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Doula Support as a Means to Improve Birth Outcomes for Minority Women

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Abstract

Ethnic minorities such as African Americans, American Indians, Hispanics, Laotions, Hmongs, and Alaskan Natives have higher rates of cesarean delivery, pre-term birth, fetal demise, perinatal laceration, and congenital abnormalities than their white counterparts (Bryant et al., 2010). Continuous labor support by way of doula care has been recommended for all pregnant women as a means to prevent adverse birth outcomes. Despite this, the population most in need of such support in unable to access doula services due to low socioeconomic status, availability of services, and cultural inaccessibility. This paper focuses on my capstone experience with UCSF and Roots of Labor Birth Collective as we created a program to provide and evaluate the impact of culturally competent doula care to improve the birth experiences of women of color.

Introduction

Roots of Labor Birth Collective (RLBC) is an organization whose mission is to provide free, culturally relevant birth support for low-income, minority mothers in Alameda County. Although the collective is based in Oakland, it receives referrals from clinics through Fremont to El Sobrante. RLBC is comprised of 28 doulas who provide non-medical support during the ante-, intra-, and post-partum periods. Members of the collective include the executive committee known as "Roots", and volunteers who serve on committees. Each volunteer serves on a committee ranging from sustainability, peer-support, education, art, and childcare.

Background

Poor Birth Outcomes

In 1915, the maternal mortality rate (MMR) in the United States was 607.9 maternal deaths per 100,000 live births (Singh, 2010). In 2015, the MMR was at 14 deaths per 100,000 live births at the advent of improved health and welfare services for mothers and children as well as technological advancements such as hemorrhage protocols (WHO et.al, 2015).

Despite an overall decrease in the number of pregnancy-related deaths in the last century, there are considerable racial disparities in birth outcomes. Delivery related complications occur with highest frequency among women of color and women from low socioeconomic backgrounds (Elixhauser & Wier, 2008). African American women are more than 3 times as likely to die from pregnancy related causes than non-hispanic white women (Singh, 2010; CDC, 2015). Mortality aside, ethnic minorities such as African Americans, American Indians, Hispanics, Laotions, Hmongs, and Alaskan

Natives have higher rates of cesarean delivery, pre-term birth, fetal demise, perinatal laceration, and congenital abnormalities than their white counterparts (Bryant et al., 2010). Breastfeeding, a normative standard for infant feeding in a baby's first six months, is less common in African American women than Caucasian women (CDC, 2013). In 2014, the CDC released a *Morbidity and Mortality Weekly Report* which found hospitals in zipcodes with more than 12.2 percent of black residents were less likely to meet 5 of 10 indicators that encourage breastfeeding compared to facilities in zipcodes with fewer black residents (Lind, Perrine, Li, Scanlon, & Grummer-Strawn, 2014).

Income, race, and ethnicity correlate strongly with adverse birth outcomes although research to reduce such health disparities is new and lacking (Lu & Halfon, 2003; Collins, Herman, &David, 1997; Lu et al., 2010; Behrman & Stith Butler, 2007).

Cesarean Deliveries

As of 2015, 1 in 3 mothers gave birth via cesarean delivery compared to 1 in 5 mothers in 1995 (Menacker & Hamilton, 2010). Although cesarean sections can effectively prevent maternal and newborn mortality when medically necessary, the World Health Organization (WHO) states the ideal rate of cesarean deliveries within any country is 10-15% of all births. When the rate surpasses 10%, there is no evidence mortality rates improve (WHO, 2015).

Over the last decade, increases in c-sections has been related to cesarean delivery on request, a decrease in patients who are willing to try vaginal birth after cesarean delivery (VBAC), advanced maternal age at first pregnancy, and an increase in women with chronic medical conditions such as Diabetes Mellitus and congenital heart disease (Menacker & Hamilton, 2010). Cesareans delivery is considered major abdominal surgery and has been associated with 8 to 10 times higher maternal mortality risks when compared to vaginal births

(Clark et al., 2008). Cesareans have also been correlated with higher rates of surgical complications, maternal rehospitalization, morbidly adherent placenta, scar pregnancy, low-birth weight, infant mortality, and stillbirths (Menacker & Hamilton, 2010; Betran et al., 2015; Saleh, Dudenhausen, Ahmed, 2016). Cesareans also cost 50% more than vaginal births when paid for Medicaid and by private insurance, and was found to add $6,898 and $8,199, respectively, to the total cost per birth in New York (Agency for Healthcare Research and Quality, 2013). In 2012, the National Institute of Health, the American College of Obstetrics and Gynecologists, and the Society for Maternal Fetal Medicine held a joint-conference on the prevention of primary cesarean deliveries (Spong, Berghella, Wenstrom, Mercer, & Saade, 2012).

Doula Care as a Health Intervention

A 2013 Cochrane systematic review of continuous labor support revealed higher rates of spontaneous vaginal birth, lower odds of cesarean delivery, lower rates of regional anesthesia, shorter labors, lower rates of instrument-assisted delivery, and higher levels of satisfaction from women who received labor support. The authors concluded that all women should receive continuous support during labor, by which trained doulas were the most effective at providing (Hodnett, Gates, Hofmeyr, & Sakala, 2013). A 2008 review of 41 birth practices found doula support to be the most effective birth intervention along with placing the mother in an upright position during the second stage of labor and perineal massages after 34 weeks (Berghella, Baxter, & Chauhan, 2008). Among African American women, 92.7% of those with doula support initiated breastfeeding, compared with 70.3% of the general Medicaid population (Kozhimannil, Attanasio, Hardeman, & O’Brien, 2013).

Despite the merits associated with introducing doula care for all mothers, use of doulas in the birth setting is largely restricted to middle-to-upper class white women who have the knowledge and financial capacity to seek one. Doulas themselves tend to be middle-aged, married, and well-educated white women from upper-middle-class households (Lantz, Low, Varkey, & Watson, 2005). For women who struggled to obtain doula care, 88% said cost was a barrier (Strauss, Giessler, & McAllister, 2015). As of 2016, only Oregon and Minnesota have expanded Medicaid coverage to include doula services. Proportionately, larger shares of ethnic minorities are covered by Medicaid when compared to Caucasians, which may be related to socioeconomic status (Figure 1). The lack of insurance coverage for doula care and limited ethnic diversity of doulas restricts access to care for low-income and ethnically diverse clients.

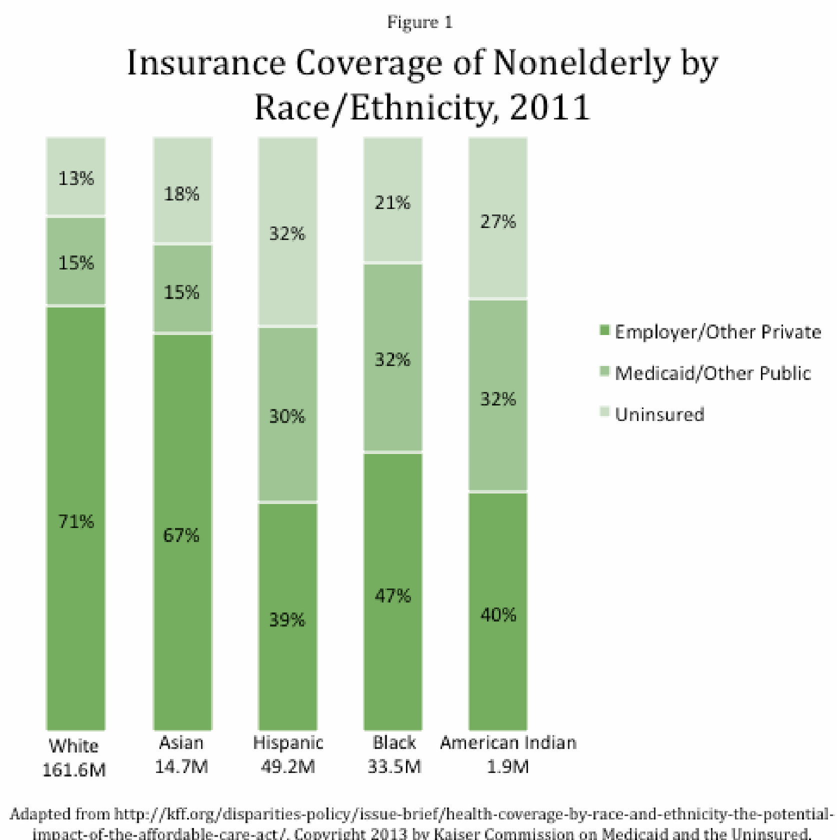

Figure 1

Insurance Coverage of Nonelderly by Race/Ethnicity, 2011

Adapted from http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/. Copyright 2013 by Kaiser Commission on Medicaid and the Uninsured.

Success in Oregon and Minnesota should be mimicked as an evaluation of doula care and birth outcomes among Medicaid beneficiaries found women with doula support had a cesarean rate of 22.3%, compared to Medicaid-funded births at 31.5%. Doula care in the Medicaid population was associated with a 40.9% decreased odds of cesarean delivery (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013). In

four in-depth focus groups with low-income pregnant women, doula care was associated with personal agency, improved knowledge in the health care setting, a sense of security, connectedness, and respect (Kozhimannil, Vogelsang, Hardeman, & Prasad 2016). One Medicaid-recipient described her experience with a doula as

> "having someone that is not only knowledgeable, but can put things I guess in layman's terms, but also in a way that you understand it and respects your culture … your well-being, your upbringing and things about you that you like to make sure that the baby is okay too" (Kozhimannil, Vogelsang, Hardeman, & Prasad 2016).

Doula support plays a significant role in reducing racial and ethnic disparities in vulnerable populations and should be made financially and culturally accessible.

Scope of the Project

RLBC is an Oakland-based collective of doulas aiming to provide free birth support to low-income and minority populations within Alameda County. It was founded under the name East Bay Community Birth Support Project (EBCBSP) in collaboration between Black Women Birthing Justice, The Birth Justice Project, and University of California in San Francisco's Advancing New Standards in Reproductive Health (ANSIRH) department. EBCBSP was originally granted $50,000 in February 2014 by Alameda County's Department of Public Health to implement doula training for formerly incarcerated and low-income women. The hope was to reduce recidivism while improving sustainability for these populations. Participants were blinded to reduce stigmatization of the formerly incarcerated women. Since the completion and success of this doula-training, Alameda County re-granted $38,000 to continue the mission of the program. Members of EBCBSP rebranded themselves as RLBC in

June 2016 and invited new members into the collective to continue the peer support they had experienced during their doula training.

RLBC is comprised of 28 doulas of color, many of whom are multi-lingual and/or identify as queer or non-gender conforming. Their mission is to provide free, culturally-relevant birth support to community members from low socioeconomic backgrounds. Oakland City is ethnically diverse (Table 1), with White, Black, and Hispanic/Latino residents at near-equal proportions of the population. However, people of color are disproportionately impacted by inequality in the forms of displacement and economic injustice. Therefore, diversity within the collective is vital to support cultural concordance between the doula and the client. Doulas of RLBC provide educational, physical, and spiritual support at the prenatal, labor, birth, and postpartum periods. Doulas also volunteer to visit mothers at Santa Rita County Jail (SRCJ) on a weekly basis, and provide educational, spiritual, and labor support throughout their pregnancies.

Table 1: Oakland's Population by Race in 2010.

HISPANIC OR LATINO AND RACE				
Hispanic or Latino (of any race)	87,467	21.9%	99,068	25.4%
Not Hispanic or Latino	312,017	78.1%	291,656	74.6%
White	93,953	23.5%	101,308	25.9%
Black or African American	140,139	35.1%	106,637	27.3%
American Indian and Alaska Native	1,471	0.4%	1,214	0.3%
Asian	60,393	15.1%	65,127	16.7%
Native Hawaiian and Other Pacific Islander	1,866	0.5%	2,081	0.5%
Some other race	1,229	0.3%	1,213	0.3%
Two or more races	12,966	3.2%	14,076	3.6%

Retrieved from http://www.bayareacensus.ca.gov/cities/Oakland.htm Copyright Bay Area Census 2010.

Sustainability

The goal of this capstone project was to establish a means of sustainability while

promoting RLBC's mission. Doulas are paid $500 for their services, which include two prenatal visits, support during labor, and two postpartum visits. Under the Alameda County grant, RLBC is able to provide free birth support for four mothers a month. As of December, RLBC has supported 21 births since it rebranded itself in August 2016. Requests for doulas exceeded capacity in September, October, and November. Doulas subsequently volunteered their services for free to prevent denying support for mothers. As RLBC's doulas were also low-income, minority women from the community, it was unjust to allow the organization to move forward without means of financial sustainability for the doulas.

Currently, RLBC receives fiscal sponsorship from the UCSF where UCSF takes 8-10% of any grants RLBC receives. In turn, UCSF's ANSIRH is allowed to conduct studies amongst the RLBC's doula and client base. Alameda County recommended RLBC move forward as a nonprofit organization to grant tax-exemptions for both donors and RLBC. I worked directly with Resource Development Associates (RDA), a consulting firm in Oakland, to complete a 501c3 (non-profit) application with special attention given to the narrative, bylaws, and board of governance.

Throughout this process, I sat on the sustainability committee and collaborated on multiple grants, both local and national. Many of the grants, such as the Third Wave Fund and Akonadi Foundation's So Love Can Win Grant, were focused on issues of gender, racial, and reproductive justice. I was also responsible for exploring other means of sustainability so the collective would be less reliant on grant cycles. The idea of a sustainable enterprise, where for-profit activities – such as opening doula services to all populations and charging on a sliding scale – would fund non-profit ventures such as free birth support, was researched and considered.

Program evaluation

To ensure quality improvement, evaluation forms were created in both English and Spanish for clients and doulas of RLBC. Intake forms were modified to include questions about birth history and financial capacity to better inform RLBC of their client base. A qualitative approach was taken to collect information with opportunities in written narratives and open-ended questions. Doulas were given the same opportunities to disclose the results of and the impact of their support after the births.

The final goal of the project was to evaluate the perceived benefit or lack thereof of doula services for the population served by RLBC. As proven by the literature above, doula care is an evidence-based practice to improve birth outcomes. Although there is much data on the benefits of doula care for low-income mothers, there is little discussion regarding the impact of doula use amongst women of color. What is the impact of a doula that is ethnically and culturally concordant with a laboring mother?

A qualitative approach was chosen to hear and highlight the voices of our community. One-on-one interviews conducted during the postpartum period of 6-10 women of color who had received doula support would allow decompression of their experiences in a comfortable, non-medical setting. An interview guide was produced and will be used to facilitate discussion with clients pending IRB approval (Appendices).

Public/Population Health Impact: Findings and Significance

Under the grant from Alameda County's Department of Public Health, RLBC was able to pay for 4 doula-supported births a month at $500 for 2 prenatal visits, labor support, and 2 postpartum visits. In October and November, requests for doulas exceeded capacity and

doulas volunteered their services for free so mothers who needed the support would not go without it. It is important to recognize that the populations most in need for doula services – ethnic minorities such as African Americans, Hispanics, and American Indians – are often those who can not afford to access such care because of their economic status, health coverage, or availability of coverage in their area. In addition, for populations that are already marginalized, cultural concordance – being able to identify with your provider – is important in allowing a client to feel safe and to promote a sense of agency. However, cultural concordance is hard to achieve because persons of color encounter barriers to entering the workforce as doulas. Doula work is not compensated well – especially if the population they are serving is low-income. In addition, RLBC's doulas experience the same social determinants of health as their client base. Making the doula profession sustainable for minority women in turn allows pregnant women to overcome a barrier to receiving care.

For women who sought doula care, 88% cited cost as a barrier to access whereas 4 out of every 10 doulas in private practice reported sometimes turning clients away because they could not afford fees (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013). Following the success in Oregon and Minnesota, Medicaid-sponsored doula services should be protected and made accessible in all states. In the meantime, sustainability for programs providing free doula services such as RLBC should be supported. The sustainability branch of RLBC will continue applying for grants at the national and local level, and RLBC will maintain its relationship with UCSF under a fiscal-sponsor-research-entity agreement.

Although RLBC was encouraged to follow the non-profit route, non-conventional business routes should continue to be explored. A core value of RLBC is the collective mindset, in which members of the doula community all have active voices in the direction

RLBC takes. By using community-based participatory research, they listen to the voices of mothers, health practitioners, and researchers and adapt their services to meet the needs of their community. Doulas share their knowledge on nutrition, adverse birth outcomes, supportive practices, salves, and holistic medicine. They also share resources – if a mother no longer has a need for her breast pump, her doula will donate it to another mother served by the collective who does not have the means to acquire one. Two recurring obstacles arose as RLBC moved forward with their 501c(3) application. The organizational hierarchy inherent in a non-profit structure stifles the collaborative and consensus spirit RLBC fosters. They feared that assigning a Board of Directors who was not comprised of members of the collective would undercut the voices of the community they represented if the Board had full authority over RLBC's decisions. Secondly, sustainability for non-profits is unreliable and reliant on grant cycles. Although smaller grants are released on a monthly basis, heftier funds are few and far between. If funds are released, invoicing for births is based on an average and may not represent the actual demand. A sliding-scale payment model and donation model is being explored to fund births that are not covered in existing grants.

Moving forward, the collective has the capacity to expand services available through RLBC. Doulas were determined to increase community engagement by opening an education series with lactation, nutrition, and breastfeeding classes that would be free to the public. Since many of the doulas are mothers themselves, the collective model allows them to provide peer support to one another in the form of childcare or sharing information. However, they also want to establish themselves as support systems for the mothers in their community.

Conclusion

In February 2014, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine released a joint statement that continuous labor support by a doula is one of the most effective tools to improve labor and delivery outcomes (Caughey, Cahill, Guise, & Rouse, 2014). Despite this, the population most in need of such support is unable to access doula services due to low socioeconomic status, availability of services, and cultural inaccessibility. Doulas serve as community liaisons and provide social and cultural support, self-help skills, informational services, and confidence in negotiating health systems. By inviting more persons of color to provide and receive such care, we can disrupt the pathways that cause social determinants of health. For populations who have been historically marginalized, equity in access to quality birth support is imperative to disrupt the pathways to social determinants.

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Appendices

Individual Interview Guide for Individuals Supported by Doulas

The researcher will greet the participant and explain the study. After obtaining informed consent, the researcher will ask if there are any questions prior to beginning the recording. The researcher will answer any questions and then set up the necessary equipment and warn the participant before switching it on. Once the recorder is on, the interview will begin as follows.

Researcher: Thank you for meeting me and agreeing to talk about your experiences. I am interested in hearing about your life experiences and what having a doula at your birth meant to you. I really want to hear your own story and thoughts about your own birth experiences, so please take as much time as you need while we're talking. I'm particularly interested in examples of your personal feelings and experiences so from time to time, I'll ask you to give me an example of what you mean so that I can best understand. Please let me know at any time if you want me to turn off the tape or not record a particular part of your story.

Before we get started, do you have any questions or concerns you want to talk about?

(If yes, recording may be paused to protect the participant's privacy. If no, proceed to first question and turn the recorder on).

1. Briefly tell me about your family, particularly the number of children you have, were they were born and your birth experience(s).
2. What is the most significant thing you remember about your birth experience(s)?
3. Describe how you felt about the care you received while pregnant and when you gave birth.
4. What was the impact of having a doula for you?
5. If you've given birth before, how did this experience differ from your previous births?
6. What was the impact of having a doula that was also a person of color?

In the course of the interview, the researcher may also choose to ask additional questions for clarification or to expand on a particular aspect. Some questions of this type include:

- Can you tell me more about that?
- Could you give me an example of what you mean?
- How was that helpful (or harmful)?
- What happened next?
- What was your response?
- What did (specify person) say to you?
- Is there anything else you would like to add?

Individual Interview Guide

MPH Program Competency Inventory

USF MPH Competencies	Notes
1. Assess, monitor, and review the health status of populations and their related determinants of health and illness.	Researched birth-related morbidity and mortality within ethnic groups as well as within Alameda County.
2. Demonstrate the ability to utilize the proper statistical and epidemiologic tools to assess community needs and program outcomes.	Compiled a list of Alameda County's birth needs and cross-referenced with RLBC's patient base.
3. Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	Conducted academic literature review on social determinants, including income, ethnicity, and access and effects on birth outcomes. Researched health interventions to decrease morbidity.
4. Specify approaches for assessing, preventing, and controlling environmental hazards that pose risks to human health and safety.	Researched health disparities, utilized community surveys and one-on-one interviews.
5. Apply theoretical constructs of social change, health behavior and social justice in planning community interventions.	Used community-based participatory research to gain opinions of doula care as an intervention, with emphasis on restorative justice and culturally-competent care.
6. Articulate the relationship between health care delivery and financing, public health systems, and public policy.	Literature review on existing community and policies affecting financing of doula services.
7. Apply evidence-based principles to the process of program planning, development, budgeting, management, and evaluation in public health organizations and initiatives.	Utilization of qualitative methods to collect data and to adapt program planning in evaluative stages.
8. Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects.	Collaborated with multidisciplinary team to research, collect data, and ensure program sustainability.
9. Identify and apply ethical, moral, and legal principles in all aspects of public health practice.	Individual interview guides and participant consent forms have been sent for IRB approval.

10. Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.	Acknowledged the demonstrated need for birth support in Alameda County, and developed free, culturally-competent services for low-income mothers from members of the same community.
11. Effectively communicate public health messages to a variety of audiences from professionals to the general public.	Will publish results in academic journals and maintains social media presence.
12. Advance the mission and core values of the University of San Francisco.	Advocating for low-income, minority women with emphasis on reproductive justice, social justice, and restorative justice.