forums (4)
☐ Telephone (5)
☐ Health care providers and institutions (6)
☐ Community-based programs (7)

63. What type of doula practice are you a part of? (check all that apply)

☐ Solo practice (1)
☐ Group practice with 2-4 doulas (2)
☐ Group practice with 5+ doulas (3)
☐ Hospital-based practice (4)
☐ Clinic-based practice (5)

64. How often do you charge clients for your doula services?

    - Always (1)
    - Sometimes (2)
    - Never (3)

65. How much do you currently charge ($USD) per client for (check all and type amount):

☐ Birth doula (1) _____
☐ Postpartum doula (2) _____
☐ Prenatal doula (3) _____
☐ Abortion doula (4) _____
☐ Full Spectrum doula (5) _____
☐ Radical/Justice doula (6) _____
☐ Death/Grief/Loss/Bereavement doula (7) _____
☐ Prison doula (8) _____
☐ Other (Specify) (9): _____

66. Do you plan on charging for your doula services in the future?

- Always (1)
- Sometimes (2)
- Never (3)

67. How much do you think you should be paid (ideally, in order to reach standard of living) per client for (check all and type amount):

☐ Birth doula (1) _____
☐ Postpartum doula (2) _____
☐ Prenatal doula (3) _____
☐ Abortion doula (4) _____
☐ Full Spectrum doula (5) _____
☐ Radical/Justice doula (6) _____
☐ Death/Grief/Loss/Bereavement doula (7) _____
☐ Prison doula (8) _____
☐ Other (Specify) (9): _____

Doula Services During COVID

68. In what ways have you and your work been affected by COVID-19? (Check all that apply)

☐ Stopped taking on clients (1)
☐ Unable to accompany clients in the delivery room (2)
☐ Limited prenatal and postpartum visits (3)
☐ Increase in client home births (4)
☐ Use of protective equipment (i.e., masks, gloves) when working with clients (5)
☐ My work has not changed as a result of COVID-19 (6)

69. Are you interested in providing doula services virtually (i.e., video and phone calls)?

☐ Yes (1)

☐ No (2)

70. Have you provided virtual doula services?
☐ Yes (1)
☐ No (2)

71. Have you provided doula services virtually during the COVID-19 pandemic?
☐ Yes (1)
☐ No (2)

Skip Pattern: Continue to Virtual Doula questions if YES to providing virtual doula care, skip to Beliefs about Doula Services if NO

Virtual Doula Services During the Pandemic

72. How many clients have you served virtually since the onset of the pandemic? _____

73. Do any of your clients have difficulties accessing the internet?

☐ Yes (1)
☐ No (2)
☐ Unknown (3)

74. How do you connect with your clients virtually? (check all that apply)
☐ Video calls (Zoom, Microsoft Teams, Facetime) (1)
☐ Phone (2)
☐ Other (3): Specify _____

75. (If Video Calls is selected) What platform do you use for video calls?
☐ Zoom
☐ Skype
☐ Teams
☐ Other: Specify _____

Beliefs about Doula Services

76. For each of the following, mark the answer that you most closely agree with.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I believe current pricing of doula services helps me to provide doula services.					

I believe current pricing of doula services helps my clients access doula services.					
I believe current insurance coverage of doula services helps me to provide doula services.					
I believe current insurance coverage of doula services helps my clients access doula services.					
I believe current doula training helps me to provide doula services.					
I believe current doula training helps my clients access doula services.					
I believe current doula certification requirements help me to provide doula services.					
I believe current doula certification requirements help my clients access doula services					
I face challenges in starting my doula business.					
I face challenges in building my client base for my doula business.					
I face challenges in making enough profit to continue my doula business.					

Possible Changes for Doula Service Reimbursement

77. How interested would you be in Medicaid reimbursement for your doula services?

☐ Not interested at all
☐ Mostly uninterested
☐ Neutral
☐ Somewhat interested
☐ Very interested
☐ Mixed feelings (Explain: _____)

78. How interested would you be in Georgia doulas being classified as Community Health Workers who are reimbursed through Department of Public Health?

☐ Not interested at all
☐ Mostly uninterested
☐ Neutral
☐ Somewhat interested
☐ Very interested
☐ Mixed feelings (Explain: _____)

Appendix IV: Codebook

Code	Descriptions	Exclusion Criteria	Notes
Background	Description of work before becoming a doula, training before being a doula, reasons for becoming a doula		
Training	Training that doulas received to develop or expand their doulas skills and services		Possible double code with doula scope and building doula business, this includes any additional training they gained along their careers
Doula Scope of Work	Scope of doula services and the skills they apply to those services	Labor support work prior to training or awareness of doula work	Double code with misconception if mention that people have misconceptions about the scope of doula care
Prenatal/birth	Doula's prenatal and birth services		
Post partum	Doula's post-partum services		
Other	Other doula services		
Home Births	Doulas support their clients during their home births		Double code with COVID impact if mentions attending home births during COVID
Virtual Services	Services doulas provide to clients through virtual methods such as the phone, Zoom, facetime etc.		Possible double codes: Scope subcodes, benefits subcodes, Covid
Family Planning Counseling/Services	Doula's family planning/contraception services including counseling, education, referrals, etc.		This includes services and counseling for abortion and Plan B
Building doula business	use when doulas describe building their businesses		
Mentorship through networking and partnerships	Doula looked for a mentor or started a mentorship, attended networking events, reached out to other birth workers, or reached out to businesses in the health and wellness field, and partnered with other doulas to form or join a group/collective/agency	all mutually benefit	
Social media	Doula use social media to build her doula business		

Underserved Populations	Populations doulas mentioned have difficulties accessing doula care		
Ethnic minorities	Includes immigrants and refugees who have difficulty accessing doula care		this might be linked with discrimination code
Rural communities	individuals living in rural communities who have difficulty accessing doula care		
Sexuality/Gender identity	Specific sexuality or gender identity (LGBTQIA+) that has difficulty accessing doula care and other specific needs		
Sliding Scale Payment	How doulas ensure they are paid or compensated for their services. (ex-payment plans) including bartering (nonmonetary compensation) and pro bono (free services)		Double code with challenges if mentions that making money as a doula is difficult or clients have difficulty affording services, can include grants for doula work
COVID impact	Changes in service delivery that doulas have encountered in response to COVID		Possible double codes with challenges, payment accommodations, client stories, doula scope (if added or changed services)
Hospital protocol	Hospital COVID OB/GYN and L&D protocol, abortion clinic protocol, and other medical facilities protocols related to doula care		Double code with challenges if protocols restricted doulas from entering the hospital
Challenges	Challenges doulas encounter in providing services and building/sustaining their business		
Demanding Schedule	Emotional and physical difficulties associated with being on call and long and demanding births		Double code with partnerships with other doulas if mentions that the demanding schedule led to the partnership
Medical model of birth	Frustration with medical model of birth that is at times incongruous with emerging research		Ex. include not letting birthing people eat during birth, C-sections for non-emergencies
Doula Misconceptions	Misconceptions providers, clients or the public have about the doula scope of work and access		Possible double code with payment (ex. doulas are a luxury item/too expensive)
Abortion Stigma	Feeling stigmatized for offering abortion services		
Client stories	Stories doulas have about their experiences with clients including birth stories		Can be double coded with many other codes, these stories may include cycles of violence
Negative experiences with healthcare team	combo of neglect and violation of patient autonomy	negative experiences with the doula themself	
Relationship w/Clients	How doulas build relationships with clients and describe those relationships with clients who are the same/different race as themselves		
Benefits of Doula Care	Benefits of doula care for pregnant women		
Education	Education about what is going on throughout the preconception, pregnancy, and post-partum period	Not the same as awareness	

		of doula services	
Advocacy/Empowerment/Catalyst for movement and accountability	Doulas advocating for their clients (advocacy) or doulas giving their clients the tools to advocate for themselves (empowerment) including doulas helping amplify the needs of their client (for example because they have different social positionality)		Includes examples of when doula gets the chain of action moving for example raising the alarm or amplifying the concerns of their patient
Support	Doulas providing emotional and physical support with clients throughout their time in the doula's service		
Medical/Mental Health Outcomes	Any mention of medical outcomes during preconception, pregnancy, L&D, and the postpartum periods		Possible double codes: Training, Benefits of doula care subcodes, medical model of birth
Ways to improve or expand doula care	Ways to improve doula care in Georgia		Can include grants for doula services, having doula care covered of reimbursed by Medicaid or insurance, including statements about the Medicaid doula pilot by HMHB, Having legislation or meeting with legislators about doula care
Provider Collaboration/Interaction	Providers incorporating or acknowledging that doulas are a part of the birth team, also includes discussion of negative or positive interactions that medical providers have with doulas		Double code with challenges if doula mentions that not having provider collaboration is an issue
Awareness/education of doula services	When the doula mentions the need, benefit of, and ways to increase awareness and education about doula services	Not education doulas provide to clients	Possible double codes: provider collaboration (includes saying providers such tell patients about doula care), ways to improve doula care
Discrimination	Mention of any kind of discrimination that doulas/clients experience		
Doula racial discrimination	Mentions of racial discrimination that doulas may experience at the hands of clients, the medical care team, etc.	Not the same as doula discrimination	
Doula Discrimination	Mentions of discrimination because of the doula role and not for other reasons		
Discrimination against Black clients	Doulas describing discrimination they have witnessed against their Black clients		
Cultural Sensitivity/Humility/Competency	doula mentions incorporating cultural practices into the provision of care (i.e., rituals, culturally specific knowledge)		
Language	Apply when participant talks about language-related issues, including lack of translation or interpretation and need for additional dialects of a given language; Also use when shared language is a benefit		Double code with discrimination as needed
Cultural traditions and norms	Apply when participants talk about cultural norms of their clientele		