


# Birth Doula Care in California During COVID-19: The Impacts of Social Distancing on a High-Touch Helping Profession

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## Abstract

Birth doulas were deemed “non-essential” personnel during the COVID-19 pandemic and were generally excluded from attending hospital births in person. This study documents the impacts of pandemic-related contextual factors on birth doula care in the San Francisco Bay Area, examines how doulas adapted their services, and explores implications for policy and practice. We employed a contextually bound qualitative case study methodology driven by social action theory and conducted interviews with 15 birth doulas. The pandemic disrupted physical settings, the social environment, communication modalities, contractual arrangements, and organizational level factors. The historical context also amplified awareness of institutionalized racism in birth settings and highlighted birth doulas’ advocacy role. Striking deficits exist in birth doulas’ integration into US healthcare systems; this made their services uniquely vulnerable to the pandemic circumstances. Birth doulas’ value ought to be more formally recognized within health policy, health insurance, and hospital systems as complementary care to that provided by medical providers to improve access to high-quality perinatal care.

## Keywords

birth doula, childbirth, perinatal care, COVID-19, hospital visitor restrictions, contextually bound case study

## Background

On March 13, 2020, the San Francisco Department of Public Health issued an order placing restrictions on hospital visitations in response to the growing urgency surrounding the unprecedented Coronavirus (COVID-19) pandemic ([City and County of San Francisco Department of Public Health, 2020](#)). Public health departments across the US quickly replicated these restrictions, excluding “Visitors and Non-Essential Personnel” from entering hospitals.

*Doulas* were one class of affected personnel that was deemed “non-essential.” Birth doulas are not medical providers. Instead, they are skilled labor companions who provide physical, emotional, and informational support to mothers during childbirth and the immediate postpartum ([DONA International, n. d.](#)). In modern US maternity care practices, physicians, midwives, and nurses are not often able to offer continuous support throughout the birthing process due to factors such as high patient volumes, staff

shortages, shift changes mid-labor, and competing demands such as keeping records and managing technology ([Bohren et al., 2017](#)). Birth doulas, on the other hand, provide continuous labor support. Research has demonstrated positive impacts of birth doula support on maternal and child health outcomes, including lower rates of birth

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complications, higher likelihood of breastfeeding initiation, greater satisfaction with their perinatal experiences (Gruber et al., 2013), as well as reductions in the possibility of cesarean delivery, length of labor, and use of epidural (Hodnett et al., 2011).

Various access-related factors contribute to the limited utilization of doula services in the US. In 2012, about 6% of births surveyed in a large national sample were attended by a birth doula (Declercq et al., 2013). In CA, about 9% of births were attended by a doula in 2016 (Sakala et al., 2018). The current nature of doula care, in which doulas attend less than 10% of births and are privately hired in most instances, rendered their services uniquely vulnerable to hospital restrictions on outside visitors in response to COVID-19.

Hospitals quickly began enforcing policies limiting labor and delivery patients to one support person. For example, on March 18, 2020, the University of California at San Francisco (UCSF) issued a letter to pregnant families planning to deliver at the UCSF Birth Center asking the birthing person to identify one person to be their designated support person during their stay (i.e., a family member, friend, or doula). Despite a robust public response arguing that “doulas are essential” (Rubio-Mills, n. d.), hospital visitor restriction policies were enforced with few exceptions until well after the COVID-19 vaccine rollout began. This timeline reflects more than a year during which doulas were primarily excluded from attending hospital births in person.

The widespread barring of birth doulas from in-hospital labor and delivery support was concerning due to their critical role in improving both physical and psychological outcomes during pregnancy, childbirth, and postpartum.

Further, the pandemic caused staff shortages and required the reallocation of medical personnel to virus-related patient care, meaning that labor and delivery providers may have been even less likely to provide continuous support for birthing persons. When the Centers for Disease Control and Prevention recommended taking additional actions to manage stress and anxiety in response to community mental health concerns (CDC, 2020), we must examine the impact of institutional policies that limit services known to enact positive influences on pregnant individuals. Ironically, the unique experience of giving birth during a pandemic may be a time when the support of a birth doula could be most beneficial. Thus, the present study examined ways in which Bay Area birth doula services were impacted by visitor restriction policies, how doulas adapted their services, and the role birth doulas played during the COVID-19 pandemic.

## Theoretical Framework

Social action theory (Ewart, 1991) was the primary theoretical framework that guided research and analysis. It highlights the role of social mechanisms (e.g., interpersonal processes between doulas and clients) in public health responses. Its conceptualization of *action contexts* (i.e., contextual factors) demands careful consideration of the influence of settings (e.g., physical, task, financial, and historical), relationship systems, and organizational systems on supportive social relationships. Social action theory also suggests that the social connections fostered between birth doulas and their clients may have played a role in facilitating birthing persons’ adaptation processes to a novel socio-environmental context. Thus, the following methodology reflects a theory-driven approach to understanding how birth doulas supported clients as they adapted to the experience of giving birth within the global pandemic context while doulas adapted to delivering care in new ways.

## Methods

### Study Design

A qualitative case study methodology was utilized to examine doula care within the bounded context of the COVID-19 pandemic in the Bay Area of CA. The case study was *descriptive* in that it documented a phenomenon in the real-life context in which it occurred (Baxter & Jack, 2008). It was *intrinsic* because we were interested in learning about this particular case and capturing its complexity, rather than something this case represents or may be generalized to (Stake, 1995). The case was *contextually bound* (Baxter & Jack, 2008) to the nine counties of the San Francisco Bay Area, within the period in which hospital visitor restrictions were most strict, and to independently contracted birth doula care in hospital settings. The limited case described above—one geographical region, one limited time, and one type of healthcare service—may be considered a *single case* design with *embedded* units of analysis (Yin, 2003). Individual birth doulas were the units of analysis, serving as our primary informants.

### Data Collection Procedure

We used a snowball sampling approach paired with purposeful outreach to maximize participant diversity on dimensions such as geographical region, race/ethnicity, and years of experience. In total, approximately 80 doulas were contacted via email to recruit a final sample of 15 doulas. Respondents were eligible to participate if they lived in the San Francisco Bay Area and were contracted

to work with two or more clients with estimated due dates after March 13, 2020, as the primary birth doula before the enactment of hospital visitor restrictions.

Interested participants completed a Qualtrics survey in which they first provided informed consent to participate and answered questions assessing eligibility. If eligible, participants responded to questions about 1) their doula services (e.g., certifications, client volume, and years in practice), 2) the impacts of COVID-19 on their family via the COVID-19 Exposure and Family Impact Survey (CEFIS; Kazak et al., 2021), and 3) demographics. The primary researcher then conducted a one-hour telephone interview conducted with each participant. We developed a semi-structured interview guide with 10 questions and corresponding sample prompts based on social action theory. This interview guide contained mainly descriptive or “grand tour” questions (Spradley, 1979), experience questions, and one example question. Examples include the following:

Reflecting on the Coronavirus pandemic’s circumstances, what circumstances factors have you encountered that may have impacted your doula care?

Please tell me about a specific client who has delivered her baby during the Coronavirus pandemic. Walk me through how her birth experience ultimately played out, particularly your role.

Participants selected pseudonyms that were used throughout the research process. These interviews were audio-recorded and transcribed verbatim. UNC Charlotte’s Institutional Review Board approved the study. Participants received \$25 Amazon e-gift cards for completing the study.

### Participants

All participants had been working as a birth doula for at least 1 year, completed all study requirements in English, and were over 18. Although efforts were made to represent gender diversity, all participants identified as female, which is reflective of the vastly female-dominated profession. A majority of participants ( $N = 15$ ;  $M_{\text{age}} = 42.33$ ) identified as white, earned an annual household income of \$50,000 or more, attended at least some college, had no physical disability, spoke more than one language, were married, had one or more children, and were politically Democrat. All respondents resided in four of the nine Bay Area counties (Alameda, San Mateo, Santa Clara, Sonoma); however, all doulas reported servicing clients in multiple counties, thus increasing geographical coverage for the clients they served and hospitals in which they worked. Participants also reported

intraprofessional diversity, including the number of years working as a birth doula ranging from 3 to 28 and an approximate number of births attended as the primary doula during the previous year ranging from 4 to 60. This sample represented various certifications and certifying organizations, services offered, and types of practices.

### Analysis

Hypothesis coding, a theory-driven approach to analysis in which an initial coding schema is created prior to data collection based on the study’s theoretical framework and research questions (Miles & Huberman, 1994; Saldana, 2013) was used to analyze the qualitative interview data. This method offered efficiency and focus, as relevant social action theory literature (Ewart, 1991) *guided* analysis; a “start list” of codes based in social action theory was generated at the outset. Following transcription, the primary researcher conducted a round of “pre-coding” (Saldana, 2013) to refine the preliminary coding scheme, adding codes within the social action theory framework and deleting codes or categories that were not represented in the interviews. We then used QSR International’s NVivo 12 software for formal coding and analysis. A reflexive journal was kept throughout the analysis process. Brief analytic memos were written for each addition, removal, or other development in the researcher’s understanding of a code or category.

### Rigor

To enhance the trustworthiness of interpretations, the primary researcher conducted a “member check” after each interview (Lincoln & Guba, 1985), in which she provided a summary of interview findings via email and invited participants to confirm, clarify, or expand on key takeaways. To increase the integrity of interpretations, a research assistant served as a second formal coder for five of the fifteen interviews (33%) and met regularly with the primary researcher for peer debriefing about code assignments (Lincoln & Guba, 1985). Intercoder reliability indicated substantial agreement between coders (overall Cohen’s kappa coefficient = 0.69; Cohen, 1960). Kappa statistics at the level of the individual code or category facilitated methodologically rigorous revisions to the codebook and subsequent conclusions. To further establish credibility, quotes reflective of the full spectrum of responses were included in the interpretation of results and subsequent write-ups, intentionally highlighting all respondent voices and increasing objectivity to the extent feasible (Davies & Dodd, 2002). Finally, all products of the study have been retained to ensure that a dependability and confirmability audit may be conducted (Lincoln & Guba, 1985).

## Results

### *The Role of the Doula*

The birth doulas in this sample depicted their role as one of providing tailored, whole-person care that included: “informational, physical, and emotional support,” according to Adair; being a “constant support person in whatever capacity is possible,” according to Stella; “helping them feel confident and supported,” according to Rose; bridging “that gap between communicating with the care provider,” according to Noemie; and acting as “advocates” or “supporting clients in advocating for themselves,” according to Lenore, Kathy, Lucy, and Stella. Analogies included Monica’s comparison to “a tour guide,” Chrissie’s similarity to “a navigator,” and Jody’s view of herself as a “beacon reminding you of who you are.”

Participants frequently discussed emotional support, as the COVID-19 crisis increased the degree to which doulas were called upon to play a stress management role. As Kathy described, doula interventions often target “fears or anxieties specific to birth or parenting or pregnancy or postpartum, and so now with this extra layer of COVID, it’s like it takes more time to navigate that.” Doulas are trained to understand the intersection between psychosocial stress and birth experiences. For example, four of Kyle’s clients went into labor during the week following the enactment of hospital visitor restrictions which she attributed to the idea that “stress causes women to go into labor and they were very much under stress.” Nine doulas in this sample mentioned themes along these lines, like Kareema, who observed:

...there were a lot of people in the birth community who were really outraged to be excluded that way because it seemed to us that a natural response for somebody who is getting ready to give birth, to their response to what was happening would be a heightened fear, heightened panic, heightened stress, which, as we know, has a massive impact on outcomes and on the experience.

Participants recognized that many aspects of doula care were even more valuable and continued uninterrupted during the pandemic, such as emotional and informational support. In contrast, other components, namely physical support, became less feasible. Kareema summarized, “I think that we continue to play the role that we always have, of supporting folks, being a container for people to have their experiences.”

### *Multi-Level Contextual Factors Influencing Birth Doula Care*

We examined contextual influences based on Ewart’s (1991) conceptualization of settings, including physical features of doulas’ and their clients’ environments, tasks

routinely performed, interlinked financial contexts, the social environment, and organizational level factors.

**Physical: Health care settings.** Doulas continued to support hospital births, including twelve doulas who reported serving as the primary in-person labor companion in some cases. Eight participants supported families who faced challenges finding childcare; this was a primary reason some clients chose to rely on a doula to accompany the birthing person to the hospital so the partner could care for other children at home.

Participants described aspects of hospital settings that operated differently during the pandemic. For example, Kareema explained, “They don’t have yoga balls for patients anymore so if you want one, you need to bring one with you. The cafeteria is closed, so you need to bring food or have food dropped off.” Nina added that “some of the hospitals that had tubs, they weren’t allowing people to use tubs at the time,” and further, that for doulas, “once you were in the room, you could not leave anymore, no matter what. You have to use the restroom? You have to use the same restroom as the mom.” Similar limitations were described by participants related to access to ice machines, refrigerators, and microwaves. Kathy confessed that during one mid-March birth, she was not permitted to leave the labor and delivery room and resorted to “just like sleeping on a chair, like covering myself with a blanket just to get some space, with my headphones in, just for a little bit.”

**Use of virtual technology.** Doulas and clients also adapted to relying on virtual technologies to interact remotely, primarily video conferencing technologies (e.g., Zoom and Facetime) and wireless Bluetooth earbuds. This switch to virtual support demanded a high degree of adjustment and a learning curve for many doulas. Kyle remarked, “I was like, ‘What’s this Zoom? What are we doing now?’ and had to learn all of that technology.” She commented:

In non-pandemic days, we would never encourage someone to be connected to a screen or technology in their labor. It was always, ‘Put the screen down,’ and it’s not that you even have to tell someone; she doesn’t want to be connected to technology in her labor.

This sample generally emphasized that virtual support was neither their clients’ nor their preference. Three doulas, like Lucy, expressed that they “did not get into this work to be in front of a screen all the time.” Adair highlighted that partners were often burdened with facilitating the use of virtual technology:

...it’s not only their responsibility to have their hands in there and they don’t get a break to go and get themselves water or

eat food themselves, but they also have the added responsibility of setting up the technology and ensuring that the doula is on the line, the phone is plugged in, all of this stuff. They're angling the camera or they're bringing the phone closer to the partner... so it's just more stress onto them, which is so hard to see as a doula because your job is to support and help alleviate some of these responsibilities... and you feel like you're adding to it, at some times.

On the flip side, virtual technology increased accessibility for one of Chrissie's clients whose partner was deaf, which was beneficial for their communication. She shared that "Zoom actually helped us because he was not only able to read my lips on the screen, but he was also able to get the closed captioning on the screen..."

**Physical: Home environments.** Fourteen participants observed an upward trend in out-of-hospital births related to many clients' sense of unease about the risk of contamination associated with entering a hospital setting. Stella described that some "clients jumped into wanting a home birth right away, like, 'We don't want to go to the hospital during a pandemic; that seems like the least safe place for a healthy mom and a healthy pregnancy.'"

Eleven doulas met with clients in their home environments for prenatal appointments and sometimes during early labor, using safety precautions. Stella shared that for her:

The most ideal situation is a client goes spontaneously into labor, we labor at home until they're in transition, or in those final stages of labor, and then they get to the [hospital] door and they have their baby within 2 hours or 3 hours or so after arriving there.

Others equipped their own homes with the necessary features to enable successful virtual support; some were more conducive to virtual work than others. For example, Lenore described:

...my brother-in-law is a massage therapist. So, I have a table. He also does videography. So, I have a table to perform, and his girlfriend is my model ... I have him as a cameraman, and I can use his massage equipment or his massage table to guide my families through position work or massage and touch.

**Tasks: Roles and responsibilities.** Ten of the fifteen doulas described that their other roles and responsibilities contributed to the contexts from which they delivered services during the pandemic. For example, Lucy also worked as an abortion counselor, and she noted that some potential clients "felt that like my level of risk since I was physically in a hospital 2 days a week was more than they really were willing to take on." Four

doulas also noted that their activities of daily living impacted client interactions. Nina noted that it was "kind of an honor system." Chrissie described transparent conversations with her clients in which she detailed possible risks. The necessity of these disclosures seemed particularly salient because, as members of a vulnerable group, many pregnant individuals took extra precautions to protect their pregnancy health, such as "getting their groceries delivered and completely isolating," according to Stella.

Thus, all doulas described collaboration that occurred between doulas and clients to problem solve virus contamination itself, some following their clients' leads and others negotiating more actively. Resulting actions included masking, social distancing, air purifiers, and open windows, taking temperatures before meetings, being COVID regularly tested, quarantine periods following in-hospital work, and limiting other social contacts as much as possible.

Five participants noted the relevance of their roles within their families, particularly as mothers. Lenore gave birth during the summer of 2019 and disclosed that she became "emotional" during the interview, reflecting on the differences between her perinatal experiences and that of her clients:

I empathize a lot because I've been through it. I had such a different experience, and it was a joyful one ... I didn't have to think about a pandemic ... all the same pregnancy things are going on and people still have the same aches and pains that pregnant people have, but then they have this added... I feel grief for them even if they don't tell me that they're grieving; I feel grief for what they- for what their pregnancy could have been.

Kathy was pregnant at the time of our interview and noted that she began maternity leave earlier than planned because of bidirectional effects between her personal experience of being pregnant during the pandemic and her role as a birth doula:

I found myself ... bringing things from these births into my own experience and into my own kind of fears and anxieties ... I really had to kind of step back and be a little more gentle with myself because this work is very, very, intense... it's been a very strange and interesting time to be a doula and to be pregnant right now.

Nine doulas described other roles and responsibilities that helped them sustain their businesses, such as training new doulas, providing virtual childbirth education classes or support groups, offering consultation to newer doulas on creating multiple income streams, and expanding their postpartum offerings. Adair



described that “there’s been a lot of weird pivots that people have been doing where they’re kind of turning their business into another entity, to kind of deal with the revenue loss.”

**Financial context.** Eleven of the fifteen participants discussed contextual financial factors. The contractual agreements between doulas and their clients, which hinge upon payment for agreed-upon services, made doulas financially vulnerable during the pandemic. As Kyle explained:

...the bottom line was that people were not getting the service they signed up for and of course looking to me to figure out what this meant for us all professionally and financially and forgive me... for not being financially prepared for a pandemic...

Five doulas resolved this by issuing refunds to clients who requested them, like Kareema, who shared, “I didn’t fight anyone on refunds... I just wanted everyone to feel as safe as they could in the moment and then I also knew that I had things I could pivot into, to continue to create an income.” Six doulas offered fee reductions to reflect a shift in the services they offered, like Suzi, who noted that her financial context allowed her to incur a lower income for a period, saying, “I am in a place right now in my life that I didn’t need to keep uh, that number of clients, so I was like, just charging them a different [lower] fee... I think it made people be more at ease.”

Other doulas instead opted to adapt their services and largely retain their pricing structure. A few noted that at least a portion of clients with whom they were already under contract graciously honored agreements rather than renegotiating, like Monica, who described:

...these were people who felt that we were still providing services they had retained us for. So we did not have people like, ‘Oh we can’t have you in hospitals, we want our money back.’ Which was great... We immediately revamped and reached out to our clients and were like, ‘Okay, here’s what we’re going to do.’

Reflecting on underlying reasons for and broader implications of the requests that many doulas received to issue full or partial refunds, Adair reflected:

...it felt like during the first couple months the role of a doula was devalued for everyone, because they really saw us as a physical support person... it’s weird to have people try to cut down your services, because I price myself based on what’s sustainable for my family, you know? It’s my family supporting your family. It’s not just me. When I leave for a birth

that’s like 72 hours long, I’m leaving my husband at home. We don’t have children, but some of these other doulas are leaving their kids at home. And it just became transactional. I just hate seeing women’s health, and mental and physical, emotional well-being and support getting devalued.

**Relationship systems.** Participants in the sample illustrated meaningful relationships that contributed to their clients’ and social contexts. Fourteen of the fifteen doulas noted that clients experienced more limited social support due to pandemic circumstances, from family and friends, other pregnant folks, healthcare providers who conducted more appointments virtually, and so on. Kyle described that doulas filled some of these social support gaps:

I think having a doula has helped women to feel in some way normal in her pregnancy and not so alone because we’re so alone now, we don’t get to see our friends, we don’t get to go to the yoga class, we don’t get to see the mama in line at the coffee shop that is pregnant too – ‘When are you due?’ ‘Who’s your doctor?’ We don’t get that anymore.

Stella commented further on the importance of doulas in combating increased isolation from social support systems:

...we’re in this crazy, crazy time where we’re feeling very disconnected from family and friends and community, and a doula kind of... helps you remember where you came from and what you’re made of. We talk a lot about like, ‘How did your mom birth? Or your aunts? Or your grandma? And what does that mean to you?’

**Partners.** All participants discussed the role that their clients’ partners played. Kyle recalled that during the first days of the shelter-in-place order, some hospitals “were restricting all visitors and even dads were being kicked out.” Once it became standard policy to permit at least one visitor, most clients designated partners as their primary birth support persons. So, fourteen doulas offered live virtual consultation to partners during labor and delivery. As Stella explained, she was “really working through the partner now, which in some ways is really a special opportunity for partners to feel competent and helpful through the process.” Additionally, doulas provided partners with information and taught them prenatally skills, enabling them to serve as the sole in-person birthing partner. Rose remarked:

...it’s really nice to see them feeling more motivated to just stand in the space and be not just you know, dad, because it’s both of their birth and welcoming the baby, but also be the birth partner and the birth coach for mom, just feeling more motivated, because of all the knowledge he gained.

Other doulas, such as Nina, also commented on some of the downsides to relying on partners during labor and delivery:

The husband is great, but the husband is also someone close to them and someone that sees them in pain and is, you know, just a little fearful too. I mean they're like, this is their wife, and they don't know what to do... if this is normal, that's normal. When we were there ... there was always like that—those moments between a partner and a doula where they'd look at each other and you kind of nod at them to let them know everything's fine.

**Healthcare Providers.** Fourteen participants reported that obstetricians, midwives, nurses, and other providers were important members of their relationship systems. Four participants missed working alongside other members of their clients' care teams, like Monica, who shared, "I really love and admire when all of us understand our roles." Noemie described the role each fulfills, saying, "I have a good understanding of the physiological process and the care provider has a good understanding of the medical process of birth, right? So, I really see it as a counterbalance." Jody lamented that her clients missed "the playfulness and the synchronicity and the team that built with the doula in the [labor and delivery] room." Adair elaborated that virtual support sometimes led to tension during birth:

...being removed from hands-on support has affected my relationship with the birth partner, with the nurses, with the midwives that attend them, or the OBs. It's just everything has a layer of separation to it, which adds to, kind of a miscommunication if you're not really careful...

**Other doulas.** Fourteen of the fifteen participants in this sample pointed to other doulas as essential members of their relationship systems. Noemie described coming together with "the doula community, trying to support each other. Trying to figure out, 'How can we make this work?'" Veronica participated in "a weekly meeting with a huge group of doulas to see what people are doing" and swap tips. Chrissie exchanged information with "the doula community via Facebook or emails or texting," and Kareema received "a daily update from other peers, basically about the situation at the applicable hospital so that I could give my clients the most up-to-date information."

**Organizational systems.** Six participants also shared observations that the pandemic increased the extent to which birthing people experienced challenges navigating hospital systems. Kyle expressed:

...my clients aren't necessarily scared of labor in their body, what they're afraid of is the hospital system and what they're gonna make them do and not let them do and I think what Coronavirus has done has—people just feel out of control in so many ways.

Lucy went on to further situate the role of the doula within healthcare systems, saying that doulas:

...help folks like, justify their decision to give birth in an institution that they don't trust... Doulas are like a Band-Aid to a broken system and like a distrust between client and institution... And I was outraged that doulas don't have a union. We don't have collective bargaining power. We don't have any rights. Like, we don't have jack s\*\*\*. We have no labor protections as workers, and so, we were just out of a job because the institution decided that we were inessential.

Adair added, "It's been very challenging to be working with these larger institutions and have them kind of turn their back on us."

Participants unanimously discussed the impacts of hospital policies on their work. Stella confessed resistance to visitor restriction policies that reflected the remarks of most other doulas in the sample, saying, "in the beginning, I was like, 'This cannot be.' I was obstinate. I was calling the hospital and demanding answers and trying to figure out like, 'This can't be possible that you would kick us out.'" By the time data collection for this study was nearing completion, participants had begun reporting that some hospitals implemented "doula policies," enabling doulas to re-enter the birth room. According to participants, the requirements of these policies sometimes included proof of doulas' certifications, a negative COVID test within the past 30 days, a printout of the labor and delivery visitor policy, or other documents.

Additionally, participants discussed difficulties obtaining information about hospital policies, particularly because they were frequently revised and variably enforced by hospital staff. Lenore observed that some requirements, such as whether their clients were required to wear masks during labor and birth, depended "on who their nurse is that day." Regarding permitting doulas, Chrissie described that "there have been times that hospitals have said yes and then 10 days later said no, so I've had to stay really on top of each hospital." Monica noted that this type of variability between hospitals, care providers, and from one time frame to another existed prior to the pandemic as well, saying, "We were able to very easily validate that this is how hospitals run. You don't know what you're going to get, it's a grab bag every single time you're in the hospital."

**Historical context.** Overlapping with the unique historical context of the COVID-19 pandemic, this study took place during a critical historical moment of the Black Lives Matter movement when protests erupted internationally following several instances of police brutality, and in particular, the killing of George Floyd. Five participants named connections to birth work, including institutionalized and systemic racism in birth settings, the lack of Black obstetricians and midwives in their area, and broad treatment of people of color, particularly women, within healthcare systems. Veronica pointed out that the national conversation led to increased awareness of maternal health disparities for Black birthing persons, now with “mainstream media telling them that they have a . . . higher rate of having a C-section or dying,” which prompted many of her Black clients to inquire about out-of-hospital birthing options.

Kathy celebrated that doulas “are playing more of a social justice and anti-racism role” and noted that advocacy is one of her primary goals. Monica shared that pre-COVID, she valued providing doula care to “people of color who hired us because they knew we would protect them.” Relatedly, Kareema argued:

...the restrictions hospitals put into place; they compounded what was already happening, you know? They didn't make it safer for Black people, or trans people to give birth in the hospital, they made it even more dangerous. And part of what made it more dangerous was that they excluded all the advocates who could have been there to support those people, you know? In some shape or form...

## Discussion

This contextually bound qualitative case study yielded a nuanced depiction of birth doula care during the COVID-19 pandemic on multiple levels, capturing individual experiences, interactions between doulas and clients, and the influences of setting, organizational factors, historical timeframe, and other components of the bioecological system. Birth doula care delivery changed significantly in response to pandemic-related contextual shifts, namely in the reduced provision of *physical* birth support, increased importance of *informational* support, and increased demand for *psycho-emotional* support due to elevated stress. Doula-client dyads faced challenges in adapting to the use of virtual technology, negotiating financial arrangements for agreed-upon services, compensating for reduced social support systems and access to healthcare providers, staying apprised of changing policies and practices, and avoiding increased risks including virus exposure. Similar findings have been reported in the literature for other hands-on health professionals such as lactation consultants during COVID-19 (Dhillon & Dhillon, 2020).

The present research revealed important contributors to many of the challenges birthing individuals face and that doulas play a role in addressing, particularly highlighting how little power both doulas and birthing individuals continue to hold within the US healthcare system despite recent movement towards person-centered and collaborative care models broadly. This study adds to growing literature demonstrating the value of birth doulas and uncovers deficits in their current integration into hospital systems.

## Implications for Policy and Practice

This research is consistent with evidence reported in the extant literature that birth doula care offers a means to increasing access to individually tailored continuous support and advocacy that is responsive to psychosocial concerns within medical contexts that may not make such investments. The doulas in this sample described gracefully and respectfully partnering with their clients' care teams and celebrated when each team member served their unique function. Hospitals and care providers ought to embrace the utility and importance of adding birth doulas to labor and delivery care teams whenever possible, as they provide *complementary* care to that provided by medical providers. Birth doulas are responsive to aspects of care that physicians, midwives, and nurses are not trained or employed to address.

Kareema made an important point: “the world severely underutilizes us because they don't completely understand what we do, or how we contribute to that space.” The impact of hospital visitor restrictions on birth doula care highlights a glaring opportunity to reevaluate the doula's physical and philosophical place within the healthcare system. The same systems that recently deemed them non-essential visitors are now presented with a historical moment to reset and reimagine the integration of doulas within hospital settings.

The challenges doulas faced during the COVID-19 pandemic point to ways the workforce could be elevated or further mobilized, with the goals of 1) improving access to quality care for all birthing individuals, 2) acknowledgment of birth doulas as essential members of the care team by hospitals and healthcare providers, and 3) reducing power differentials between recognized hospital employees and doulas, as well as between birthing persons and their care providers. These goals both hinge upon and could increase the likelihood of doulas' eventual recognition by health insurers as a reimbursable service. Recent frenzied policy activity in this area ([National Health Law Program](#), n. d.) has emerged from decades of work by doulas and other birth workers in partnership with researchers, lawyers, policymakers, and other advocates. In large part, it also reflects the current urgency



around increasing access to doula care for vulnerable populations, especially Black women.

Lastly, we recommend with the utmost gravity that doulas' voices are included in the determination of future directions and offered seats at any table where decisions are made about policies, laws, insurance structures, employment, or any other aspect of the philosophical and practical positioning of birth doulas within the healthcare system. The birth doulas that we spoke to were incredibly insightful, eager to contribute, and ought to be centered as experts in all action planning and research going forward.

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### Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This research was approved by the University of North Carolina at Charlotte's Institutional Review Board (Study #: 21-0024).

### Informed Consent

Informed consent was obtained from all individual participants included in the study.

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### Supplemental Material

Supplemental material for this article is available online.

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