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Shelby L. Crosier Date

“Part mother, part sister, part champion, part coach”: Doulas’ perspectives on their roles in supporting lactation and hospital birth

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Bachelor of Science in Public Health

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2017

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“Part mother, part sister, part champion, part coach”: Doulas’ perspectives on their roles in supporting lactation and hospital birth

By Shelby L. Crosier

Birth doulas provide continuous support to their clients throughout the perinatal period. They improve health outcomes for birthing people, including facilitating near-universal breastfeeding initiation and reducing instances of medical interventions like emergency c-sections during birth. These outcomes are consistent regardless of sociodemographic factors like a client’s racial or ethnic background. Despite this, doulas often do not feel accepted by healthcare providers and able to fully perform their jobs when working in the hospital setting. This study aims to understand doulas’ perceptions of their role in supporting lactation and working alongside healthcare providers to support births in the hospital setting. Data were collected through 14 semi-structured in-depth interviews with doulas currently living and working in the Atlanta Metro Area, which were recorded, transcribed, and de-identified. Themes were generated using a thematic analysis approach. Three major themes were identified: the role of the doula in lactation support, the role of the doula in supporting hospital births, and the effect of doula-healthcare provider relationships. These themes were explored and described through the lens of person-centered care outcomes as presented in the Person-Centered Care Framework for Reproductive Health Equity. Doulas provide person-centered, compassionate care to birthing people. However, they face barriers to providing their vital services in the hospital setting. Hospital systems should explore ways to increase acceptance of doulas by providers and incorporate doulas into their birth teams. Legislators and advocates should continue to push for greater structural support for doulas, such as Medicaid reimbursement of doula services.

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Chapter 1: Introduction

Introduction and Rationale

Birth doulas are non-medical birth support professionals trained, either formally or informally, to give emotional and physical support, as well as information, to clients before, during, and after birth (DONA International, n.d.; Hunter, 2012). The support given by doulas to their clients can look very different depending on the doula themselves and their background and training, their client's preferences and background, and the setting they are in (for example, in clinical setting or a client's home). Commonly, doulas provide information sharing, mediation for birthing people leading up to and during labor, encouragement, and physical comfort measures such as massage and breathing techniques (Hunter, 2012; Steel et al., 2015). Doulas' presence and continuous support during a birth has improved outcomes for both birthing persons and their babies. Some of these positive outcomes include shorter labor, reduced rate of caesarean section, reduced rate of epidural use, and higher five-minute Apgar scores (Bohren et al., 2017; Gruber et al., 2023; Hunter, 2012). Use of a doula throughout the prenatal period and during birth has also been shown to improve breastfeeding rates (Gruber et al., 2013; Kozhimannil et al., 2013a).

Breastfeeding is the optimal source of nutrition for infants (Lessen & Kavanagh, 2015). The American Academy of Pediatrics and World Health Organization (WHO) recommend exclusive breastfeeding for about the first six months of age, with continued breastfeeding along with complementary feeding (a practice in which lactating individuals continue to breastfeed while introducing solid foods) for up to two years of age or longer (Meek et al., 2022). Even if an individual does not practice exclusive breastfeeding, any breastfeeding is protective for both members of the mother-infant dyad. It has been shown to reduce infants' risk of sudden infant

death syndrome (SIDS); lower women's risk for certain cancers, type 2 diabetes, and hypertension; and promote bonding and attachment between parent and baby (Centers for Disease Control and Prevention [CDC], 2023a). Despite these well-known benefits, breastfeeding rates in the United States (U.S.) lag behind many other countries (WHO, 2022). Although 83.2% of U.S. babies are breastfed for some duration of time, less than 25% exclusively breastfeed for six months, and only 35.9% are still being breastfed at all at one year. There is also a significant racial disparity in breastfeeding rates in the U.S.; while 85.3% of non-Hispanic white babies are ever breastfed, only 74.1% of non-Hispanic Black babies are (CDC, 2023b). This is despite both non-Hispanic white and non-Hispanic Black birthing people not having differences in their intention to breastfeed before birth (Hamner, et al., 2021).

Doulas have been shown to increase breastfeeding rates in their clients, especially in minoritized women. The period directly leading up to and following a birth is crucial for the planning for and initiation of breastfeeding, and having a doula present at a birth increases the chances that a birthing person will successfully initiate breastfeeding, a fact which holds true across all racial and ethnic groups (Acquaye & Spatz, 2021; Gruber et al., 2013; Kozhimannil et al., 2013a). Doulas can also be advocates during the birth process, which has been shown to be especially true and important for minoritized birthing people. It is common for Black and other minoritized women to feel mistreated or disrespected by the healthcare system, and birth is no exception to this (Arteaga et al., 2022; Vedam et al., 2019). In fact, about 30% of birthing people from Black, Hispanic, and multiracial backgrounds report mistreatment during the course of their maternity care (Mohamoud, et al., 2023). A doula can be a vital support for new parents to prepare and assist them in exercising their autonomy, navigating the medical system, and feeling safe and respected (Arteaga et al., 2022; Cattelona et al., 2015; Kozhimannil et al., 2016). Doulas

also can offer a sense of connectedness to culture, community, and tradition; this allows their clients to gain access to resources and honor birth practices that are important to them, further exercising their autonomy (Kang, 2014).

In spite of the crucial role that doulas hold for many families during the birth process, they often find themselves feeling like outsiders on maternity care teams when attending hospital-based births. Where a healthcare professional such as an International Board Certified Lactation Consultant (IBCLC) may be able to give input, be consulted by the medical team, and perform their duties without pushback or questioning, doulas are often not respected, despite years of training and experience (Torres, 2013). This is contrary to the numerous benefits that arise from doulas acting as integrated members of maternity care teams. New parents often stop breastfeeding in part due to conflicting messages they receive from different members of their medical team (Louis-Jacques et al., 2022). To that end, better cohesion between doulas and other healthcare providers in the hospital setting could result in decreases in early termination of breastfeeding. In fact, increased integration of doulas into interdisciplinary healthcare teams not only has been shown to lead to a ten-fold increase in rates of breastfeeding initiation, but also lower rates of caesarean section and epidural use (Thurston et al., 2019).

Purpose Statement

Although there has been some research into doulas' perceptions of their roles in and effect on lactation support and integration into maternity care, there has yet to be in-depth research into the intersection of those factors. The purpose of this study is to further a growing body of research about doulas, their role, and their impacts on the health and well-being of birthing people and their babies. By exploring the unique role that doulas serve in supporting their clients through many stages of the prenatal, birth, and postpartum periods, the positive

impact of the profession can be better understood and recognized. This study will assess doulas' perspectives on what their role is in lactation support and how they perceive their work in interdisciplinary teams of healthcare providers during hospital-based births. The results of this study may, in the future, inform practices, policy, or programs to support doulas and the care that they impart and make them more accessible to more birthing people.

Research Aims

This qualitative research study explores the experiences of doulas living and working in the Atlanta Metro Area (AMA) in providing lactation support to their clients and working with interdisciplinary teams of healthcare providers in the hospital setting. Informed by the Person-Centered Care Framework for Reproductive Health Equity, this study aims to:

1. Understand how doulas perceive their role in providing lactation support to their clients
2. Describe the experiences of doulas working alongside healthcare providers, and their perceptions of their role in the hospital setting

Significance Statement

In recent years, there has been a growing body of literature centered on doulas and their work, experiences, and effect on health outcomes, including breastfeeding outcomes (Acquaye & Spatz, 2021; Arteaga et al., 2022; Cattelona et al., 2015; Chor et al., 2012; Crawford et al., 2023; Falconi et al., 2022; Gruber et al., 2013; Kozhimannil et al., 2013a; Kozhimannil et al., 2013b; Kozhimannil et al., 2016; Mosley et al., 2023; Sayyad et al., 2023; Sobczak et al., 2023). However, there is a lack of research which uses the experiences and perspectives of doulas themselves to contextualize these outcomes in relation to how they see their role in care, specifically in the AMA and Georgia at large. Given Atlanta's location in a state which has one of the highest maternal mortality rates in the country (National Center for Health Statistics

[NCHS], 2021), and where Black women are about three times more likely to die from pregnancy-related complications than their white counterparts (Center for Reproductive Rights, 2019), it is critical to understand how doulas can play a part in improving this landscape. By hearing in doulas' own voices the part they play in uplifting birthing people in their health, advocating for them, and equipping them with the necessary tools to have a healthy pregnancy, birth, and postpartum, the profession itself can be further uplifted.

Theoretical Framework Overview

The theoretical framework guiding this study is the Person-Centered Care Framework for Reproductive Health Equity (PCCFRHE). This framework, developed by Sudhinaraset et al. (2017), builds on previous work in Person-Centered Care (PCC) to describe multilevel factors that impact quality of care and reproductive health outcomes. The three levels at which this framework operates are societal and community determinants of health equity, such as health systems, gender norms and roles, and stigma and discrimination; health-seeking behaviors; and facility quality, which encompasses the interplay between provision of care and person-centered outcomes. The person-centered outcomes are the eight domains of person-centered reproductive health care (PCRHC) defined by this framework: dignity, autonomy, privacy/confidentiality, communication, social support, supportive care, trust, and health facility environment. This thesis, working within the context of doula care, touches on all domains, with a strong emphasis on autonomy, social support, dignity, and supportive care. Past studies using this framework have focused mostly on abortion care and hospital births (Baum et al., 2023; Nakphong et al., 2023; Seymour et al., 2023), and there is room for application of this theoretical framework to PCC in the lactation space as well given the importance of the framework's domains for high-quality

breastfeeding education and support. This thesis explores the interplay of PCC, doula-provider interactions, and lactation through the lens of PCCFRHE.

Definition of Terms

Atlanta Metro Area (AMA): Consists of Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties (Emory University, 2023).

Birthing person: "Someone who gives birth, regardless of their gender identity, which may be female, male, nonbinary, or other." (Brooks, 2021).

Certified Lactation Counselor (CLC): CLCs are professionals in lactation counseling who have demonstrated receipt of 45 hours of lactation education and who possess the necessary skills, knowledge, and attitudes to provide breastfeeding counseling and management support to families who are thinking about breastfeeding, who have questions, or who have problems during the course of lactation (Healthy Horizons, 2020).

Doula*:* In this study, refers to "a trained professional who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible" (DONA International, n.d.).

International Board Certified Lactation Consultant (IBCLC): Allied healthcare providers certified by an international body who have obtained 300 to 1000 hours of clinical practice, 90 hours of lactation education, and have passed an examination. They are the only lactation professionals able to have services reimbursed by insurance companies in the US (Healthy Horizons, 2020).

Minoritized people*:* An alternative to using the term “minorities”, which can be stigmatizing and inaccurate. This refers to people belonging to racial and ethnic minority groups (JAMA Network, n.d.).

Chapter 2: Review of the Literature

Introduction

This chapter provides an overview of literature relating to doulas, lactation, healthcare, and their interplay in the United States. It first defines doulas and their role and lays out the current state of lactation in the country and in Georgia. Then, the positive effects doulas have on birth outcomes (including breastfeeding rates) are addressed, as well as previous literature about interdisciplinary maternity teams involving doulas. Finally, the theoretical framework guiding the thesis is discussed.

The Role of the Doula

A birth doula is a support person, outside of a friend, family member, or other loved one, who provides labor support to a birthing person (Gilliland, 2002). These can be individuals with formal or informal training, who may or may not carry a certification from a training program. Among the most widely known and used of these certification programs are those from DONA International, Childbirth and Postpartum Professional Association (CAPPA), Childbirth International (CBI), and the International Childbirth Education Association (ICEA); these also tend to be the training programs recognized by most programs which offer Medicaid reimbursement for doula services (Chen & Rohde, 2023). In the U.S., the majority of doulas are between 30 and 40 years old, operate in solo practices, and attend four to 11 births per year (Steel et al., 2015). Support from doulas can come at any point in the perinatal period, including prenatally, during labor and birth, and postpartum (Gilliland, 2002; Steel et al., 2015). In more recent years, doula practice has expanded to include other critical moments in an individual's reproductive health; for example, there has been an emergence of abortion doulas (Chor et al., 2012).

How exactly a doula provides support to a birthing person can vary based on the doula and their training, the client's preferences, and at what point during the perinatal period they are working together. During the prenatal period, a doula may share information and education about childbirth, help their client create a birth plan, or connect them with other helpful resources to cover needs or gaps in care (Gilliland 2002; Mosley et al. 2023; Steel et al., 2015; Wint, 2019). During birth, doulas use both physical and emotional support methods to assist their clients. Physical labor support can include things such as helping the birthing person to switch positions or walk around, practicing breathing techniques, or physically holding them during birth (Gilliland 2002; Hunter, 2012; Mosley et al., 2023). Emotional support can take many different forms but could include encouraging words, support and direction to partners and family members present at birth, and presence and companionship (Hunter, 2012; Kozhimannil et al., 2016). This emotional support dimension of doula care, in combination with relationship building and the intimacy that it brings, is often seen by both doulas and their clients as one of the most important aspects of doula care, and one of the reasons that doulas are such effective caregivers (Hunter et al., 2012; Steel et al., 2015).

Doulas often act as a "translator" between healthcare providers and their clients, ensuring that their client understands medical terminology and suggestions made by doctors and nurses, so that they can make informed decisions about their care (Arteaga et al. 2022; Cattelona et al., 2015; Kozhimannil et al., 2016). Sometimes this translator role can also take on a more literal linguistic and cultural meaning. Cultural and linguistic barriers and provider bias can greatly reduce minoritized people's ability to self-advocate for themselves during labor (Sayyad et al., 2023). Minoritized people, including immigrants, often do not feel that they have the necessary skills to navigate the medical system and often feel they receive lesser treatment when giving

birth. In these instances, doulas can be important navigators, offering additional context, appropriate communication, support, and advocacy (Arteaga et al., 2022; Kang, 2014; Kozhimannil et al., 2016; Wint et al., 2019). When doulas and their clients share similarities in their racial, ethnic, or cultural backgrounds, it increases affinity and comfort, helping birthing people feel understood and empowered (Arteaga et al., 2022; Maher et al., 2022; Kang 2014). All of this allows birthing people to feel increased agency and respect in a setting where they may not have otherwise.

The State of Lactation in the United States

Breastfeeding is recommended exclusively for the first six months of an infant's life and in combination with solid foods thereafter until a child is two years old (Meek et al., 2022; Office of the Surgeon General [OSG], 2011). This is because of the myriad of health benefits that breastfeeding provides to not only infants, but their lactating parent as well. Children who are breastfed have a lower risk of sudden infant death syndrome (SIDS) and stronger bonding and attachment with their parent (CDC, 2023a; Ip et al., 2007). Women who breastfeed have been shown to have reduced levels of postpartum depression and anxiety, ovarian and breast cancers, endometriosis, and cardiovascular diseases, among others (Del Ciampo & Del Ciampo, 2018). Both members of the mother-infant dyad have lower rates of obesity, type 2 diabetes, and hypertension later in life, which has profound impacts on long-term public health (Binns et al., 2015; Ip et al., 2007).

Healthy People 2030 has set goals for the U.S. to increase the proportion of infants being exclusively breastfed to six months to 42.4%, and the proportion of infants breastfed at one year to 54.1% (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). In 2020, although 83.1% of U.S. infants were ever breastfed (meaning breastfeeding was at least initiated), only

25.4% were exclusively breastfed until six months, and 37.6% were breastfed at all through one year of age (CDC, 2023b). This shows that the U.S. currently falls short on Healthy People 2030 goals relating to both exclusivity and duration of breastfeeding. In 2019, the most recent year for which state-level data are accessible, Georgia's breastfeeding rates lagged slightly behind the U.S. at large on most metrics. In that year, 82.6% of infants in Georgia were ever breastfed, which was mostly on par with the national rate of 83.2%; however, the six-month exclusive and 12-month breastfeeding rates in the state were 18.7% and 33.7% respectively, compared to the national rates of 24.9% and 35.9% (CDC, 2022). Breastfeeding exclusivity at six months is the indicator where Georgia is the farthest behind the rest of the country.

Breastfeeding rates and challenges are not equal across the U.S. or between different groups in the country. Well-defined social determinants of breastfeeding include but are not limited to educational attainment, employment status, food access, housing status, and neighborhood safety. Lower breastfeeding initiation and duration are associated with food insecurity, lack of housing stability, shorter maternity leave, fewer workplace protections for pregnant and breastfeeding individuals, and living in a dangerous neighborhood. However, education is a well-known protective factor for breastfeeding, with higher levels of educational attainment tending to coincide with higher rates of breastfeeding (Kopp et al., 2023; Standish & Parker, 2022).

One very notable disparity is between racial and ethnic groups. Non-Hispanic Black women have the lowest breastfeeding rates across the board (including initiation, continuation at six months, and continuation at 12 months) and are 2.5 times less likely than Non-Hispanic White women to ever breastfeed. American Indian/Alaskan Native have the second lowest rates of breastfeeding exclusivity and initiation (Chiang et al., 2021; Jones et al., 2015). Hispanic

individuals of any racial background tend to have the highest rates of breastfeeding initiation and duration, though not exclusivity; however, these rates are different between groups with different countries of origin and tend to be higher in less acculturated individuals (Beck, 2006; Jones et al., 2015). These trends tend to hold true in Georgia, especially between Black and white individuals, whose breastfeeding initiation rates in 2019 were 77.0% and 84.5%, respectively (Chiang et al., 2021). Much of the disparity between racial and ethnic groups can be explained by the history of structural racism in the United States creating barriers for minoritized people. Structural racism is an underlying cause to many of the social determinants of breastfeeding, which tend to affect minoritized individuals much more frequently than white individuals and contribute greatly to the differences seen in breastfeeding rates between racial groups (Standish & Parker, 2022).

There are well-documented barriers and facilitators to breastfeeding for parents. Some barriers include physical issues like pain and problems latching, social norms not being supportive of breastfeeding, lack of knowledge and information about breastfeeding, workplace policy and culture not supporting breastfeeding, and lack of family and social support (Cohen et al., 2018; Jones et al., 2015; OSG, 2011). Conversely, having adequate education about breastfeeding and its benefits, having a workplace that supports breastfeeding and offers adequate maternity leave, and having adequate social support are proven protective factors for breastfeeding (Cohen et al., 2018; Morse & Brown, 2022; Viera et al., 2021). Specifically for early breastfeeding initiation in the hospital setting, facilitators include vaginal delivery versus delivery by cesarean section, and immediate skin-to-skin contact and rooming-in post-delivery (Cohen et al., 2018).

Doulas' Effects on Health Outcomes

Doulas positively impact a variety of maternal and infant health outcomes. One of the most important and common findings about doulas' impact on health outcomes is the lower likelihood of intervention during birth. Birthing people accompanied by doulas during labor are less likely to use epidurals, require emergency c-sections, or need instrumental assistance during vaginal delivery (Bohren et al., 2017; Falconi et al., 2022; Gruber et al., 2013; Hans et al., 2018; Kozhimannil et al., 2013b; Sobczak et al., 2023). This is significant because c-sections are associated with risks to both the birthing person and the infant, such as increased chance of bleeding, risks to future pregnancies, and increased risk of asthma and obesity in the child (Keag et al., 2018). Having a doula present at birth is also associated with shorter labor, higher birth weight, fewer preterm births, reduced risk of hypertension, and lower maternal stress and anxiety (Crawford et al., 2023; Falconi et al., 2022; Gruber et al., 2013; Sobczak et al., 2023).

In the U.S., Black women are three times more likely to die from pregnancy and birth-related complications than white women (CDC, 2023c), and Black infants are over two times more likely to die in their first year of life than white infants (NCHS, 2022). However, doula care benefits have been shown to have equal impact on birthing people, regardless of race or ethnicity (Falconi et al., 2022; Kozhimannil et al., 2013a). Using a doula, then, can be an evidence-based practice to help even the playing field and protect the health of Black and other minoritized birthing people and their infants. In states such as Georgia, which not only has one of the highest maternal mortality rates in the country but also see Black women dying at almost three times the rate of white women (Healthy Mothers, Healthy Babies Coalition of Georgia, 2022), support providers such as doulas are especially critical.

There is also a positive association between doula care and breastfeeding rates. Individuals who use doulas during the perinatal period and especially during pregnancy have higher breastfeeding initiation rates, with some studies showing almost universal breastfeeding initiation for birthing people who used doula services (Acquaye & Spatz, 2021; Gruber at al., 2013; Hans et al., 2018; Kozhimannil et al., 2013a; Mottl-Santiago et al., 2008). Although more research still needs to be done to more fully understand the effect of doulas on breastfeeding outcomes, the increase in breastfeeding intent and initiation when working with a doula is very promising.

Doulas and the Healthcare System

Despite proven benefits to both birthing parents and infants of doulas being integrated into hospital teams during birth (Thurston et al., 2019), doulas often face challenges in the hospital setting. The American College of Obstetricians and Gynecologists (ACOG) recommends continuous labor support, such as doulas, during births as a strategy to limit interventions and poor health outcomes (ACOG, 2018). However, there are varying levels of acceptance of doulas by healthcare providers (HCPs). Many times, HCPs, especially labor and delivery (L&D) nurses, have positive attitudes about doulas and see them as valuable assets due to the relationships they have with clients, and the ongoing support they are able to provide (Deitrick & Draves, 2008; Neel et al., 2018; Roth et al., 2016). Negative attitudes about doulas from HCPs are mainly driven by experiences where doulas tried to interfere with clinical decision making, work outside of their scope, or misinterpret medical results to their client. This can leave HCPs feeling like the enemy, or like their intentions are being miscommunicated to clients (Neel et al., 2018).

Doulas, on the other hand, often feel a lack of respect or feeling like a true member of the maternity care team when they are working in the hospital setting (Adams & Curtin-Bowen, 2021; Torres 2013). In order to gain more acceptance, they often must strategize to appease HCPs. This can include emphasizing the supportive role they play which HCPs themselves do not have time for (Torres 2013), and adopting non-confrontational, deferential, or subordinate behavior toward physicians (Adams & Curtin-Bowen, 2021).

One proposed way to improve working relationships and attitudes between doulas and HCPs is to increase exposure and time working together, as attitudes tend to become more positive with more exposure (Lucas & Wright, 2019; Roth et al., 2016). Other proposed tactics include ensuring that introductions between doulas and HCPs happen outside of the birth room, education for all parties that includes clarification of roles and training, joint conferences and meetings to increase familiarity with each other's work, and commitment to mutual respect for each other's professions (Neel et al., 2018; Roth et al., 2016). More research is still needed into the interplay of doulas in the healthcare system in Georgia specifically.

The Person-Centered Care Framework for Reproductive Health Equity

The Person-Centered Care Framework for Reproductive Health Equity (PCCFRHE) is a relatively new theoretical framework which builds upon previous research on person-centered care, quality of care, and reproductive justice to improve reproductive healthcare (Sudhinaraset et al., 2017). The Institute of Medicine called for person-centered care (PCC) as early as 2001, listing it as an essential improvement aim for the American healthcare system and defining it as "providing care that is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine & Committee on Quality of Health Care in America, 2001). McCormack and McCance (2006) then

proposed a framework for person-centered nursing, focusing on constructs which lead to person-centered outcomes, or the results of effective PCC. PCCFRHE uses these concepts as the base for its definition of PCC, which is expanded through understandings shaped by additional frameworks focused on reproductive health outcomes and equity.

One such framework is the World Health Organization's (WHO) Quality of Care framework for maternal and newborn health. This framework defines PCC as an outcome in and of itself, conceptualizes PCC in the context of reproductive health for mothers and infants, and describes the bidirectional relationship between the provision of care and a patient's experience of care (Tunçalp et al., 2015). This is an important building block for the quality of care as described in PCCFRHE. Another essential dimension to PCCFRHE is societal and community determinants of health, which is heavily grounded in Cultural Health Capital (CHC) theory. CHC posits that cultural resources, behaviors, past experiences, and values affect patient-HCP interactions and health outcomes (Dubbin et al., 2017). In situations of historical inequalities and in the context of reproductive health, where factors such as gender norms and violence against women must be considered, CHC is a crucial element of achieving the outcome of PCC.

With this context and theoretical grounding in mind, Sudhinaraset et al. (2017) propose the following eight domains of patient-centered care outcomes: dignity, autonomy, privacy/confidentiality, communication, social support, supportive care, trust, and health facility environment. This thesis focuses primarily on the domains of autonomy, social support, dignity, and supportive care, and the ways in which doulas are poised to uplift these patient-centered care outcomes.

PCCFRHE defines autonomy as the implication that "providers of health services respect women's views of what is appropriate and support women, her family, and companion of choice

to make informed choices" (Sudhinaraset et al., 2017). Interventions targeted at increasing autonomy of patients during birth have been some of the most common types of PCC interventions, and also some of the most effective at decreasing poor health outcomes and obstetric interventions (Rubashkin et al., 2018). Doulas can play a vital role in increasing the autonomy of birthing people during labor. The presence of a doula at birth is felt by many birthing people to help increase their agency and the respect they receive for their decisions during birth, especially for minoritized individuals, and many doulas see this as a crucial component of their job (Hunter 2012; Kang, 2014; Kozhimannil et al., 2016; Maher et al., 2013). This is also important to the domain of autonomy, defined by PCCFRHE as "the ability of women to receive care in a respectful and caring setting" without mistreatment or disrespect from providers or other professionals with whom they interact (Sudhinaraset et al., 2017).

Social support as a domain of PCCFRHE is defined as "the extent to which women have access to their companion of choice when receiving care" (Sudhinaraset et al., 2017). Social support interventions—whether utilizing group sessions, male partner involvement, or doula presence at birth— generally have positive results in obstetric outcomes and patient comfort and satisfaction (Rubashkin et al., 2018). Social support through continuous labor support is a defining characteristic of the role of the doula, and through that role they are also able to offer supportive care. This domain is defined within the framework as "providers providing care in a timely, compassionate and caring manner, as well as integration of care in a way that is responsive to patient needs", and also includes patient safety and protection from harm (Sudhinaraset et al., 2017).

Another important aspect of this domain is culturally responsive care, which has been under-studied within the field of PCC interventions (Rubashkin et al., 2018). Doulas are vital

players to bridge the gap between patients and providers in providing adequate, responsive, and culturally appropriate care, which uphold the domain of supportive care. Especially when doulas come from the same background as their clients, they consistently have been shown to improve birthing experiences, especially of minoritized people, navigate the medical system, and receive the care that they need during labor and birth (Arteaga et al., 2022; Mosley et al., 2023; Wint et al., 2022). Thus far, these concepts have not been used to study doulas roles in PCC regarding lactation, and this thesis will explore those topics through the PCCFRHE lens.

Chapter 3: Methodology

Introduction

Semi-structured, in-depth interviews were used to explore the perceptions of doulas in the AMA on breastfeeding, their role in lactation support, and their role within interdisciplinary maternity care teams. This study received an exemption from the Emory University Institutional Review Board on July 7, 2023, under 45 CFR 46.104(d)(ii).

Study Design

This qualitative study involved 15 semi-structured, in-depth interviews with doulas residing and working in the AMA. The principal investigator (SC) conducted all interviews and used a semi-structured interview guide to facilitate discussion (Appendix A). Interviews were selected as the method of data collection in order to gain deep insight into the individual lived experiences of doulas and their approaches to their work. Questions in the interview guide centered around doulas' perceptions on barriers and facilitators to successful breastfeeding faced by clients, their experiences and views on their role in providing lactation support, their experiences working with interdisciplinary teams of healthcare providers in the hospital setting, and their experiences working with minoritized birthing people. The guide was informed by previous studies exploring similar topics, as well as pilot testing of the interview guide by the principal investigator during a previous class project. Following pilot testing with three AMA doulas, the guide was revised.

Sampling and Recruitment

Recruitment of participants for this study happened via email. The Georgia Doula Study research team at the Emory University Rollins School of Public Health Center for Reproductive Health Research in the Southeast (RISE) and Healthy Mothers, Healthy Babies Coalition of

Georgia (HMHBGA), led by Elizabeth Mosley, PhD, previously conducted interviews with doulas throughout the state of Georgia, and provided contacts at HMHBGA and Embrace Refugee Birth. Contacts then disseminated a recruitment email which included a brief overview of the study, a link to the demographic screening survey, and contact information for the PI (Appendix B). In addition, the PI used the online contact lists maintained by DONA International and CAPPA, two major doula training and certification associations, to reach additional potential participants.

Purposive sampling was used to recruit eligible individuals from those who completed the demographic screening survey. The survey covered basic background, eligibility, and demographic information, and could be completed in approximately 3 minutes (Appendix C). To be eligible to participate in the study, an individual must have been actively working as a doula at the time of recruitment; residing and working as a doula in the AMA; and practicing as a doula in Georgia for a minimum of six months. Individuals must not have been practicing as CLCs or IBCLCs. The PI followed up with interested and eligible potential participants via email to schedule interview times.

Data Collection Procedures

Fourteen semi-structured, in-depth interviews were conducted over Zoom and lasted between 45 and 60 minutes. All interviews were conducted by the PI. Prior to the interview, participants were asked to electronically sign a consent form. Additionally, at the start of the interviews the PI read through the consent script and obtained verbal confirmation of consent to participate and be recorded. As previously detailed, an interview guide was used to guide the discussion, and the PI also used probes to draw out additional information and explore topics as necessary. Interview questions relating to doulas' perceptions on breastfeeding and their role in

lactation support included, for example "*How do you support and counsel [clients] through [challenges]?"*, "*What do you see as your role in Lactation support?"*, and *"How does your role in supporting breastfeeding differ from others, such as an IBCLC or doctor?"* Interview questions related to doulas' experiences working with healthcare providers during hospital births included, for example *"How do you interact with the rest of the maternity care team (including doctors, nurses, midwives, lactation consultants) during a birth?"*, *"How do you advocate for your clients in the hospital setting?"*, and *"As a doula, what do you wish healthcare providers knew about doulas like you?"*. Each participant received a $50 electronic gift card for their participation after the conclusion of the interview.

Interviews were audio recorded on Zoom with participant permission. Trint, an AI-based transcription service, was used to transcribe interviews from their audio recordings. Additionally, the PI reviewed and edited the transcripts while listening to the audio recording to ensure accurate, verbatim transcription.

Data Analysis

After transcription, cleaning, and deidentification, all transcripts were uploaded into *MaxQDA 2022* (VERBI Software, 2021) for coding and management. Data were analyzed using a thematic analysis approach as outlined by Braun and Clarke (2006), encompassing six phases: familiarization, coding, generating initial themes, developing and reviewing themes, refining themes, and writing up. First, data were read during and after transcription for familiarization, and both deductive codes based on the in-depth interview guide and guiding theoretical framework, and inductive codes based on emerging topics in the data were generated into a codebook. Each interview transcript then had codes applied to relevant segments, based on the developed codebook. After coding is completed, the data within each code were examined to

determine initial themes. Subsequent review of codes and connections between them informed the process of refining and finalizing themes.

Chapter 4: Results

All 14 doulas who participated in this study were currently practicing doulas in the AMA. The majority (n=10, 71.4%) identified as Black or African American, with three (21.4%) identifying as white, and two (14.3%) identifying as mixed-race. Four doulas (28.6%) identified as Hispanic or Latino, regardless of race. The largest number of doulas (n=6, 42.9%) had been practicing for two to five years at the time of the interview. Four doulas (28.6%) had been practicing for six months to two years, three (21.4%) for five years or more, and one (7.1%) for less than six months. Although none of the doulas were CLCs or IBCLCs, some had participated in formal lactation support training without receiving a certification.

Through thematic analysis, three major themes were identified relating to the main research aims, including: (1) the role of the doula in lactation support, (2) the role of the doula in supporting hospital births, and (3) the effect of doula-healthcare provider relationships. These themes, as well as several related sub-themes, are explored below.

The Role of the Doula in Lactation Support

The doulas interviewed generally shared a view that although they do not have the clinical knowledge to support major lactation challenges such as mastitis or tongue tie, their role is still vital. Many referenced seeing themselves as a "*first line of defense*" to help their clients work through challenges before seeking out the help of an IBCLC or other healthcare provider, and all discussed seeing part of their role as knowing the signs to look out for that would necessitate a referral to a provider with more lactation management knowledge or specialized expertise, such as mastitis, severe engorgement, or tongue tie. Most doulas discussed this in the context of the importance of knowing their scope of practice—not diagnosing, assessing, or

supplementing, but giving non-clinical support and seeking additional help if a challenge is outside the scope of their knowledge and practice. One participant shared:

> *...we're there to make sure they have the most successful outcome. We may not always know how to get them to that outcome, but we stay with them until they get there.* (Black, two to five years of experience)

This sentiment was shared by many. For example, one participant described the difference between a doula and a healthcare provider in providing lactation support:

> *So I want to say that I'm more so the nurse when it comes to breastfeeding. And the lactation consultant is more so the doctor, they're going to come in, they're going to tell the diagnosis, they're going to tell you what's wrong. And I can't do all of that for them. I can just merely be support and give them resources.* (Black, two to five years of experience)

Giving resources to and educating clients about lactation during the prenatal period was commonly cited as a main lactation support activity for the doulas interviewed. Examples of this included talking about the benefits and potential challenges of breastfeeding, creating a breastfeeding plan, and practicing positions and holds to facilitate a good latch. Most also shared that they provided breastfeeding education to their clients' support people such as partners and family members as well.

Most doulas mentioned that they stay in the hospital with their clients for one to two hours after birth, until the baby has been able to latch for the first time, to give any necessary support. Some doulas felt comfortable being more hands on during this process, repositioning mom and baby or showing mom how to put their nipple in their baby's mouth to achieve a good latch. Other doulas felt that such support was outside of their scope or comfort level. Doulas who

had additional training in lactation support beyond their doula certification courses or had breastfed their own children tended to be more comfortable with that type of support. Some doulas reported that they schedule a check-in visit with their clients 24 to 48 hours after the birth, which often includes breastfeeding support.

Person-Centered Care

The doulas all demonstrated principles of PCCFRHE in their support of clients' breastfeeding to varying degrees, in particular the domains of autonomy, social support, supportive care, and dignity.

Autonomy manifested in the doulas respecting the choices of their clients around breastfeeding, including the choice to breastfeed or not, even if they did not personally agree with it. Most doulas mentioned having intake forms or meetings with new clients which include asking about breastfeeding intentions, as well as having conversations with their clients about hesitations they have about breastfeeding. Some mentioned that they would try to give more information to "*make breastfeeding look really good*" if the client stated an intention not to breastfeed or a hesitation, but also acknowledged that "*I can't make them do anything. I just kind of lead them with the information and it is what it is.*" Giving all of the information necessary for a client to make an informed choice about breastfeeding was important to many of the doulas, and they saw it as an important part of their role.

Some doulas also acknowledged that often there are factors outside of a client's control that affect their ability or desire to breastfeed, such as trauma or other mental health concerns. One doula stated:

> *I understand that sometimes other things come into play like sexual abuse and just other things that are very hard. So I consider those as well. Or maybe I even have some moms*

> *who like, you know, they have a really bad postpartum anxiety or depression. And they said this time around, because breastfeeding was so hard on me it caused that, so they're like, I'm not going to do it. So I'm very well aware of that. And I'm like, congratulations for treating yourself and knowing what's best for you, mom.* (Mixed-race and Hispanic/Latino, five or more years of experience)

Doulas frequently described respecting and celebrating their clients' choices and their ability to know what is best for their individual situation, especially in the face of mental health struggles. This respect also helped to uphold the dignity of their clients, which doulas also do through helping their clients feel comfortable with lactation and view it as a normal and acceptable practice. One doula shared that "*my role is basically to make them [her clients] feel comfortable with themselves*", which she and others do through methods such as sharing social media accounts that share photography of breasts and breastfeeding.

Doulas believed that recognizing a client's history in regard to health history, trauma, or mental health, and how that could impact their breastfeeding journey was also a critical piece of supportive care, as it allows doulas to be responsive to their clients' individual needs and provide compassionate care. Some doulas talked about going deeper in questioning to find out the "why" behind their clients' motivations, so that they can tailor their support to individual clients and not just "*give one-size-fits-all advice*". Many also mentioned being observant and attentive during postpartum check-in visits in order to provide the breastfeeding support a client needs at the moment they need it. One doula stated that if she is supporting or observing a lactation session during one of these visits:

> *...if I see the temperature in the room starting to rise, I'll be like, let's take a break. Like, I'll just rock baby, get baby to calm down, and kind of talk through things. Maybe*

> *demonstrate a better technique. And then we'll try again.* (White and Hispanic/Latino, six months to two years of experience)

The social support offered during these check-in visits, both prenatally and postpartum, was often cited by doulas as one of the most important aspects of their role in supporting breastfeeding. Almost all of the doulas interviewed talked about giving encouragement and positive feedback to their clients and being there to cheer them on. This was emphasized as being especially important when their clients did not have many other supportive people in their lives. Many shared that this was so important because it allowed their clients to feel comfortable asking questions and being vulnerable in a way that they may not be able to be with healthcare providers, with one adding that "*it feels more like we're just two moms sitting together chatting about this*" rather than feeling formal as it might in a clinic. Some doulas also emphasized availability for around-the-clock support when it was needed, which also set them apart from healthcare providers:

> *So it's just being hands open and available. Like, you know, you can call me anytime tonight because I'm a night owl anyway. If you're feeling some type of way and you just need that reassuring talk or a pep talk, I make myself available. And a lot of people feel like, you know, it could be three in the morning. You can't call the doctor; you can't call these people. But you can call me, and I'll make the time. Even if it's through text just to say, like, you got this, or just a few inspiring words.* (Black, six months to two years of experience)

Doulas perceived that this type of availability, encouragement, and comfort allows doulas to form close bonds with their clients, which allow them to be emotionally supportive and allow their clients to feel safe and comfortable asking them for help.

Perspectives on Barriers and Facilitators of Lactation

The majority of the doulas mentioned that all or almost all of their clients intended to breastfeed and did not commonly have hesitations; however, they acknowledged that the type of person who would seek out a doula may also tend to be the same type of person who intends to breastfeed—someone who wants to have a more natural, holistic approach to birth and postpartum. They generally see that people want to breastfeed because of lower costs, distrust of formula, a desire to bond with their baby, knowledge of the health benefits, and societal pressure in recent years. Conversely, the main reasons doulas have seen that individuals do not want to breastfeed are fear of pain, the belief that it would be too time-consuming or too much work, and medical reasons such as medication and breast augmentation. Many doulas also shared hearing concerns from clients that breastfeeding was "*nasty*", "*too sexual*", and would ruin the individual's body or breasts.

The main things that doulas noted as being facilitators of lactation success were having sufficient leave from work and workplace policies about breastfeeding when returning to employment, being educated about breastfeeding, and having access to an IBCLC if needed. They also shared that a lactating person having supportive people around them, or "*having a village*", was vital to breastfeeding success. Partners and family members not being on board and not helping out was identified as a major barrier to longevity in breastfeeding. Other barriers identified by doulas included mental health struggles in the postpartum period, physical issues such as mastitis, exhaustion, and early return to work.

The Role of the Doula in Supporting Hospital Births

When doulas attend births in the hospital setting, all shared a sentiment of being a support, comfort, and observer to the birth experience. One doula shared that they see their role

as "*mothering the mother*", which many echoed through discussion of providing continuous emotional and sometimes physical support to their client throughout labor and birth. There was also emphasis placed on "*being a witness*" to the birth journey and recognizing that they cannot center themselves or their own emotions or desires, but rather the needs of their client.

Often, doulas discussed that their exact role while attending a hospital birth can vary greatly depending on the hospital that they are in. In some hospitals, where HCPs are more familiar with doulas and have interacted with them more, doulas felt that they had more freedom to be involved in the labor and delivery process. In hospitals that are "*less doula-friendly*", doulas often found that they needed to be more hands-off in order to not step on toes. In these situations especially, doulas mentioned being very aware of their scope of practice and being sure to not do anything that could be construed as giving medical advice or diagnosing.

Some doulas disagreed about their role as an advocate in the hospital setting. One doula explained:

> *When we ask them, you know, why are you interested in working with a doula? Like, well, we just really want to make sure we have an advocate in the hospital. And we have to kind of like walk that back and really, you know, explain to them our scope of work and that we are not in a position to advocate for you if we want to continue being a doula at these hospitals. And, you know, this is what our advocacy looks like, it looks like me reminding you what your preferences were, me checking in with you, amplifying what those preferences were and not speaking for you.* (White, two to five years of experience)

This was a commonly shared sentiment. Most doulas felt that their form of advocacy is to educate their clients beforehand about birth, help them make a birth plan to feel prepared, and check in throughout the birth to make sure that their clients' preferences are considered when

decisions were made. This was often referred to as teaching clients (and their support people) how to advocate for themselves. However, a couple of the doulas more willingly referred to themselves as advocates for their clients and felt more comfortable speaking up about things in the birth room.

Person-Centered Care

All doulas demonstrated principles of PCCFRHE in their support of clients in the hospital setting to varying degrees, particularly in the domains of autonomy, social support, supportive care, and dignity.

Doulas demonstrated support for client autonomy through working to teach their clients how to advocate for themselves. This included different activities for different doulas, but common among them were discussing a birth plan together (while also knowing that it could change), roleplaying before the birth to practice asking questions and interacting with HCPs in different scenarios, and making sure that all of the information doctors share is understood by their client by acting as a "*translator*" or "*buffer*" between them. About the latter, one doula shared:

> *They want me there specifically to ensure that whatever is happening, we all understand what's going on so that she can make decisions that her and her husband or partner or whomever want to make. And so, you know, I'm really there, again, as the advocate and as the observer, just ensuring that my client got the full picture, got the full scope. And if they don't understand what was being said to them, I encourage them to ask your doctor or that nurse to break it down.* (Black and Hispanic/Latino, five or more years of experience)

Doulas also discussed supporting their clients' autonomy by slowing things down to give them time to think through any medical decisions that need to be made and trying non-medical interventions that will support clients in "*having a birth their way*". These measures also support dignity for clients in the hospital, especially when doulas are conscious of taking a trauma-informed approach to their support. For doulas, a trauma-informed approach involved being aware of past traumatic experiences of their clients, what their triggers may be during or after labor and delivery, and how to avoid situations that could retraumatize them. For example, one doula discussed an experience with a client who had past sexual trauma and needed extra consideration around pelvic exams:

> *If I see that maybe someone is doing a vaginal exam and my client is in immense pain, and it's just very painful and traumatic for her, and all she can do is just clench and she's not able to say, can you please stop? I can then say, I feel like that's enough. My client is responding in an uncomfortable way.* (Black and Hispanic/Latino, two to five years of experience)

Being aware of the needs of their clients in regard to past trauma, possible accommodations they need, lifestyle, and cultural traditions was brought up frequently as an important part of the doula's role in the hospital. Awareness and attention to these details about a client's needs allow doulas to provide compassionate and appropriate care, or help ensure that HCPs are doing so, an important component of supportive care. Providing culturally appropriate care was important to many doulas, with one exemplifying this attitude saying:

> *Culturally congruent care is very important. And that means just having birth workers that are in alignment with your traditions or in alignment with your lifestyle, or maybe in alignment with the way you want your birth to be or your culture and things like that, and*

> *understanding that we may not be always able to get that in a provider, but working closely with a doula, with someone who is ministering to your soul and your spirit and your atmosphere.* (Black and Hispanic/Latino, two to five years of experience)

That level of culturally congruent care was often discussed in tandem with the role doulas play in slowing things down in the hospital and continually checking in with clients throughout the labor process to see what their needs are in a particular moment.

All doulas talked about providing continuous emotional care and support to clients in the hospital, and it being an important aspect that sets them apart from HCPs, whose duties don't allow for that. A doula shared:

> *What I always joked and said was that the midwife was at the foot of the bed, or the OB was at the foot of the bed, but the doula's at the head of the bed. The doula was making sure that mentally, emotionally, physically, you were not only educated to have this sense of confidence, you have this sense of awareness. You have this sense of advocacy and self-advocacy that can allow you to feel comfortable.* (Black, two to five years of experience)

Social support from doulas in the hospital setting goes beyond simply giving encouragement, comfort, and stress relief. Many doulas also stated that they make it a point to also work with the other support people, such as partners, that will attend the birth, to make sure that they are equipped to offer the social support that the birthing person needs.

The Effect of Doula-Healthcare Provider Relationships

As previously stated, almost all doulas talked about the difference that different hospitals make in their role at a birth and how they can support a birthing person, and much of that sentiment was grounded in how HCPs at the hospital view doulas and interact with them. Among

the doulas interviewed, there was a wide spectrum of experiences with HCPs. Many reported having had mostly neutral or positive experiences with providers, although almost all also described having some negative experiences. Some talked about purposely keeping quiet, only interacting with the provider through their client, and generally staying out of the way in order to have an easier time at the birth. One doula noted her experience with this tactic:

> *So we try to really stay in the shadows because health care providers…it's rare to find ones that are for doulas, you know, that want doulas there to help out. They kind of feel like we may be stepping on their toes. So personally, I try to stay in the shadows.* (Black, two to five years of experience)

"Trying not to step on toes" was a common sentiment, as was the hierarchical nature of hospitals and the medical profession. Some doulas discussed feeling that many doctors and nurses have large egos, and may also be stuck in old ways, which could contribute to them being less welcoming to doulas. Aside from trying to stay "*in the shadows*", another common tactic used by doulas to smooth interactions with HCPs was going out of their way to be overly respectful, accommodating, and helpful when they could be. This was often successful in creating a more welcoming atmosphere for the doula and a calmer atmosphere for their clients.

Although all doulas acknowledged that biases toward doulas as someone who might make a HCPs job more difficult abound and effect relationships, that was not always the case. Many doulas noted that they have had many births where after introducing themselves to nurses or OB/GYNs, they receive a positive response, such as "*Oh you have a doula with you? You're going to have a great birth*". Generally, doulas felt that these more positive and welcoming experiences made not only their jobs, but their clients' births, easier. Some felt that nurses, and

especially midwives, are more likely to have a positive attitude toward doulas than OB/GYNs, who doulas viewed as being more stuck in their ways and therefore not as accepting of doulas.

Across the board, doulas thought that HCPs having more knowledge of what doulas do, what their scope of practice is, and how they can help birth outcomes would be beneficial to improve relationships, which doulas generally wanted and viewed as being beneficial to clients' birth outcomes. A doula summed up this sentiment:

> *Another thing that I wish they [health care providers] knew about doulas is that we want to work with y'all. We're not trying to compete. We're not trying to fight y'all or overstep any boundaries. We actually want to work in tandem and in congruency and in alignment with them. And if we could have more spaces where OB/GYNs, midwives, and doulas work together so that we can all better understand what we do and how we do it. I think that would make things more clear and more understanding.* (Black and Hispanic/Latino, two to five years of experience)

Chapter 5: Conclusions, Implications, and Recommendations

This qualitative study expands on existing literature about the experiences of doulas supporting birthing people with lactation, attending births in the hospital, and working with HCPs, and how they view their role in those activities. While previous literature examines each of those individually, this study unifies the three through the lens of the PCCFRHE, which has not previously been used to study the person-centered approaches doulas take in their interactions with and care of their clients. Three major themes were identified through thematic analysis: (1) the role of the doula in lactation support, (2) the role of the doula in supporting hospital births, and (3) the effect of doula-healthcare provider relationships. There were also sub-themes identified which demonstrate how a doula's role in supporting lactation and hospital births use person-centered approaches, specifically the domains of social support, dignity, autonomy, and supportive care from the PCCFRHE. Doulas uphold these ideals in the normal activities they take part in as part of their role, whether they are conscious of it or not. The results of this study underscore the important role that doulas play in providing PCC.

Lactation Support

Doulas have a strong sense of what their scope of practice is in lactation support and show a willingness and enthusiasm to refer their clients to IBCLCs or other providers when necessary and possible. However, they also have a vital role to play when it comes to addressing the breastfeeding challenges that clients experience that cannot be solved by clinical care and doing so with a person-centered approach. Although the importance of person-centered approaches to breastfeeding support are understudied, they are recommended by the AAP (Meek et al., 2022) and the World Health Organization (World Health Organization, 2018).

Doula perceptions of the barriers that their clients face when breastfeeding—including lack of knowledge about breastfeeding, lack of social support, lack of workplace support when having to return to work, pain, latch issues, and social or cultural norms not being supportive of breastfeeding—confirm previous literature (Cohen et al., 2018; Jones et al., 2015; OSG, 2011). Lack of knowledge and lack of social support are two barriers that doulas are poised to help their clients overcome. Doulas reported that prenatal education and resource provision are main lactation support activities that they undertake, not just with the birthing person but also with other family members and support people who will be with them after birth.

Given the close, comfortable relationship that doulas foster with their clients, and the personalized education and advice that they give, birthing people may be more likely to trust and apply knowledge they receive from doulas, as opposed to from other sources. This relationship is also a vital component of doulas' social support. Doulas improve social support for their clients by giving encouragement, allowing them to ask questions comfortably, and being available to them when they need someone to talk to. This particular relationship and type of support differentiates doulas from other HCPs, who provide more formal, clinical, and less accessible support.

The findings from this study confirm what limited previous research has found about doulas' perspectives on their role as breastfeeding supports (Louis-Jacques et al., 2022): it is the time spent in relationship building, getting to know a particular client and their needs, respecting clients' desires and boundaries, and being a source of encouragement and comfort for clients that facilitates positive breastfeeding experiences. While Louis-Jacques et al. (2022) also studied a doula cohort in the southeastern U.S. (Florida) compromised of mostly Black and Latina doulas, that study focused on a state-funded doula program based at a clinic. The doulas in that study

received lactation training from an IBCLC, and they provide group breastfeeding education classes to community members in addition to supporting their clients, which may have influenced the way that they see their role in lactation. Although this study's population and setting is similar, there is much more varied experience and training (particularly in regard to lactation) among the current study sample. This could mean that doulas, regardless of their level of lactation support training, have similar views on their role in supporting clients on their breastfeeding journeys.

Attending Hospital Births

Birthing people who receive person-centered maternity care tend to have better mental and physical health outcomes (Attanasio et al., 2022; Sudhinaraset et al., 2021). Doulas, through their role as witness, support, translator, and advocate in the hospital setting, provide PCC for their clients during the birth process. Being a witness means that although doulas are present, the birth is not about them or their own desires, and their primary goal is making sure that their clients' wishes are being considered and respected. The translator role that doulas play is vital to assuring that all information is understood by their clients during the labor and delivery process and their clients can make informed decisions. Through these roles, doulas uphold their clients' autonomy and dignity while at the hospital.

An interesting finding was around doulas' perspectives of themselves as advocates for their clients in the hospital setting. Although previous literature has outlined doulas' role in advocacy (especially for minoritized people), including how clients view this advocacy (Arteaga et al., 2023; Sayyad et al., 2023), the doulas in this study tended to shy away from the term "advocate". They believe that this has a connotation of being too assrtive or fighting back against the recommendations of HCPs or speaking on behalf of their clients. This form of advocacy is

viewed as something that doulas wanted to distance themselves from, as it contributes to negative perceptions and biases that some HCPs have against doulas and can even get a doula removed or banned from a particular hospital. Instead, the doulas in this study focused on advocating through interpersonal support and education, arming their clients with the tools to advocate for themselves.

Another salient finding was the role that doulas see themselves playing in "slowing things down" during birth. Often, birthing people report feeling like HCPs are rushing interactions, and that may lead them to feel pressured to make certain decisions quickly during labor and birth (Hunter, 2012), and doulas often see this during births that they attend. To combat this, doulas often will act as a mediating force to step in and ask to let the birthing person have time to think and talk through decisions or try non-medical techniques to ease the issue at hand. This often allows birthing people to avoid interventions. Doulas also stay continuously with the birthing person not just during labor, but after delivery for, in some cases, up to two hours, as opposed to HCPs who must leave the room shortly after birth to attend other patients. This allows doulas time to ensure that their clients are safe, comfortable, and able to latch if they want to initiate breastfeeding.

Healthcare Provider Interactions

Doulas' experiences interacting with HCPs while attending hospital births align with what was found in previous studies (Adams & Curtin-Bowen, 2021; Torres, 2013)—they often feel unwelcome, and like they need to change their practices to be overly deferential and helpful to HCPs and not "step on toes". These previous studies, however, mainly consisted of white doulas, and only one of them included doulas from the southeastern U.S. (with only one doula being from Georgia). "Staying in the shadows", as one doula expressed, allows doulas to attend

births without having conflict with HCPs, allowing for a calmer atmosphere that is better for the client; however, this can make it harder for them to perform parts of their job, namely physical support and the previously discussed form of advocacy that doulas often employ. It is important to note that although negative experiences were nearly universal for the doulas in this study, many had also had positive experiences where HCPs (especially nurses and midwives) were very welcoming and glad for the extra support of having a doula attend a birth.

Doulas want to improve the relationship between themselves and HCPs in order to provide a better birthing atmosphere for their clients. Previous studies have shown that these relationships can be improved through increasing HCPs' exposure to and knowledge about doulas (Lucas & Wright, 2019; Roth et al., 2016), and doulas agree that those two things would be key. They suggest this could be achieved through continuing education for providers about doulas or hospitals offering "meet and greet" opportunities between doulas and HCPs.

Strengths and Limitations

There are several limitations to this study that should be considered when interpreting results. While the number of participants and their wealth of shared experiences allowed for rich data, there were additional themes about doulas' roles, particularly in supporting minoritized individuals, that could have been explored with better saturation of data on this topic. Hennink et al. (2016) describe code saturation as "the point in which no additional issues are identified" and meaning saturation as "the point when we fully understand issues, and when no further dimensions, nuances, or insights of issues can be found". While this study reached code saturation, with no new topics emerging after a certain point in data collection, it did not achieve meaning saturation on the topic of doulas' role in supporting minoritized birthing people. This

could have been achieved either by interviewing additional doulas or probing further about this type of support during interviews.

Another limitation comes from the method of recruitment. Using contacts from previous studies to send out recruitment emails and contacting doulas from DONA and CAPPA contact lists yielded only doulas with formal training and certification. Informally-trained doulas—such as family members who support their daughters, granddaughters, or nieces at births—are an important part of the landscape of maternal care and support and would have also lent a valuable perspective to this study. Finally, the intake survey asked participants if they were an IBCLC or CLC, as having one of those certifications would disqualify them from the study. However, it did not ask if they had received any lactation training. Because of that, several participants were either Certified Lactation Educators or had gone through CLC training but not taken the exam to receive certification. Because of this, some participants had vastly more breastfeeding knowledge than others, which influenced how they view their role and scope of practice for supporting lactation.

Regardless of limitations, this study also has several strengths. Its use of a person-centered care lens to explore doulas' roles in lactation and birth support from their perspective is unique. This lends a novel perspective to the growing body of literature about doula support. Additionally, data collection over Zoom was a strength. This allowed for interviews with doulas across the AMA that may have otherwise been difficult to interview in person and allowed for a more convenient experience for the participants, who could schedule at a time best for them and be interviewed from the comfort of their homes.

Implications and Recommendations

In a state and country with unacceptably high maternal and infant death rates, doula use of person-centered approaches to their care is a vital component of the maternity care system. They are uniquely situated to improve birth and breastfeeding outcomes through their practices of deep relationship building, centering clients' needs, respecting clients' choices, and offering continuous support. However, more research is needed to further establish the link between PCC from doulas and positive health outcomes, as well as person-centered outcomes such as patient satisfaction with care.

Future directions for research could include exploring the elements of PCC doulas provide from patients' perspectives, or quantitatively tying outcomes to PCC practices. Given the wealth of previous research showing that doula support results in higher rates of breastfeeding initiation (Gruber et al., 2013; Kozhimannil et al., 2013a), further research could also examine the role of doulas, specifically postpartum doulas, in supporting the continuation of breastfeeding over time.

Outside of research, the results of this study indicate that greater integration of doulas into hospital labor and delivery wards to some capacity could be useful. This could include hospitals having doulas on staff, starting volunteer labor support programs, requiring continuing education about working with doulas, holding "meet and greet" hours for HCPs and doulas, or changing their policies to become more doula friendly. An opportunity for future research, then, would be piloting these strategies to test their effectiveness and scalability. This increased integration could increase exposure to and comfort with doulas at births, resulting in better doula-HCP relationships and better birth experiences.

For doulas to continue to deliver quality PCC to clients, more structural support is needed. Doulas in Georgia face challenges providing their vital services to clients, such as insufficient pay, trouble growing their businesses, and the high out-of-pocket costs of birth for uninsured people making it hard for minoritized individuals and low-income families (people who often need this type of support the most) to afford to work with doulas (Mosley et al., 2023). One avenue to address these challenges is through Medicaid reimbursement of doula services, which would increase access to doula care for low-income individuals while allowing doulas to receive adequate payment for their services. HMHBGA conducted a successful Medicaid doula pilot program in 2022-2023 (HMHBGA, 2023), and two bills have been proposed by Georgia policymakers to allow for Medicaid reimbursement for doula services, however neither have passed (Chen, 2022). An additional bill was introduced in February 2024, which would create a state-sponsored pilot program for Medicaid reimbursement for doulas (Chen, 2022). Passing legislation such as this is vital for doulas to be able to reach the pregnant people most at-risk for adverse outcomes, and most in need of their services.

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Appendices

Appendix A: In-Depth Interview Guide

Introduction

Hello! My name is Shelby. Thank you so much for agreeing to speak with me today and thank you for all of the work you do to support your community as a doula. This is a study about doulas' perspectives on lactation support and their role in interdisciplinary maternity care teams. Your perspective is incredibly valuable, as it will help us understand the experiences of doulas and their clients, and how doulas can be further supported and uplifted to keep making changes in the health of moms and babies. We will talk a bit about your own preparation and experience as a doula, and the ways in which you support clients. This interview will be recorded (with your permission) and transcribed, but any identifying information will be removed. Your participation is completely voluntary, and you can choose not to answer a question, take a break, or end the interview at any time.

Do you have any questions?

Do you agree to participate?

Is it okay for me to record?

[ONCE PERMISSION IS OBTAINED, BEGIN RECORDING]

Opening Questions

I'd like to start by learning about your journey as a doula.

1. What motivated you to become a doula?
2. What training have you received?
    a. Formal? Informal?
    b. Lactation-specific training

3. What are your typical clients like with regards to racial/ethnic/cultural background?
    a. Is this background typically similar to your own or different?
    b. Are they first time or repeat parents?

Main Questions

Now, let's talk about breastfeeding.

1. Based on your experience, what are some reasons that new moms/parents want to breastfeed?
2. What are some reasons that they don't want to breastfeed or feel hesitant about breastfeeding?
    a. How do you support and counsel them through that?
3. What makes is hard for women and birthing parents to breastfeed?
    a. initiation in the hospital, continuation after they leave the hospital
    b. challenges specific to POC clients
    c. What do you do as their doula to support with challenges?
4. What helps women and birthing parents be able to breastfeed?
    a. initiation in the hospital, continuation after they leave the hospital
    b. supports specific to POC clients

Now, I'm interested in learning about your experience in offering lactation support to your clients.

5. What do you see as your role in lactation support?
    a. How does your role in supporting breastfeeding differ from others such an IBCLC or doctor?

Now, I'm interested in hearing about your experience working with healthcare providers.

6. What is your role within the maternity care team?
    a. What challenges do you have in carrying out your role?
    b. What makes it easier for you to carry out your role?
    c. How do you advocate for your clients in the hospital setting?
    d. Are there any special considerations for attending births with POC clients?
7. How do you interact with the rest of the maternity care team (including doctors, nurses, midwives, lactation consultants) during a birth?
    a. What has contributed to your positive or negative interactions?
8. As a doula, what do you wish healthcare providers knew about doulas like you?
    a. Your role?
    b. Your expertise?
    c. Why?

<u>Closing Questions</u>

1. What advice would you give to someone just starting out as a doula?

We are now reaching the end of our discussion. Before we do…

2. Is there anything else you would like to add about the topics of doula support, lactation, or working with medical teams that we have not covered?

Thank you so much again for taking the time to speak with me today and share your experiences. Your insights are extremely valuable.

Appendix B: Recruitment Email

Subject: Paid Opportunity to Participate in Thesis Research About Doula Care

Hello!

I hope that this email finds you well! My name is Shelby Crosier, and I am a Master of Public Health Student at Emory University.

As part of my thesis, a requirement to graduate with my MPH, I am conducting a study about the perspectives of doulas on their role in providing lactation support to their clients and working with healthcare teams. I recognize how critical doula support is to postpartum and infant health, and hope to contribute to greater knowledge, awareness, and support for doula care. I am looking to speak with doulas across Georgia about their experiences, and I would love to have the opportunity to talk with you!

This would be a one-time, **45-60 minute interview on Zoom**, which we can schedule at your convenience. You will receive a **$50 electronic gift card** for your participation.

If you are interested in participating, **please fill out a brief eligibility survey here**: https://redcap.link/doulac. I will then contact you to schedule an interview!

Thank you in advance for your time and consideration. Feel free to **contact me with any questions via email at shelby.crosier@emory.edu**, or via phone at 734-389-5692. I also welcome sharing information about this study with other doulas practicing in Georgia.

Best,

Shelby

Shelby Crosier (she/her)

MPH Candidate | Behavioral, Social, and Health Education Sciences

Emory University | Rollins School of Public Health

Appendix C: Screening Survey

1. First name:
2. Last name:
3. Zip code:
4. Chose one or more races that you identify as:
    a. White
    b. Black or African American
    c. American Indian or Alaskan Native
    d. Asian
    e. Native Hawaiian or Pacific Islander
    f. Other
5. Do you identify as Hispanic or Latino/a?
    a. Yes
    b. No
6. Are you currently working as a doula in Georgia?
    a. Yes
    b. No
7. How long have you been working as a doula in Georgia?
    a. Less than 6 months
    b. 6 months to 2 years
    c. 2 to 5 years
    d. 5 years or more
8. Are you, or have you ever been, a Certified Lactation Counselor (CLC) or International Board Certified Lactation Consultant (IBCLC)?
    a. Yes
    b. No