A Critical Intersectional Analysis of Black Doulas' Experiences in Maternal Healthcare

Emely Matos
University of Central Florida

Part of the Maternal and Child Health Commons, and the Race and Ethnicity Commons
Find similar works at: https://stars.library.ucf.edu/etd2020
University of Central Florida Libraries http://library.ucf.edu

This Masters Thesis (Open Access) is brought to you for free and open access by STARS. It has been accepted for inclusion in Electronic Theses and Dissertations, 2020- by an authorized administrator of STARS. For more information, please contact STARS@ucf.edu.

STARS Citation
https://stars.library.ucf.edu/etd2020/1254
A CRITICAL INTERSECTIONAL ANALYSIS OF BLACK DOULAS’ EXPERIENCES IN MATERNAL HEALTHCARE

by

EMELY MATOS
B.S. University of Central Florida, 2020

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Applied Sociology in the Department of Sociology in the College of Science at the University of Central Florida Orlando, Florida

Summer Term
2022
ABSTRACT

According to the U.S. Centers for Disease Control and Prevention (CDC), maternal death ratios are severely racially stratified as African American women face the most significant risk. Currently, Black women are four times more likely to die from pregnancy-related death in the United States than white women. Race disparities in maternal health outcomes may be exacerbated by the Covid-19 pandemic as preliminary research suggests that the pandemic's disproportionate impact on Black communities and existing concerns about Black women's medical treatment may indicate an increase in mortality within the next few years. Racial health disparities reflect the nation's flawed maternal healthcare system and highlight a need for alternative healthcare models, including increased use of doulas, who provide physical, emotional, and educational support during pregnancy, childbirth, and postpartum. Research has shown that doula care effectively mitigates adverse perinatal outcomes for socially disadvantaged women and their infants. Black doulas have distinct knowledge and insights about how race operates in the maternity care system as birth workers who serve Black birthing women, however there is little research illuminating their perspectives.

The current study is a qualitative analysis of the perspectives of Black doulas on their experiences with birth work in the U.S. maternity health care system during the Covid-19 pandemic and beyond using a critical intersectional lens. Data consist of in-depth, semi-structured qualitative interviews with 11 Black doulas throughout the U.S. Interviews were transcribed with the aid of Otter.ai and coded and analyzed thematically using NVivo. The results yielded four overarching themes: Advocacy and Trust are Key Components of Doula Work, Barriers to Accessing Doula Services and a Need for New Hospital Policies, COVID-19
Worsened Restrictions on Doula Work and Increased Distrust of Hospitals among Black Indigenous and People of Color (BIPOC). The final theme focused on the History of Racism in Reproductive Health affects Quality of Care Today and included a sub-theme regarding the Prevalence of Dismissive and Abusive Care.

This study expands existing knowledge of race inequalities in maternal health by contributing the experiences and perspectives of Black doulas, who are uniquely positioned to observe Black patients’ treatment in maternity care. Findings demonstrate a need for medical institutions to address systemic racism within their policies and procedures and highlight actionable solutions proposed by doulas to mitigate existing injustices.
# TABLE OF CONTENTS

LIST OF FIGURES ....................................................................................................................... VII

CHAPTER ONE: INTRODUCTION .................................................................................................. 1

CHAPTER TWO: LITERATURE REVIEW .......................................................................................... 4

U.S. Maternal Mortality in Global Context ................................................................................... 4

Maternity Care ............................................................................................................................. 6

Pregnancy and COVID-19 .............................................................................................................. 10
  Racial Disparities during the Pandemic ..................................................................................... 11

Doula Care ................................................................................................................................... 13
  Radical Black Doulas ................................................................................................................. 15

Reproductive Justice .................................................................................................................... 16

CHAPTER THREE: METHODS ..................................................................................................... 19

 Participant Demographics ........................................................................................................... 19

 Data Collection ............................................................................................................................ 20

 Data Analysis ............................................................................................................................... 22

 Reflexivity Statement .................................................................................................................... 23

CHAPTER FOUR: RESULTS ....................................................................................................... 25
LIST OF FIGURES

Figure 1: United States map showing the geotags of doulas certified through the National Black Doulas Association (NBDA). ................................................................. 20
CHAPTER ONE:
INTRODUCTION

Maternal mortality is a global indicator of a nation’s health as it reflects inequities in the healthcare system (Costello and White, 2000). The leading causes of maternal death can be attributed to preventable complications during pregnancy or labor, such as obstetric hemorrhages, infections, and hypertension (MacDorman et al., 2016). The United Nations and the World Health Organization have used this knowledge to allocate resources and create initiatives worldwide to reduce maternal mortalities (Neggers, 2016). Despite the worldwide advancements made by various health initiatives, the United States is one of two countries, along with the Dominican Republic, that have witnessed their maternal mortality rates double in the last twenty-seven years (Declercq and Zephyrin, 2020).

The United States has the highest maternal mortality rate of all developed nations, ranking 60th in the world in 2017 (World Health Organization, 2017). According to the Centers for Disease Control and Prevention (CDC), Black women face the most significant risk of maternal death (44.0 per 100,000 live births). Hispanic mothers have the lowest ratio of maternal mortality (12.6), similar to those of Non-Hispanic White (17.9) women (Centers for Disease and Prevention, 2019). Black women are, therefore, nearly four times more likely to die from pregnancy-related death in the U.S. than white mothers (Centers for Disease Control and Prevention, 2019). Breakdowns of maternal death ratios in terms of race in the U.S. expose disparities produced by obstetric racism and bias in the maternal healthcare system (Davis, 2019a: Davis, 2020).
Black women report higher levels of medical mistrust than women of other races due to historical events and ongoing discrimination in clinical settings (Davis, 2019a, 2019b; Lang and King, 2007: Wint et al., 2019). For centuries, medical institutions in the U.S. have used Black bodies without consent to advance medicine (Myles, 2021: Taylor, 2020: Wells and Gowda, 2020). These injustices have shaped the foundation of medical institutions and their policies and continue to affect the quality of care that Black birthing people receive (Davis, 2019a). Their interactions with medical personnel continue to be tainted by the prejudice, stereotypes, and exploitation that Black people and their ancestors have had to navigate their entire lives in this country (Davis, 2019a). In a reproductive setting, this manifests as obstetric racism wherein Black birthing people consistently cite interactions that display clear dismissiveness, lack of informative care, and abuse (Davis, 2019a; Davis, 2020).

We are seeing health disparities amplified in the U.S., as Black Americans are more likely to be diagnosed, hospitalized, and die from COVID-19 (Bogart et al., 2021: Oparah et al., 2021). Prior to the pandemic, Black pregnant women consistently reported poor treatment from hospital staff, fueled by harmful prejudices and stereotypes (Taylor, 2020). There is little research concerning the effect that COVID-19 has had on the U.S.’s maternal mortality rate. However, preliminary findings suggest that the pandemic's disproportionate impact on Black communities and existing concerns about Black women's medical treatment may indicate an increase in mortality within the next few years (Bogart et al., 2021; Carvalho et al., 2021).

Research consistently cites increased access to doula care as a solution to reducing adverse maternal health outcomes (Kozhimannil et al., 2016: Thomas et al., 2017: Wint et al., 2019). Doulas provide alternative care that prioritizes emotional, physical, and informational support throughout the perinatal, labor, and postpartum periods. They are similar to community health
workers as they do not offer medical services but work alongside healthcare providers. They are hired privately by expectant families to provide comfort and support and ease communication between clients and their medical staff (Kozhimannil et al., 2016). In the postpartum period, doulas remain with their clients and support parents throughout the first few weeks of the newborns' lives (Thomas et al., 2017). Studies have shown that doula support is associated with reduced cesarean births, reduced need for induction, and shortened labor duration (Gruber et al., 2013; Thomas et al., 2017; Wint et al., 2019). Unfortunately, doula services remain largely inaccessible to the women who need them most. Considering that Black and low-income women have the highest risk of poor birth outcomes we must uncover how best to increase accessibility to potentially life-saving resources, like doulas (Kozhimannil et al., 2016: Thomas et al., 2017). Although a few studies have focused on doulas' experiences as birth workers, there is little research on Black doulas' experiences working in the maternity care system. Black doulas have distinct knowledge and insight about how race operates in the maternity care system as birth workers who serve Black birthing women. Therefore, this study aims to understand Black doulas' experiences navigating birth work during the pandemic and beyond.
CHAPTER TWO:
LITERATURE REVIEW

Maternal death has been at the forefront of global health initiatives for the past few decades (Costello and White, 2000). The World Health Organization defines maternal death as the death of a pregnant woman while pregnant or within forty-two days of the termination of their pregnancy (World Health Organization, 2019). The forty-two day window is prudent as maternal deaths occur around labor/delivery and the immediate postpartum period (Ronsmans and Graham, 2006). The United Nations has worked on a series of goals and interventions to reduce maternal mortality by at least three quarters. The Sustainable Development Goals (SDGs), generated by the United Nations initiative, created the standard for maternal health through a transformative agenda (Costello and White, 2000: World Health Organization and Unicef, 2015). The SDG focuses on reducing maternal mortality rates and stresses the importance of improving maternal health in all aspects (World Health Organization, 2019).

U.S. Maternal Mortality in Global Context

Research has found that the burden of maternal mortality globally is felt most strongly in Sub-Saharan African and South Asian countries. Most maternal deaths are preventable, occur primarily within hospitals, and are commonly attributed to low-income countries (Ronsmans and Graham, 2006: World Health Organization, 2019). The leading cause of maternal death worldwide is obstetric hemorrhage. However, in developing countries, based on local illnesses and laws, other major causes of maternal death can be attributed to unsafe abortions, malaria, and
HIV/AIDS (Ronmans and Graham, 2006). The exact number of deaths due to unsafe abortions is unknown, although various scholars note their substantial influence on maternal death rates. In 2014, unsafe abortions accounted for about fifty percent of over 56 million abortions performed that year (Ngo et al., 2021).

The World Health Organization (WHO) estimates that a significant number of maternal deaths in sub-Saharan Africa, South Asia, Latin America, and the Caribbean result from unsafe abortions (Ronmans and Graham, 2006). Carine Ronmans and Wendy Graham (2006) posit that the indirect causes of maternal deaths are rooted in poverty. They state that poor women in remote areas are less likely to receive proper care, especially in the most at-risk nations in Sub-Saharan Africa and South Asia. All women should be afforded the same right to care from skilled healthcare professionals before, during, and after childbirth (World Health Organization, 2019).

On a global scale, there has been recent progress made towards the reduction of maternal deaths. Research suggests that within the next twenty-five years, we can expect to see a 75 percent reduction since some industrialized countries have halved their ratios through the use of professional midwifery care (World Health Organization, 2019). South Asian countries like Thailand, Malaysia, and Sri Lanka have benefitted from long-term investment in midwifery care and access to free care in the past forty years. In less than seven years, Egypt and Honduras halved their rates through global policy changes, professional training networks, and health-and-family planning services dispelling misinformation (Ronmans and Graham, 2006). However, since 1950, the United States has experienced increased maternal mortality rates (MacDorman et al., 2016). According to Marian MacDorman et al. (2016), data show that between 2000-2014, rates in the United States have more than doubled from 9.8 maternal deaths per 100,000 live
births in 2000 to 21.5 in 2014, while international trends continue to steadily decline (MacDorman et al., 2016: 6). Two global reports indicate that the U.S. and the Dominican Republic are the only countries that have experienced an increase in maternal mortality rates in the past twenty-five years (Declercq and Zephyrin, 2020: Neggers, 2016).

The United States has the highest maternal mortality rate of all developed nations (Carroll, 2017: MacDorman et al., 2016: Neggers, 2016). The higher rates of maternal mortality in the U.S. compared to other industrialized nations reveal shortcomings in the U.S.’s maternity care system; these shortcomings are exacerbated by structural inequalities. Statistics released by the United Nations ranked the United States as sixtieth in the world, well below virtually every other developed nation (Neggers, 2016: World Health Organization, 2019). In the United States, maternal mortality is the sixth most common cause of death among women aged 25 to 34 years old (Carroll, 2017: MacDorman et al., 2016). As of 2016, "women giving birth in China or Saudi Arabia [were] at a lower risk of dying than in the United States" (Neggers, 2016:1). The CDC identified the three leading causes of pregnancy-related death in the United States: hemorrhage, preeclampsia, and cardiomyopathy (Hantoushzadeh et al., 2020: MacDorman et al., 2016).

Contributing factors include barriers to hospital access before and after birth, quality of traditional prenatal care, and the effects of obstetric and structural racism (Centers for Disease and Prevention, 2019: Weigel, 2019).

Maternity Care

Maternity care refers to all aspects of antepartum, intrapartum, and postpartum care. Pregnant and postpartum women's interactions with the healthcare system have significant
implications for their maternal health outcomes (Taylor, 2020). Menard et al. (2015) posit that the focus of improving maternity care in hospitals as a response to surging maternal deaths has diminished the importance of community-based care and consistently disregards the effects of socioeconomic position, poor quality care, and structural racism.

According to the CDC, maternal death ratios are disproportionately racially stratified as Black women face the most significant risk. As it stands, Black women are nearly four times more likely to die from pregnancy-related death in the United States than white mothers (Carroll, 2017: Division of Reproductive Health, 2019: Lang and King, 2007). Inconsistent access to care, obstetric racism, and chronic antenatal conditions are to blame for the United States' upward trend in maternal mortality and declining quality of maternal care (Agrawal, 2015).

Due to the United States' disintegrated healthcare system, many lack access to proper and necessary care or avoid it due to high costs (Carroll, 2017). Barriers to access are particularly salient for birthing women when legislators and policy makers argue that "maternity care should not be considered essential benefits" (Carroll, 2017:1). Over "60 percent of pregnancy-related death in the United States are preventable" (Omeish and Kiernan, 2020), yet morbidity and mortality rates cannot be remedied if clinics continue to close, and insurance fails to provide adequate coverage for maternal care. Moreover, having access to quality care has been proven by numerous researchers not to be enough to eliminate the racial inequalities of maternal mortality and severe maternal morbidity (SMM) (Omeish and Kiernan, 2020). Black women are still experiencing complications after childbirth (Omeish and Kiernan, 2020). As a result, racial disparities in healthcare require a truly comprehensive approach. It commands a deep understanding of how implicit and explicit healthcare biases endanger Black women's lives (Omeish and Kiernan, 2020).
Likewise, obstetric racism affects all pregnant persons. It is widespread and negatively impacts their reproductive agency (Campbell, 2021). Because of its prevalence, it is becoming recognized as gender-based violence as women continue to report mistreatment and feel pressured to partake in medical interventions during birth (Campbell, 2021). This phenomenon can be attributed to the naturalization of physician authority (Davis, 2019, 2020). Additionally, various points differentiate Black women's medical experiences from others—for example, the history of medical exploitation of Black women and African Americans. More specifically, modern American medicine is intrinsically enmeshed in the abuse of Black and African American women for the advancement of medical knowledge (Campbell, 2021).

Childhood poverty, limited employment opportunities, low income, and segregation have lifelong effects on stressors, health-risk behaviors, and the availability of healthcare. These factors are all more likely to affect Black lives than white American's lives, which helps explain why chronic diseases like hypertension, diabetes, and obesity are becoming more common among Black Americans (Hayward et al., 2021: Lang and King, 2007).

Minorities tend to reside in more socioeconomically disadvantaged neighborhoods, therefore quality healthcare is difficult to access (Lang and King, 2008). Chronic conditions are typically a result of long-term socioeconomic conditions rather than from a single point in time (Agrawal, 2015). Jo Link and Bruce Phelan (1995) argue socioeconomic status, social support, gender and race/ethnicity are fundamental causes of disease because they represent access to necessary resources like money, knowledge and power. Existing resource barriers influenced by socioeconomic conditions prevent already vulnerable populations from engaging with preventative care (Adams and Thomas, 2017). Access to these resources can be used to completely avoid or minimize diseases, therefore health inequities are produced and reproduced
through the interaction of fundamental causes (Link and Phelan, 1995). Similar to socioeconomic status, racism and stigma are linked to health and mortality. Systemic racism, independent of socioeconomic status, is a fundamental cause. However, inequities produced by structural racism are associated with racial disparities within socioeconomic positions. Regarding maternal mortality, it is essential to recognize that racial discrimination maintained by governing institutions has amplified racial disparities: in this case, racism is a fundamental cause of maternal health disparities. Structural racism affects Black women’s lives outside of the clinical setting and the combined effect of lifelong discrimination contributes to disparities in maternal outcomes (Adams and Thomas, 2017). Social determinants like educational attainment, social or economic status are not protective factors for Black mothers. For instance, Black mothers with college educations are five times more likely to die than white mothers with a college education (Declercq and Zephyrin, 2020).

The ramifications of the obstetric racism Black women endure both within and outside of the maternity care system result in vulnerable birth environments that lead to adverse maternal health outcomes (Rivera, 2021). Black women often report experiencing poor treatment from hospital staff during their clinical prenatal appointments (Oparah et al., 2021: Taylor, 2020). Prejudices and stereotypes produced from negative cultural representations of Black people have manifested into a medical falsehood that Black women are 'obstetrically and gynecologically hardy' (Taylor, 2020). Gynecological hardiness refers to the prejudiced belief that Black women have higher pain tolerances (Taylor, 2020). Therefore, Black mothers' pain has become invisible to healthcare providers and, in turn, the healthcare system (Suarez, 2020: Taylor, 2020). The devaluing of Black women's pain and autonomy through public policies and practices perpetuate racial disparities and contribute to rising maternal mortality rates (Taylor, 2020). The blatant
racial disparities in maternal mortality epitomize the repercussions of structural racism within the healthcare system.

Pregnancy and COVID-19

The world continues to navigate the repercussions of the spread of the coronavirus disease 2019 (COVID-19). The World Health Organization officially announced the pandemic on March 11, 2020, and it is still ravaging the globe two years later. Since the pandemic's beginning, researchers have worried about what this means for pregnant women, as they constitute a vulnerable population. Pregnant women are more likely to be affected by respiratory illnesses than non-pregnant women, increasing risk during the pandemic, considering that COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which has led to "increased infectious morbidity and high maternal mortalities" (Dashraath et al., 2020: 1). However, early studies of COVID-19 infections in pregnancy revealed promising results compared to the previous SARS outbreak. Researchers found that the most significant risk occurred in the second or third trimester of pregnancy (Dashraath et al., 2020). Pregnant women infected with COVID-19 during their second or third trimester are more likely to experience fatal heart complications and postnatal deterioration (Hantoushzadeh et al., 2020). Fetal complications of COVID-19 were also high: they included preterm birth (39%), intrauterine growth restriction (10%), and miscarriage (2%) (Dashraath et al., 2020).
Racial Disparities during the Pandemic

The spread of coronavirus disease aggravated existing social disparities within Black maternal health caused by underlying systemic oppression (Singh, 2021). COVID-19 has disproportionately affected people of color and those in lower socioeconomic positions. The spread of the disease has only highlighted pre-existing inequities within the healthcare system as preventable cases of Black mothers' deaths grew in quantity (Metz et al., 2019; Rivera, 2021). The same underlying chronic conditions that make pregnancies risky for Black women make COVID-19 diagnoses potentially fatal. Deepa Dongarwar et al. (2020) believes that inherent prejudices against minorities within the healthcare system pose a more significant threat to pregnant women of color as it was found that healthcare providers are less likely to refer Black Americans for COVID-19 testing. However, Black Americans and Latinos were less likely to be able to work from home, leaving them at higher risk of infection (Dongarwar et al., 2020). Social distancing guidelines further restricted Black women’s ability to access prenatal care by enforcing the one-visitor policy and reducing access to healthcare providers for miscarriages or abortions (Dongarwar et al., 2020).

Mariel Rivera (2021) captured the unique experiences of community-based doulas’ experiences acclimating to the restrictions shortly after the pandemic announcement. Doulas around the nation began to transition their in-person courses into virtual platforms designed to accommodate for state-wide lockdowns and hospital restrictions (Oparah et al., 2021; Rivera, 2021). Their virtual services encompass the same prenatal, labor, and postpartum services as they did before. Transforming childbirth courses into Zoom lectures eliminated potential barriers to transportation and increased the average turnout of some doulas’ courses (Rivera, 2021).
However, not all aspects of the transition have been beneficial. Some mothers and doulas lamented the lack of physical support doulas were able to provide due to COVID-19 fears. Many doulas were concerned with the undue stress that having to attend doctor's visits alone caused mothers. Doulas feared that the restrictions meant their Black clients would face even more discrimination in the hospital setting. They found that the only way to communicate with their clients during these visits was through FaceTime; however, some doctors viewed this as a liability and discouraged mothers from speaking to their doulas on the phone (Oparah et al., 2021: Rivera, 2021).

Pregnant women in the United States expressed increased interest in community birthing centers and doulas during the pandemic due to growing fears of COVID-19 exposure, limited access to their support systems, and uncertainty surrounding hospital restrictions (Adams, 2020: Rivera, 2021). Doulas responded to their concerns by devoting extra time to prepare mothers during the prenatal period and emphasized designing and developing various contingency plans. When it became clear that doulas were not going to be allowed to attend their clients' births, doulas taught them hands-on techniques and comfort strategies and increased the level of educational knowledge they gave. They hoped that by encouraging their clients to speak for themselves by providing them with as much information as possible, they could mitigate the effects of any medical racism they may encounter (Adams, 2021: Oparah et al., 2021). The limitation and banning of doulas in the hospital "exposed what doulas feared— that they are low in the maternity care team hierarchy and not valued for the expertise they offer" (Adams, 2021: 5).

Doulas that served mostly marginalized communities described the intersectional barriers to doula care that typically manifested as the mistreatment of Black mothers. They noted that
Black, Indigenous, and People of Color (BIPOC) communities had less access to COVID-19 tests and were more likely to face disrespectful care and unnecessary procedures and examinations (Oparah et al., 2021). Several doulas noticed that hospitals were separating mothers from their babies immediately after birth as a precaution, even when the mother tested negative for COVID-19. They also noted that this meant that hospital staff neglected patients as they waited for their test results and refused to acknowledge or treat them before laboring mothers tested negative (Oparah et al., 2021).

Unfortunately, a negative test result did not guarantee that hospital staff would give proper care to Black mothers. In the early stages of COVID-19, prejudiced assumptions of Black people as carriers of the virus created racialized fear amongst health professionals (Rivera, 2021). These prejudices came from higher infection rates of Black communities. However, this view discredits the socio-political factors that influence higher infection rates. Black people are not carriers of the COVID-19 virus; instead, they are more likely to be exposed as they occupy a large percentage of the working-class and risk exposure more frequently (Oparah et al., 2021). Black people were also more likely to receive inadequate healthcare and had higher chronic conditions that made COVID-19 infections deadlier (Oparah et al., 2021). Research like Julia Oparah et al. (2021), Mariel Rivera (2021), Crystal Adams (2021) and Deepa Dongarwar et al., (2020) has revealed immediate repercussions of the pandemic on Black births, however we have yet to see how COVID-19 restrictions will impact future maternal mortality rates.

**Doula Care**

Historically, labor companions have assisted mothers through the birthing process. Evidence suggests that labor companions, whether friends, family, or professional, can lead to
increased health outcomes (Uban, 2012). Professional labor companions, or doulas, emerged from a grassroots movement during the early 1990s in the United States to supplement standard maternity care practices for women desiring natural births (Adams and Curtin-Bowen, 2021: Torres, 2013).

Doulas provide physical, emotional, and educational support during labor, birth, and immediately postpartum (Gruber et al., 2013: Marsden, 2020). A doula's primary objective is to give mothers the tools to navigate the healthcare system and self-advocate if necessary (Wint et al., 2019). Doulas are similar to community health workers as they do not offer medical services but work alongside healthcare providers (Kozhimannil et al., 2016). Midwives, on the other hand, are trained to provide medical care throughout all periods of pregnancy, labor and, postpartum and are even certified to perform deliveries. Doula services are linked with decreased cesarean rates, higher infant Apgar scores, shorter labor durations, and increased breastfeeding retention rates (Adams and Curtin-Bowen, 2021: Gruber et al., 2013: Wint et al., 2019).

In a 2013 study comparing two similar at-risk groups of mothers, doula-assisted mothers were two times less likely to experience a birth complication and four times less likely to have a low birth weight (Cancelmo, 2021: Gruber, 2013:). Doulas are unregulated at the federal and state levels: therefore, those not working for organizations have near complete control of their services and procedures (Menzel, 2020). However, since doulas frequently work in hospitals, it is common for them to receive certification from training organizations to either satisfy hospital policies or gain credibility from medical institutions. Training organizations include, but are not limited to, Doulas of North America (DONA), Childbirth and Postpartum Professional Association (CAPPA), National Black Doula Association (NBDA), and many others. A doula's choice of program typically centers around their alignment with the curriculum's ideals. For
instance, NBDA is known for connecting Black Indigenous People of Color (BIPOC) with BIPOC birthing people in the hopes of mitigating the high Black maternal and morbidity rates in the US.

In addition, doulas working in their communities have first-hand experience in this untapped field and its benefits. Some doulas in Annie Menzel’s (2020) research reported how important it is to maintain good relationships with clinical labor staff to support their clients throughout their pregnancy and birth properly. To create good relationships with staff, doulas typically help doctors and nurses with non-clinical tasks and give gifts and thank you notes to nurses they worked beside (Menzel, 2020). Annie Menzel’s (2020) and Jennifer Torres’ (2013) investigations both revealed doulas ‘need to strategically feign subordination to medical staff so that they would be allowed to assist their clients through labor. Their studies found that doulas try their best to express deference to physicians by feigning to yield absolute authority to them. Their feigned subordination was not because they disagreed with physicians' medical expertise: rather, they were actively hoping to counteract the stereotype of the outspoken, confrontational doula (Torres, 2013). Doulas reported deferring to doctors while remaining hyperaware of their role as their client's advocate and their role to protect them from neglect, insensitivity, and obstetric violence (Menzel, 2020: Torres, 2013).

*Radical Black Doulas*

Intersectionality asserts that social identity categories like race, gender, class, sexuality, and socioeconomic status operate simultaneously to reflect interlocking systems of privilege and oppression at the structural level (Bowleg, 2012: Smooth, 2013). This framework acknowledges
that categories of social identities are intrinsically linked to discrimination and influence individuals' health statuses. Intersectionality facilitates examinations of marginalized people's health as it calls for research to consider individuals' positionally (Bowleg, 2012). Research shows that minority doulas, particularly Black doulas, become doulas out of a desire to help their communities and protect other women from facing similar injustices to the ones they experienced during the birthing process (Bowleg, 2012: Suarez, 2019).

Therefore, Black radical doulas' focus on assisting marginalized women before and during childbirth alleviates the harm perpetuated by medical abuse and racism (Bowleg, 2012). Black doulas support their clients emotionally and physically, while simultaneously ensuring their clients remain safe from being medically coerced or abused through nonconsensual procedures or disparaging language (Cancelmo, 2021: Wint et al., 2019). Black mothers claimed to feel empowered by their doulas in a system they often felt overlooked or invisible (Gentry et al., 2010: Henley, 2019: Wint et al., 2019). When Black doulas empower Black mothers to use their voices and regain control over their birth experiences, they challenge "the absolute authority imbued in obstetric medicine (Henley, 2019: 2)."

Radical or community doulas offer services to typically underserved women for free or reduced-cost before, during, and after labor (Cancelmo, 2021: Wint et al., 2019). They are committed to making doula services more accessible even though they often do not make livable wages (Suarez, 2021).

Reproductive Justice

Reproductive Justice activists have been fighting for increased access to doulas in the hopes of reducing racial disparities in maternal mortality. Reproductive Justice is a social movement
that combines social identity categories such as gender, race, and socioeconomic status with community-developed solutions to structural inequalities in maternity care. This movement evolved from the original legal activism that emphasized choice without addressing the barriers to having children that women of color and low-income women face (Luna and Luker, 2013). Cara Cancelmo (2021) argues that the same way that reproductive rights language became problematic as women debated over abortion rights, activists fighting to expand doula and midwife care as a woman's right issue limited access to poor women, immigrants, and women of color (Davis, 2019b: Suarez, 2020). She states that women's rights to bodily autonomy were intertwined with capitalism and consumer choice. White wealthy women's encouragement to exercise consumer choice within the healthcare system was unattainable for low-income women. Often, white activism for women's rights has neglected to incorporate the needs and concerns of Black women (Davis, 2019b). For instance, several authors cite the Sheppard Towner Maternal and Infant Protection Act of 1921 as a prime example of early maternal health activists further restricting access to quality prenatal care for marginalized women in the United States while simultaneously improving maternity care for white mothers (Cancelmo, 2021: Menzel, 2020). The success of this legislation limited Black women's birthing choices and job opportunities, while white women gained access to better maternity care (Suarez, 2020).

In response to the rising infant and maternal deaths following the enactment of the Sheppard Towner Maternal and Infant Protection Act, officials began to blame "the alleged ignorance, unhygienic practices, and superstitions of Black midwives" (Menzel, 2020: 1). In 1921, Black midwives were essential in their communities as they cared for white and Black people through births and deaths. Black midwives' delegitimization through the spread of prejudiced superstitions and continued segregation laws contributed to the service fee model seen today for
midwives and doulas. It effectively removed Black women from reproductive care and alienated the Black women who needed maternal support. Annie Menzel claims that the "persistent disproportion in infant and maternal mortality bespeaks the persistence of obstetric racism: routine hostility and neglect from the still White-dominated medical profession against a backdrop of toxic stereotypes and punishing policies from a White society morbidly obsessed with the Black female reproductive body” (Menzel, 2020: 22).

Fortunately, effective reproductive justice community programs spearheaded by Black midwives and doulas have garnered the interest of city-wide health initiatives across the nation. Some Black doulas and midwives leading these initiatives openly share their connection to the Black midwives targeted by the Sheppard Towner act back in the mid-1900s. Black reproductive justice-oriented doulas and radical doulas are working to dismantle the fatal effects of obstetric racism by offering their services to Black women who need it most (Menzel, 2020).

Existing literature supports that doula services are beneficial for positive health outcomes. Few studies have focused on Black doula’s experiences working in the maternity care system and how their unique position as both doulas and Black people allows them to have distinct insight into how race operates in the maternity care system.
CHAPTER THREE:

METHODS

This study is a qualitative, in-depth analysis of the perspectives of Black doulas on their experiences with birth work in the current maternity healthcare system using a critical intersectional lens. Semi-structured interviews were conducted with 11 Black doulas in the United States. Interviews were transcribed with the aid of Otter.ai and coded and analyzed thematically using NVivo. Thematic analysis lends itself well to inductive design as it allows researchers to identify emerging patterns in the data (Braun and Clarke, 2006).

Participant Demographics

Eleven Black doulas certified through the National Black Doula Association (NBDA) completed interviews. The mean age was 39.4; respondents ranged between 30 and 48 years old. All worked officially as certified doulas for less than seven years, while unofficially, three doulas were involved in birth work for over ten years. The average length of work history was 3.5 years. All the doulas served primarily Black women; however, most had clients from a wide range of marginalized groups. Their specialties ranged from fertility doulas and birth doulas to full-spectrum doulas. They represented the following states: Florida, Georgia, South Carolina, Mississippi, Arizona, and California. Four (36%) participants reside in California, three (27%) in Georgia, one (9%) in Florida, one (9%) in South Carolina, one (9%) in Mississippi and one (9%) in Arizona. Participants were asked their ethnicities, sexual orientation, and gender identity to ensure that the sampling remained intersectional. Three participants belonged to the LGBTQIA+
community, and one identified as nonbinary. Two of the doulas were of Caribbean descent, while one was Latinx.

Data Collection

To collect data for this study, I conducted 11 semi-structured interviews with participants recruited through the national directory provided by the National Black Doulas Association (NBDA). Figure 1 is the directory map retrieved from the National Black Doulas Association webpage.

![United States map showing the geotags of doulas certified through the National Black Doulas Association (NBDA).](https://www.blackdoulas.org/national-directory)

Figure 1: United States map showing the geotags of doulas certified through the National Black Doulas Association (NBDA).

Source: NBDA National Black Doulas Association

https://www.blackdoulas.org/national-directory

I chose the NBDA due to its mission statement striving to fight the high Black maternal mortality and morbidity rates in the United States by easing access to Black Indigenous People Of Color (BIPOC) doulas for BIPOC women. Their directory has 200 birth worker profiles, of
which I contacted 113 via email. In total, 21 birth workers expressed interest in participating in this study, of which 14 arranged a time for an interview. Two did not come to the scheduled meetings, while one declined to reschedule after technical difficulties on my part. The 113 profiles were from the following states: Florida, Georgia, South Carolina, Alabama, Mississippi, Louisiana, Oklahoma, Texas, Colorado, Arizona, Nevada, California, Washington, New York, and New Jersey.

The functionality of the geotags was as follows: each geotag represented a Black doula in the area. When opened, each geotag provided a picture of the doula, their full name, company name, provider type, specialties, brief bio, general location, contact email, personal website, and social media handles. Although not all geotags in the directory gave all the information listed above, all listings required the doulas’ names, provider type, general location, and contact email.

Once eligible participants scheduled their interviews, they received a Zoom link and a copy of the Summary of Research Explanation via email, which I read aloud to them before starting the interview. All interviews took place virtually through Zoom and were recorded after their express permission. The consent form assured participants that although voice recordings would be saved, their identities would remain confidential. Interviews lasted approximately 45 minutes and were no longer than 1 hour and 30 minutes. All interviewees received a 25-dollar Amazon gift code for their time.

Interviews were conducted using a semi-structured interview guide (Appendix A) consisting of four major categories: Doula Work, Accessibility, Racial Inequality, and Solutions. Most questions were open-ended to ensure that participants were guiding the interviews (Hesse-Biber, 2007). Discussions began with brief introductory and demographic questions concerning participants’ work history, age, location, and typical clientele. The next portion focused on the
current state of accessibility of doula services and how the pandemic has affected their work. The bulk of the interview explored their experiences in doula work and how they believe being Black has influenced the quality of maternity care that they have witnessed. This portion of the discussion sought to understand the professional dynamic between medical staff and doulas and their experiences witnessing racial injustices unfold in the delivery room. The final questions aimed to discern their thoughts on how to enact change systematically.

The interviews were recorded through Zoom and transcribed using Otter.ai. Otter.ai is an automatic transcription service that allows researchers to annotate and highlight conversations. Audio recordings were assigned a letter, and any identifying information was removed. The recordings are stored in a password-protected computer that only the primary researcher can access for up to five years, per Florida law. Transcriptions were reviewed and corrected manually by me, then downloaded and analyzed using thematic coding structures on NVivo software. NVivo is a software program that helps researchers code qualitative data, including audio, interview transcripts, and other texts.

Data Analysis

The qualitative data analysis consisted of inductive, thematic analysis (Braun and Clarke, 2006) and intersectional feminism theory (Crenshaw, 1994). This study design was chosen to ensure that the intersection of race, class, gender and historical contexts surrounding Black maternal mortality inform the research (Few et al., 2003). Transcripts produced by Otter.ai were compared with the audio recordings to guarantee no errors. Therefore, transcripts were read and reread before the initial coding stage began to gain a complete picture of the data. Codes were identified and refined through three steps: initial coding, focused coding, and thematic coding.
(Thomas, 2008). The primary researcher identified 53 initial and 45 focused codes through open coding, wherein codes were organically developed and refined throughout the coding process. Focused codes culminated in constant comparison amongst the transcripts and were organized thematically into a coding framework. Once the framework was established, four overall themes and one subtheme were extracted from each interview transcript and integrated into the comprehensive thematic analysis.

**Reflexivity Statement**

I am a first-generation white Latina immigrant pursuing my Masters degree in Applied Sociology. In the research process, I had to consider my social position as a middle-class woman of color as I exclusively interviewed Black professional birth workers. Although I am also a woman of color, my personal experiences vary significantly from those of Black women in healthcare. Therefore, when I began the interviewing process, I knew that my status as a woman of color would allow me to relate to the participants; however, I was unsure if the research setting would affect what information was shared or how it was conveyed (Best, 2003).

As a young person with no experience in birth work or motherhood, I was unsure if I would face a disadvantage with interviewees older than me. I worried that they may view me as less experienced or knowledgeable in the subject and be less likely to speak on the more niche aspects of their job, however, the doulas seemed comfortable with me. This was my first-time interviewing participants, therefore, at the start I was a bit nervous. I noticed that in those instances the doulas often adopted their roles as caretakers and held space for me. The shifts were subtle, but I noted that some of the doulas would soften their tones, reassure me when I misspoke and if their camera was on they would nod and smile encouragingly at me.
It was clear that all the participants cared deeply for their clients. One doula referred to all her clients as her children and expressed outrage at witnessing improper or dismissive care. Another doula brought me to tears as she recounted a traumatic birth that had deeply impacted her two weeks before our meeting. It was clear from her words and the tears in her eyes that she deeply cares for the well-being of her clients. Many of the doulas shared resources with me regarding the history of birth work or the current mortality ratios in their state. Reflecting on my conversations with the participants, I realized that a doula's job is both personal and political.

For the past few years, I have devoted myself to Reproductive Justice; however, I am typically immersed in only theory and policy as a student and researcher. Interviews contain inherent power differences between researcher and participant that must be acknowledged and addressed. This belief is supported by Steinar Kvale (2006), who argued that, in qualitative research, the power lies in the interviewer since they exert control over the project, the schedule, and the flow of the conversations within qualitative research (Kvale, 2006).

As researchers, it is our job to ensure that our participants' voices are heard and understood. Feminist interviewing techniques are designed to counteract the power imbalance, urge researchers to practice reflexivity throughout the process, and ensure that interviews are led by participants as much as possible (Hesse-Biber, 2007). Sharlene Hesse-Biber (2007) suggests that researchers must be willing to acknowledge their positionality and address them with participants. She stresses the need to co-create meaning by listening to interviewees and following their pace, even if researchers must drop their pre-prepared guides (Hesse-Biber, 2007).
CHAPTER FOUR:

RESULTS

Four overarching themes were identified from the interview data. The first three themes consist of Advocacy and Trust are Key Components of Doula Work, Barriers to Accessing Doula Services and a Need for New Hospital Policies, COVID-19 Worsened Restrictions on Doula Work, and Increased Distrust of Hospitals among Black Indigenous and People of Color (BIPOC). The final theme focused on the History of Racism in Reproductive Health affects the Quality of Care Today and included a sub-theme regarding the Prevalence of Dismissive and Abusive Care.

Advocacy and Trust are Key Components of Doula Work

Doulas provide emotional, physical, and informational support during prenatal, labor, and postpartum periods. Advocacy, in all its forms, was the most represented set of codes within the entire dataset. References of trust, informational support, and advocacy spanned all eleven transcripts. Data showed that the bonds forged between doula and client through cultural understanding and relatability were able to assuage fears many women of color harbor surrounding their appointments and their labors. The data revealed that participants consistently cited their educational support and focused on teaching clients to self-advocate as the most critical components of their work.

The participants acknowledged that sharing their client's culture and marginalized status allowed for a deeper trust between them and their clients. Their clients felt more comfortable
asking questions because they believe they are more likely to be listened to if their doulas share their race or ethnicity. Doulas referenced how their ability to code-switch, share childhood stories, and understand family dynamics allowed their clients to relax and feel seen. Once trust was established, it made supporting their clients emotionally, physically, and educationally easier.

Doula G described the informational aspect of her work as the tool with which a doula has the potential to save a client's life.

“So that's where doula support is really helpful because I have had clients who were like “This and that is happening, and my OB said it was okay.” And I was like, “Yeah, let's go get another opinion.” So that's the kind of thing where sometimes I get clients or prospective clients, and they're like, "Can you save my life?” I'm like, "No, in the hospital I'm not going to be able to push the doctor out the way and save you." But the things leading up to it is how a doula saves you, you get what I mean? Me educating you on the warning signs. Me talking to you about what's normal in pregnancy and what's not. That's how a doula saves your life. So people literally think the day you have your baby, I'm gonna be like, "Everyone out the way! I'm doing CPR!" No, that's not necessarily how the doula is gonna save you, but hopefully, we'll get you in the right place before it gets there.” - Doula G

Doulas spoke, at length, on the importance of ensuring that their clients were equipped with the evidence-based knowledge and resources they needed to self-advocate. Many doulas stressed the significance of speaking up and voicing discomfort throughout all stages of care, from the prenatal stage to the postpartum period. They delineated myriad ways they helped their clients follow their birth plans and eased communication between medical staff without speaking over them. The participants referenced holding space as a critical skill necessary for doulas to best support their clients. Holding space for a client requires maintaining a positive, calm environment while providing the necessary physical support. During labor, this means stepping outside to discuss issues with medical staff and asking questions that the birthing person is in too
much pain to articulate or think to ask. Doula D illustrates one of how she coaches her clients to speak up for themselves during the prenatal period.

“I think you have to be willing to advocate for yourself. I think what people think is, “Once I'm with this provider, I need to stay with him no matter what.” And I think instinctually if you feel like you're with a provider who's not caring for you, you need to find a different provider. It doesn't matter if you're 36 weeks, or 18 weeks, whatever it is. If you're feeling that this person is not going to be looking after your best interest, then you need to say, "You know what? Thank you, I want my records" because they're your records, right? And it's not that 'they let me do this', or 'I get to do this.' No, this is my body. This is what I want to do. And you will honor me in that.” - Doula D

Doula D is not the only doula that encourages her clients to seek second opinions if she feels like her clients are being dismissed or abused by healthcare professionals. Many doulas expressed their strategy of informing their clients that they have a voice in their care. This theme illustrates that trust between Black clients and physicians is lacking. Advocacy in the form of educational support was a critical component of doula work. As evidenced by Doula G, the fear of death is so prevalent among Black pregnant women that most of the doulas cited that providing informational, evidence-based support was the most important aspect of their work.

Barriers to Accessing Doula Services and the Need for New Hospital Policies

Participants expressed a need for change within existing hospital policies and insurance models to increase accessibility to doula services and increase positive health outcomes. Affordability was referenced most, implying that it may be one of the most pertinent barriers to doula services. The second barrier was the lack of general knowledge regarding what a doula does or how they can help mitigate adverse health outcomes.

Doula E voiced frustrations with the current state of affairs and how insurance coverage further contributes to the issue.
“I think the biggest challenge, I mean, this is a challenge whether people have the disposable income or not, is the education of what does a doula do? How can a doula best support families and just get really honest around what kind of support we actually do, and how much we can help folks really feel empowered within their birthing space. I think what can happen with folks who are on Medicaid is that sometimes they can feel disempowered. That they kind of have to take whatever the system gives them and/or whatever the doctor says. So helping to shift that mindset is work. I mean, that's work to get people to say, “No.” You actually can ask your doctor questions. You can refuse an induction. You can refuse surgical birth outside of emergencies, and that kind of stuff. But I think that that's kind of this bigger piece around empowerment of clients, as well as that education aspect of it.” - Doula E

The second barrier was the lack of general knowledge regarding doulas. Not just about what doulas are but what benefits they provide. Doulas are known to empower their clients and help them feel heard and understood. As Doula E stated, empowerment is difficult for low-income clients covered by Medicaid to feel. As Doula E said, many birthing persons walk into their doctor’s offices already feeling “disempowered.” While some participants lived in states where Medicaid or Medi-Cal covered their services, they divulged issues with the functionality of the coverage. Part of the problem was how low the percentage of their fees was being covered by programs like Medicaid. Participants disclosed that they believed every birthing person should receive doula care. Therefore, all insurance policies should automatically offer doula services in their packages. However, as referenced above, they felt their services needed to be paid appropriately. As only four states currently cover doula services through Medicaid, in the rest of the United States, many doulas felt that the proposed policies were either too restrictive or downright exclusionary.

Hospital policies were also called into question. Two of the doulas specified that hospitals could include doula care into the existing structure as continuity of care, while one doula stated that it might be beneficial if local doulas were advertised to birthing people at their appointments. Hospitals were also criticized for having poor cultural competency training and enforcement and needing to have more people of color as the medical staff. In doing so, some of
the doulas believe it could lead to better birth outcomes and prevent many of the injustices women of color face.

They create policies that don't take us in mind. So, [sardonic chuckle] it's systemic in terms of the policy. It's systemic in terms of the training. It's individually biased in terms of who ever it is that walks into your room to care for you to complain to about the pain or the bleeding or the headache. And you might be underinsured, so it's like, “I want to have as little face time with you as possible, because what the reimbursement level that I'm going to get, you Medicaid person, is not going to be really worth my time.” And if we get to those numbers a little bit more, you'll see that a lot of those deaths don't happen in childbirth….I should not have to say that I'm not the clinician, you in patient care, should have to say that. But I've never had that with any of my Brazilian moms, I've never had that with any of my Russian moms. It's always such a mind-blowing experience when I, on the rare occasion I do have a non-Black client, or I backup for someone who has a non-Black client and [I see] the same complaints, the same concerns are completely handled at different rates, speeds, and levels of care. That's why we're dying. - **Doula C**

**COVID Worsened Restrictions on Doula Work and Increased Distrust of Hospitals amongst Black Indigenous and People of Color (BIPOC)**

According to the doulas, the COVID-19 pandemic unexpectedly increased clients seeking their services. However, this increase in interest during unprecedented lockdowns and stay-at-home mandates came with unique challenges. As fears of the virus grew, pregnant people were too scared to give birth at the hospital and endanger themselves and their newborns. As the physical aspect of doula work lessened, virtual services became necessary.

Doulas’ work has always included physical support; therefore, participants had to restructure how they ran their businesses. Consultations, routine appointments, courses, and prenatal visits all had to be converted into a digital format through Zoom meetings and web courses. The support they could provide during hospital births was similarly affected, even in states that allowed patients to have their doulas in the room. When asked if COVID-19 made doula services more or less accessible, Doula K responded:
To be honest, I’m a bit on the fence with that because once we realized that we can do things virtually, it made some clients or some people more open to the idea of actually having doulas. On the other hand, some went, "Oh, what can you do if you’re not here physically?” So, you know, it did present a challenge, but at the same time, when they realized that they were able to get services virtually, it made it better. It’s basically adjusted rate, I will say, for a digital product. Even though you’re a service-based business you try to create a digital product, in a sense, to give to your clients. Ensure that you know what, even though I’m not there physically, these are the different actions or steps you can take to ensure you have the delivery that you desire. - Doula K

In other hospitals, where doulas and other support members were barred from the delivery room, the policies created more tensions. According to one of the participants, some hospitals demanded proof of certifications, left doulas in the waiting room, and all but barred them from the process. A separate doula summed the situation up by stating, “I think it was already challenging before, pre-pandemic because some doctors don’t always feel great about having doulas in the space. And so COVID became a really great excuse for them to restrict access.”

**History of Racism in Reproductive Health affects Quality of Care Today**

The third most represented code, found across all interviews, was racism. The two common mentions of this theme in the maternal care system occurred while doulas contextualized the deep-rooted history of racism in obstetric care and related that with the dismissive, sometimes abusive care that Black birthing people endure.

A doula noted that she believes race is innately linked to how Black birthing people’s health is treated because of what they have persevered through as a culture. Nine of the eleven participants referenced the history of obstetric care in their interviews. Five interviewees brought up two key historical events in response to the question of why they believe that the Black maternal mortality rate is so high in the United States; the atrocities against Black enslaved
women committed by whom many deem the father of gynecology, Dr. James Marion Sims, and the vilification of granny midwives.

Four participants observed that the quality of care received by their Black clients differed significantly from that of their white counterparts. Black women had to approach the space differently and remain hyperaware of not coming across as aggressive or a ‘bad’ patient, while white clients had no such concerns. Doula C stated that she creates nonverbal cues with her clients and their partners so they can communicate with her in a way that won’t be met with opposition. She went on to state the kinds of scenarios that she may go over with her clients.

So, simple things just as if you're deciding on the birth plan. If the decision is to delay cord clamping Well, if you get pushback, okay, this is what we're gonna do for a non-aggressive pushback from the families, and so it's kind of blocking and tackling these things ahead of time. So that if it happens, whether it's something major, passive-aggressive, or micro, that it doesn't shock the parents or the partner, and we have a plan B, C, D, E, F. - Doula C

One doula expressed that this does not mean that white birthing people cannot experience inappropriate care, as she has witnessed an incident of neglect. However, she clarifies that situations like those are not the norm and white women more commonly receive better standards of care. Another doula exemplified the discrepancy as follows:

“Mostly what I've seen, and I'm just trying to look overall, most of what I've seen is that there's definitely more trust in my white clients between the doctors and the clients... The thing is you don't know if it's because the doctor is treating them this way or if they just assume that they can assert themselves. They assume that they can ask questions. It's kind of like, “Of course, I'm going to ask you questions. Of course, here are my birth preferences,” versus, "Ah, I'm not sure if they're gonna listen to this. I feel like I have to pick and choose my battles." Versus my white clients are just like, "I've got a doula. Here's my birth preferences, I've printed them out. Made copies in triplicate, here,” hands them to the nurse, and just has this... it's just a different way of interacting.” - Doula E

It is not just the clients that have to ensure that they come across as compliant, but the doulas as well. Many participants believe their positions as doulas alone can cause conflict and tension with medical staff. Most of the doulas referenced waiting for doctors to leave the room
before addressing concerns with their clients or speaking up by asking questions they know the answer to for the benefit of their clients. Doula F described the tacit tonal shift that usually indicates to her that a physician may be wary that she may overstep her boundaries.

*Prevalence of Dismissive and Abusive Care*

Dismissive care was the second most common code in the data; examples or direct mentions appeared in all interviews. Based on participants' recollections, dismissive care presents as condescension from medical staff and nonconsensual procedures.

Many doulas shared experiences of witnessing their clients’ feelings and pain minimized and disregarded by medical staff. Nurses and physicians told clients that they were “dramatic,” not in as much pain as they claimed, and treated them as if they were incapable of understanding their bodies and the information being relayed to them. Ten of the eleven doulas clarified that physicians tended to express the most hostility, while nurses were generally more welcoming. However, that did not exclude nursing staff from contributing to the dismissive level of care. Doula A's account describes how Black women's pain is minimized and dismissed in the delivery room. Doula G's excerpt demonstrates the same phenomenon, but she elaborates that these incidents are rooted in racist stereotypes.

“Sometimes they’re told, “Oh, it's all in your head.” I know I've been sort of told that. Not in that specific verbiage, but you kind of get what they're getting at. So, very dismissive, no type of active listening. And when it comes to pain, it's almost like it's not believable, that you're in this much pain, or that you are experiencing this, and “This must be in your head so let me prescribe you some valium so that you can sort of get your mind together, because possibly what you're thinking is really not what you're thinking type of deal.” – *Doula A*

“Nobody wants to take time to listen to a Black woman. I mean, that’s really it. Nobody wants to believe a Black woman. You go in, and your feet are swollen, and it’s like, “Oh, everyone’s swollen, you're pregnant. It's okay.” “No, I think this is more. Listen to me.” I mean, prime example, Serena Williams, for goodness sake. A big part of it is just who wants to listen to or believe a Black
woman? First off, it's still taught in some medical schools that we don't feel pain. So, if you believe
that we literally have tougher skin and that our pain tolerance is so much higher than other people
if you believe that, then why would you listen to me? If I'm saying something's not right, and then
there's the thought that we're coming in because we want to get drugs or that kind of thing. You
know a lot of it's just dismissive, not wanting to listen, not wanting to take the time, not wanting to
expend the energy, not having the sensitivity.” - *Doula G*

Two doula's claimed it was not uncommon for a nurse or a physician to mutter negative
comments about their client in front of them. Four doula's depictions of interactions with staff's
lack of accommodation revealed that rigid timetables and checklists make it difficult for medical
staff to provide patient-centered care. Most doula's stated that physicians' authority could not be
challenged for fear of punitive or retaliatory measures. One doula shared an anecdote of a client
being discharged from care in the middle of labor for attempting to self-advocate. According to
one of the doula's, in some situations, depending on hospital policy, doula's were made to sign
paperwork detailing that if they overstepped, they could be barred from the hospital.

All eleven doula's felt that informed consent was lacking within hospitals. Six spoke about
physicians' tendencies to frame routine decisions as life or death. Most participants recalled a
moment when they had witnessed a nonconsensual procedure being done to their client. Below,
Doula D's response showcases how medical staff can elicit consent through fear-based tactics,
while Doula K details a memorable experience with a client.

“I would say that it's not always nonconsensual, but it's more fear-based. Like, "Oh, we've got to
do these cervical checks. They have to be done every dada dada," right. So, I would say things like
that, or "Well, if you don't, it's already been X amount of time. So, it's up to you if you don't want
your baby to be okay." Those types of things. So usually, there's consent, but it's brought about
based upon fear versus, "Hey, these are your choices, and this is where we're at, and what decision
would you like to make?"” - *Doula D*

“She was absolutely against getting Pitocin, and I was there, and they kept trying to push it, and
she was like, "No, I don't want it." This was her second baby. She was like, "I know how I felt
when I was on Pitocin the first time, and I don't want that." And they were like, "Okay, no problem." Then I left. I came out, and this— every time I think about it, I get so upset. I left to use the bathroom
because we were there for [a long time] and I stepped out to use the bathroom. And by the time I
got back, she said, "Oh they came in, and they're giving me some pain meds," but she told me that
she started feeling the aching and the cramping feeling that Pitocin gives you. She was like, "Did they give me Pitocin?" … I looked at the bag, and it was Pitocin and there was nothing that we could have done then, but I know the mom was, she was so upset. When we asked the nurse, and I called the doctor I was adamant just, I mean, “What happened? You know, this really, truly is grounds for someone suing you or the hospital.” So, I think that they don't necessarily— they can do a better job.” - Doula K

Their testimonies reflect the United States’ inadequate policies on informed consent and stress the importance of advocacy. These examples are just two of the many instances wherein participants expressed witnessing Black birthing people facing dismissive, misleading, or abusive care.
CHAPTER FIVE:
DISCUSSION

For generations, Black women have held an outsider-within status. This status has provided Black women a unique standpoint on self and family, where they develop a distinctive perspective on reality. Black doulas embody this insight and positionality as non-clinicians involved in birth work, allowing them to be both outsiders and insiders (Collins, 1986). This work adds to existing literature addressing the racial inequalities in obstetric care and how that translates into the dynamic created in the labor room (Bridges, 2011: Davis, 2019a: Van Eijk, 2022). In a country where Black birthing people are dying at disproportionate rates, this work demonstrated the need to address structural racism and upend hospital policies and procedures that perpetuate injustices against women of color.

Unsurprisingly, results found advocacy as a critical principle of Black doulas' standard of care. A doula's purpose is to provide emotional, physical, and informational support to birthing women. This study found that Black doulas typically find that evidence-based informational support is the most instrumental characteristic of their care. They revealed that empowering clients through self-advocacy was integral and most rewarding when working with Black birthing people that so often feel voiceless in medical settings.

This research is consistent with findings from similar studies regarding Black birthing people's preference of hiring doulas that share their race and ethnicity (Wint et al., 2019). Shared cultural understanding and relatability with their doulas allow Black parents to feel comfortable and ease fears from medical mistrust, often found in the community (Wint et al., 2019). This distrust is not unfounded, as this study found that all Black doulas in the study observed
instances where physicians reinforced distrust through dismissive, sometimes abusive care. Medical staff were observed minimizing Black patients’ pain and emotions and reinforcing harmful stereotypes claiming that Black women have higher pain tolerances than women of other races. These practices are shown to have detrimental effects on maternal health outcomes for Black patients, including preterm births that could have been avoided (Davis, 2020).

Participants observed that physicians in particular were quick to anger if their authority was questioned or tested, going so far as to discharge laboring birthing people for self-advocating. Therefore, doulas preemptively coached their clients on approaching the birthing space ready for pushback and potential micro-aggressions. Great emphasis was placed on doulas and clients asserting their voices non-aggressively to avoid being perceived as contrarian doula or a “bad patient.” Another significant finding points to an issue with ensuring proper informed consent is given. The most worrying discovery was the prevalence of fully nonconsensual procedures. Often, consent was extracted through fear-based information and tactics on vulnerable people in labor. Although literature pointed to instances of nonconsensual procedures, finding it as a consistent theme that most doulas observed was unexpected (Campbell, 2021: Davis, 2019a: Davis, 2020: Taylor, 2013: Wells et al., 2020: Wint et al., 2019).

The overwhelming response to why doulas believed maternal mortality and morbidity rates are so high for Black birthing people in the U.S. was the undisputed history of racism that permeates and influences the structures within medical institutions. The father of gynecology, Dr. James Marion Sims, earned that moniker by inhumanely experimenting on three enslaved people to further medical knowledge (Khabele et al., 2021). He is lauded as the founder of gynecology, the area of medicine devoted to treating women’s reproductive health, yet his accolades were at the expense of Black women.
The second most referenced historical event regarded the vilification of midwives across the country, particularly Granny midwives in the South (Suarez, 2020). So many laboring women, white and Black, were attended by Granny midwives until the American Medical Association began to regulate their services and exclude them from labor by deeming their practices unsafe and unclean (Suarez, 2020). The current study found that some Black doulas believe that current restrictions and regulations on midwifery and doula care are reminiscent of exclusionary tactics used then.

While most participants agreed that federal insurance should cover doula services, they were wary of restrictions and stipulations in their states’ current or proposed legislation. They felt that policies threatened to be exclusionary when they proposed regulations on the type of certification required to receive compensation. For instance, some proposals stipulated a minimum number of visits, Telehealth, and service fees which many found to be restrictive or insufficient compensation. A reoccurring theme was the belief that all birthing people should have access to doula services through automatic insurance coverage or collaborative hospital policies. Many believe that an often-unspoken barrier to doula services is a lack of knowledge of the benefits of doula care. Affordability was cited as the most significant barrier to doula services, which corresponds with similar research findings (Kochmannil et al., 2016). Although community doulas attempt to make their services more accessible, it is not enough to mitigate the disadvantages that low-income people face.

Lastly, this study’s findings on the effects of the outbreak of COVID-19 and the resulting lockdowns and hospital restrictions were congruent with other studies that have been published since the start of the pandemic (Adams, 2021: Bogart et al., 2021: Dashraath et al., 2020: Hantouslyzadeh et al., 2020: Metz et al, 2019: Oparah et al., 2021: Rivera, 2021). Lockdowns
spelled a loss of the physical support doulas have always provided, resulting in an investment in virtual services and programs. Despite this, heightened anxieties surrounding hospital births during the pandemic increased the general public’s interest in doulas, leading to an uptake in clientele (Oparah et al., 2021: Rivera, 2021). Therefore, birthing people who did not know doula services existed or had not considered them for their births benefitted from the services that doulas provide.

Limitations

Midwestern and northeastern regions were underrepresented in this study; while there was an even mix of West Coast and East Coast perspectives, all participants resided in southeastern and western states. A little over half of the participants reside in the Deep South. The Deep South consists of Louisiana, Mississippi, Alabama, Georgia, and South Carolina. All these states share a unique culture and have a rich history of Black midwifery. The Deep South consists of Louisiana, Mississippi, Alabama, Georgia, and South Carolina. These states share a unique culture and, due to their connections to slavery, have a rich history of Black midwifery. Until the 1860s, childbirth was considered a social affair, typically overseen by a midwife. In the Deep South, enslaved women were expected to attend to plantation mistresses during their births and impart their traditions. These midwives became known as the Grand Midwives of the Deep South and often held respected roles as healers. Midwives' influence on the culture of childbirth in those states could impact the experiences of the doulas I interviewed (Menzel, 2020: Suarez, 2020). In addition, all doulas were certified through the National Black Doula Association, an organization with a mission statement devoted to reducing Black maternal mortality rates. Thus, the organization’s curriculum could have influenced participants' responses. However, this study
aimed to hear the voices of Black doulas and how their unique positionality affects their experiences.

**Implications and Potential for Future Research**

The data collected for this study sparked interest in exploring the role doula work plays in connecting both birthing people and birth workers to the history of reproduction in BIPOC communities. Until the 1900s, midwifery used to be regarded as a calling in the South, how much of that reverence and spirituality remains in the profession (Suarez, 2020)? Breastfeeding initiation and duration rates were briefly mentioned throughout the interviews. It would be interesting to explore doulas' experiences with current practices and investigate if, from their perspectives, their client’s racial, social, or gender identities impact breastfeeding rates.

The findings of this study highlight the importance of doula advocacy and address the need for systemic and individual biases in medical institutions. Although some hospitals are beginning to institute programs that aim to facilitate relationships between marginalized groups and doula services, their work needs to be normalized and encouraged on a grander scale. We must shed light on the systemic racism trickling down within hospitals and contributing to unjust administrative procedures and behaviors to enact change. This study further illustrates that medical professionals hold implicit biases rooted in colonialist prejudices that continue to impact Black birthing people. This research can inform future policy work and regulations surrounding maternal mortality initiatives.
APPENDIX A:

INTERVIEW GUIDE
### Part 1: Introductory Questions

<table>
<thead>
<tr>
<th>Statement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First, I have some general questions I’d like to ask about your work as a doula.</td>
<td></td>
</tr>
<tr>
<td>1.1 How old are you?</td>
<td></td>
</tr>
<tr>
<td>1.2 What pronouns do you prefer?</td>
<td></td>
</tr>
<tr>
<td>1.3 What ethnicity and race do you identify with?</td>
<td></td>
</tr>
<tr>
<td>1.4 Where are you located?</td>
<td></td>
</tr>
<tr>
<td>1.5 If you feel comfortable answering, do you belong to the LGBTQ+ community?</td>
<td></td>
</tr>
<tr>
<td>1.6 Who are your typical clients?</td>
<td></td>
</tr>
<tr>
<td>1.7 Probe: Do you primarily work with Black clients?</td>
<td></td>
</tr>
<tr>
<td>Do you work with members of the LGBTQ+ community?</td>
<td></td>
</tr>
<tr>
<td>1.8 What is your specialty? (Ex: Full Spectrum, Fertility, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

### Part 2: Accessibility

<table>
<thead>
<tr>
<th>Statement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alright, so for this next section of the interview, I wanted to touch more on your clients, how COVID has affected your work, and general accessibility to doula services.</td>
<td></td>
</tr>
<tr>
<td>2.1 What would you say is the typical income level of your clients?</td>
<td></td>
</tr>
<tr>
<td>2.2 How have you had to adapt to the ever-changing COVID-19 regulations?</td>
<td></td>
</tr>
<tr>
<td>2.3 Probes: What are the unique challenges you have faced post pandemic?</td>
<td></td>
</tr>
<tr>
<td>Do you find it more difficult to support your clients in the delivery room during the pandemic? If yes, how so?</td>
<td></td>
</tr>
<tr>
<td>2.4 How do you believe we can work to reduce existing barriers to accessing doula services?</td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>How do you believe we can work to reduce existing barriers to accessing doula services?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Part 3: Doula Work**

<table>
<thead>
<tr>
<th>Statement</th>
<th>I’d like to hear about your work as a doula, especially in relation to race/ethnicity.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.1</th>
<th>What is it like being a doula?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.2</th>
<th>Probe: What is your typical workday like?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Okay, now I would like to talk about how race or ethnicity operates within your work as a doula. How would you describe what it's like to be a Black doula?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.3</th>
<th>In what ways do you think your race impacts your work with clients?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.4</th>
<th>Probes: Do you think that race impacts how clients interact with you, or how they respond to you? Do you experience any differences based on the race of the client?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.5</th>
<th>What about with medical staff? Do you think your race impacts how you work with medical staff?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.6</th>
<th>Do you find that understanding your client’s culture allows you to be a better advocate, if need be?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.7</th>
<th>Have you had experiences where your race/ethnicity has influenced your experience with a mother? (Can be positive or negative)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.8</th>
<th>What is typically the dynamic between you as a doula and medical staff? Are nurses and doctors typically welcoming to doulas in the labor room, or not?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.9</th>
<th>Probes: Have you ever felt like medical staff has tried to exclude or remove you from the birthing process?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3.10</th>
<th>Have you ever felt like you were treated differently by medical staff due to your race or ethnicity? Or do you believe that conflict, if there is any, typically arises from your position as a doula?</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.11</td>
<td>Does the physician’s gender or race have any impact on the type of dynamic that is fostered in the birthing room?</td>
</tr>
</tbody>
</table>

### Part 4: Racial Inequality

#### Statement
For the last few sections, I want to touch on racial inequality. I will give you a bit of background and then we can discuss your experiences.

#### Background
The United States has the highest maternal mortality rate of all developed nations. Black women are nearly four times more likely to die from pregnancy-related death in the United States than white mothers.

| 4.1 | Why do you believe the United States has the highest maternal mortality rate? |
| 4.2 | Why do you think Black women have such higher maternal mortality rates than women of other races? |

#### 4.3
People of color tend to receive lower quality maternal care. What are factors that you believe contribute to Black women receiving lower quality maternal care?

| 4.4 | What do you believe needs to change systematically in order to reduce high Black maternal mortality rates? |
| 4.5 | In your work as a doula, have you ever witnessed poor or differential treatment of Black patients? For instance, receiving less visits, being listened to less? |

#### Probe
Have you ever observed blatant discrimination in the birthing room or in prenatal sessions?

| 4.6 | Have you noticed any differences in the way that your Black clients are treated as opposed to other racial or ethnic women? |

#### Statement
We have touched a bit on discrimination, but I would like to delve a bit deeper. Particularly, on the notion of gynecological hardiness.

#### Background
Prejudice and stereotypes have created a medical falsehood known as gynecological hardiness, wherein Black women are believed to have higher pain tolerances than women of other races, particularly in relation to reproduction.

| 4.7 | Have you ever witnessed this stereotype reinforced in maternal care? |

| 4.8 | |

---

43
| 4.9 | Probe | Does medical staff always take their Black patient’s pain into account? Or do you believe that Black mother's pain has become invisible to medical providers?
Have you noticed any other negative stereotypes about Black mothers in clinical settings? |
| 4.10 | In your experience, does medical staff properly inform Black clients of medical procedures? Does staff ensure that all procedures are done with full informed consent and free of medical jargon? |
| 4.11 | Probe | Have there been any instances where you have witnessed nonconsensual procedures? |
| 4.12 | | What are the most memorable instances where you felt the need to advocate for your client? |
| 4.13 | Probe | Are situations like this common? |

**Part 5: Solutions**

| **Statement** | Onto the last three questions, these are more about the big picture and your thoughts on what we can do to improve. |
| **5.1** | How do you believe we can work to reduce existing barriers to accessing doula services? |
| **5.2** | How can we make services more accessible, while ensuring that doulas can earn a living? |
| **5.3** | Some states are considering adding doula services to Medicaid packages. Do you think that would be an effective solution? |
APPENDIX B:

IRB APPROVAL LETTER
EXEMPTION DETERMINATION

March 28, 2022

Dear Emely Matos:

On 3/28/2022, the IRB determined the following submission to be human subjects research that is exempt from regulation:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>A critical intersectional analysis of Black doulas’ experiences in maternal healthcare</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Emely Matos</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00003975</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Grant ID:</td>
<td>None</td>
</tr>
</tbody>
</table>

Documents Reviewed:
- HRP-251 Faculty Advisor Waiver, Category: Faculty Research Approval;
- HRP-254 Consent Form, Category: Consent Form;
- HRP-255 Request for Exemption, Category: IRB Protocol;
- Interview Guide, Category: Interview / Focus Questions;
- Recruitment Script, Category: Recruitment Materials;

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in are detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Gillian Bernal  
Designated Reviewer
REFERENCES


Univ of California Press.


Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion Reproductive Health About Us Data and Statistics . (2019, October 10). Pregnancy Mortality Surveillance System | Maternal and Infant Health | CDC.


Omeish, Y., & Kiernan, S. (2020). Targeting bias to improve maternal care and outcomes for Black women in the USA. EClinicalMedicine, 27.


