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Doula Support Challenges and Coping Strategies During the COVID-19 Pandemic: Implications for Maternal Health Inequities

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Abstract

The COVID-19 pandemic has made birthing more stressful and isolating, which has raised particular concern for populations of birthing people affected by maternal health inequities. Doulas have been proposed as one means of improving health outcomes by providing emotional, physical, and informational support to patients and their families before, during, or after labor. However, the social and economic conditions of the COVID-19 pandemic have posed new challenges for doula care. We conducted thematic analysis on 25 semi-structured interviews with practicing doulas in the United States to explore changes to doula care during the pandemic. Although doulas have faced many challenges in providing virtual and socially-distanced support during the pandemic, the rising use of telehealth among doulas has revealed new coping strategies and opportunities for virtual communication with the doula community. Our findings indicate that doula experiences during the pandemic can inform future doula care practices, particularly for birthing people of color and low-income birthing people.

Keywords

maternal health; maternity care; obstetricians; doula; COVID-19; pregnancy; birth; telehealth; virtual communication

Doulas are professionals with expertise in pregnancy and/or birth who provide emotional, physical, and informational support to birthing people and their families (DONA International, n.d.). Doulas can take on different roles depending on the needs of the patient and their families, such as being a coach that provides guidance during labor, a bridge between family and medical staff, and an advocate for the birthing person (Horstman et

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al., 2017). Doulas can specialize in childbirth education, postpartum support, birth support, and full spectrum pregnancy support. Traditionally, continuous presence during birth is a key aspect of birth doula care. It provides significant health benefits for mothers and infants, with more desirable clinical outcomes coming from continuous support by a trained individual outside of a patient's social network who is skilled at providing labor support (Bohren et al., 2017).

Doulas employ a variety of communication strategies to provide support to their clients, such as conveying acceptance of a birthing person's decisions for their medical care, debriefing with birthing people, and offering comfort through words, facial expressions, and touch (Gilliland, 2011). As such, doulas build strong relationships with their clients and also improve communication between patients and medical professionals. Doula work can be physically rigorous, with heavy reliance on physical comfort measures and intense movements during birth and pregnancy (Castañeda & Searcy, 2021). Doulas use tools such as birth balls and Rebozos (a traditional Mexican garment or large woven scarf) to help move their clients into positions that soothe and relax their bodies. During birth, doulas may employ counter pressure techniques such as double hip squeezes to ease back pain during labor contractions. Doulas could not use these techniques as extensively during the COVID-19 pandemic, which could have important implications for birth support.

Doula Support Can Improve Health Outcomes

Existing literature indicates that doula participation in maternal healthcare improves patient outcomes and promotes health equity. Doulas communicate knowledge about pregnancy and birth in layperson terms, which instills in patients and their families a sense of confidence and self-efficacy throughout the birthing process (Kozhimannil, Vogelsang et al., 2016). Doula support also strengthens the emotional and mental wellbeing of birthing people, which increases patient preparedness and improves birthing outcomes (Kozhimannil, Vogelsang et al., 2016).

Socially and economically disadvantaged people may experience particular benefit from doula services. A study examining 3,906,088 live births in the U.S. in 2016 found that Black and Asian women considered low-risk and most favorable for vaginal delivery had significantly higher rates of cesarean sections compared to white women (Valdes, 2021). Although cesarean sections can be lifesaving, studies indicate that emergency cesarean sections are also a risk factor for postpartum PTSD (Andersen et al., 2012; Modarres et al., 2012). Birthing people of color who experience traumatic procedures often describe being ignored by providers when inquiring about what happened during birth (Altman et al., 2019). Doulas can mediate interactions when birthing people of color experience medical discrimination (Wint et al., 2019). For low SES patients who are less likely to attend prenatal education and more likely to have cesarean deliveries, doulas can be a reliable source of pregnancy education (Milcent & Zbiri, 2018). In one study, Medicaid beneficiaries had lower rates of preterm birth and cesarean sections when they received support from a community-based doula organization (Kozhimannil, Hardeman et al., 2016). Among socially disadvantaged mothers at high risk for negative birth outcomes, those who received support

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from a certified doula were less likely to experience maternal or infant health complications, and more likely to initiate breastfeeding (Gruber et al., 2013).

The processes and benefits of doula support are particularly salient during the COVID-19 pandemic. Recent evidence indicates that when controlling for baseline characteristics and trauma history, people who gave birth during the initial COVID-19 outbreak had a higher acute stress response, or exhibited physical symptoms of stress for a short period of time, than those who birthed before COVID-19 (Mayopoulos et al., 2021). Higher acute stress responses during birth carry risks, including posttraumatic stress symptoms, mother-infant bonding problems, and breastfeeding difficulties (Mayopoulos et al., 2021). While doula support could be advantageous under pandemic conditions, certain COVID-19 hospital policies that require proof of doula certification or vendor status, or otherwise exclude support personnel from being in birthing rooms, have forced people to birth alone (Boudin, 2021; Davis-Floyd et al., 2020).

Scholars have cited concerns about the co-occurrence of maternal health inequities and the COVID-19 pandemic on birthing people of color (Britt et al., 2021). A 2020 report found that among 400,000 women in the US with symptomatic COVID-19, non-Hispanic Black women experienced a disproportionately greater number of deaths relative to their distribution among reported cases regardless of pregnancy status (Zambrano et al., 2020). Birthing people of color are also susceptible to medical racism and obstetric violence; they often experience blame from medical providers for negative birth outcomes, are frequently disregarded when they voice concerns about their health, and have experienced physical violations during birth (Davis, 2019). Doulas who work with people of color can help their clients recognize when they are being treated unfairly and encourage their clients to speak up for themselves (Wint et al., 2019). It is important for research to examine promising practices, such as doula care, that could ameliorate maternal health inequities and study how these practices may be strained due to pandemic conditions.

Theoretical Framing and Research Questions

The present investigation was informed by scholarship on social support and coping, in particular the seminal work of Cutrona and Suhr (1992) and Cutrona and Russell (1990). Because doula work is fundamentally about providing support, our interest in doula practices during the pandemic is a question of how their support work has been affected by circumstances of COVID-19, and how they are coping. Cutrona and colleagues' scholarship established several theoretical premises germane to the present investigation, namely that support needs vary, attempts at support are intended to accomplish a range of functions, and support can (and should) be adapted to match recipients' needs. For example, supportive behaviors can be broadly understood as having action-facilitating and/or nurturing functions; both dimensions encapsulate the support that doulas provide to birthing people and their partners. The purpose of the current study was not to identify instances of specific types of support (e.g., informational, tangible, emotional); however, this theoretical framing of support was a point of departure for organizing multifaceted aspects of doulas' communication experiences salient to them.

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Studying doulas' experiences offers an opportunity to add to the literature on support needs and provision during pregnancy and birth. Given the centrality of communication to healthcare and doula work and the intimate knowledge that doulas have (Castañeda & Searcy, 2021), understanding the impact of the pandemic on doulas' communication with clients and healthcare professionals is vital. Although doulas are uniquely positioned to shed light on birthing people's experiences and some studies have begun to explore various challenges the pandemic has posed for doula care (Castañeda & Searcy, 2021; Ogunwole et al., 2020), there is minimal research examining lessons doulas have learned from the pandemic in the context of communication and support. For these reasons, this exploratory study was conducted. We posed the following research questions:

> RQ1: What communication and support challenges have doulas experienced during the pandemic?
>
> RQ2: How are doulas coping and adapting their communication and support?
>
> RQ3: How do doulas' experiences with communication and support during the pandemic offer perspective on maternal health inequities?

Methods

Participants

After the study received IRB approval, potential participants were recruited from professional websites, social media pages, and network and snowball sampling. All participants were birth doulas who practiced before and during the COVID-19 pandemic. Thirty-two participants provided demographic information and 25 agreed to be interviewed. Theoretical saturation (Morse, 2015) was reached after 25 interviews. Of the 25 participants, 10 (40%) were White, 8 (32%) were Black or African American, 3 (12%) were Hispanic or Latino/a/x, 1 (4%) was Asian, 1 (4%) was Asian and White, 1 (4%) was Middle Eastern or North African, 1 (4%) preferred not to answer. Twenty-three (92%) participants were female and 2 (8%) were non-binary or genderfluid. Participants practiced in a variety of locations across the U.S.: New Mexico (n=5; 20%); North Carolina (4; 16%); Texas (3; 12%); 2 each from Oregon, Tennessee, Missouri; and 1 each from Arizona, Idaho, California, Florida, New York, Arkansas, and Utah. Participants represented a variety of specializations including full-spectrum doulas (n=4), birth doulas (n=7), childbirth educators (n=2), and postpartum doulas (n=1). Some participants primarily worked with certain populations including low-income communities (n=2), BIPOC communities (n=7), and LGBTQIA+ communities (n=2). Years of practice as a doula ranged from 1–22.

Procedures

The first author conducted semi-structured interviews lasting 30–60 minutes with participants via Zoom from March 2021 to June 2021. After providing informed consent, participants were asked three sets of questions. The first asked about barriers the participant may have experienced while providing doula care during the pandemic. The second focused on opportunities the participants saw for doula care during the pandemic and how they were adapting their doula work to the demands of the pandemic. The third set asked for opinions on the state of doula care and maternal health in the U.S. during the pandemic. Participants

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were informed that they could skip any question and discontinue the interview at any time. Unless they opted out, all participants were entered into a drawing for a $25 e-gift card. Interviews were recorded and transcribed through a web-based transcription service.

Data Analysis—Thematic analysis of interview data was conducted over several months. We followed Braun and Clarke's (2014) reflexive thematic analysis approach, which emphasizes the exploration of data "to develop an understanding of patterned meaning" (Braun et al., 2019, p. 848). According to this analytic strategy, and consistent with other means of qualitative inquiry, coding of data is intended to be open and iterative, allowing for changes to the researchers' conceptualizations of the main themes as new data are gathered and incorporated critically into the emerging patterns. Steps outlined by Braun and colleagues (2019) were followed. The first author took lead in the familiarizing phase, by checking transcripts and noticing initial features, then generating codes and chunking data into potential meaning patterns. Through regular meetings, all authors engaged in the phases of constructing, revising, and defining themes based on the observations shared by respondents during the interviews. As themes were refined, probes were incorporated into the interview guide when participants' comments suggested latent content that would benefit from additional perspectives, which could serve to confirm or challenge our interpretations. Per Braun et al. (2019), we remained open to further revision to the meanings and organization of themes in the data, which indeed occurred with guidance from the expert peer reviewers of this manuscript.

Our analytical approach has been employed elsewhere in health communication research that, like our study, has been grounded in existing literature while remaining open to new insights (e.g., Kim et al., 2021). Theoretical dimensions of social support (e.g., Cutrona & Suhr, 1992) served as sensitizing concepts (e.g., Bowen, 2006) that drew our attention to moments in the data where doula support was compromised or enhanced during the pandemic. The purpose of this investigation was not to "tag" types of social support in the data, which would have resulted in a more surface-level summary than we sought here (Braun et al., 2019). Our goal was to extract latent meanings and organize the experiences of these support providers into a rendering of doula work during the pandemic, thus accomplishing the aim of reflexive thematic analysis, which is to interpret the data and structure them into a coherent story.

Results

In this section, we describe the communication and support challenges that doulas reported (RQ1). Then, we present how doulas coped with these challenges (RQ2). Throughout the results, we provide insights the doulas presented on how these challenges and adaptations may connect to issues of health disparities (RQ3). Eight subthemes fit into two larger themes: communication and support challenges (four themes) and coping (four themes).

Doula Communication and Support Challenges during COVID-19

The limitations of virtual doula support—During the pandemic, doulas used virtual technologies to provide support to their clients when they were not allowed in hospitals. With virtual support, doulas could not rely on traditional in-person techniques and physical

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comfort measures, which created challenges in establishing relationships with clients. As one doula stated:

> [Virtual communication] in some ways decreases the relationship that you have … when you're in person it's more personable. Now, when you have all of your communication via Zoom or texting, it's almost like you're meeting your client for the first time when you meet them at the hospital.

Several doulas noted that trust could be more difficult to establish virtually because they could not pick up on clients' bodily or environmental cues. One doula shared, "My clients value me being able to pick up on certain things without them having to tell me… it definitely makes forging that relationship a little more difficult than when I could provide services in person."

The role of physical presence in doula advocacy—Some doulas felt that their physical presence in a hospital setting, as a person in the room who was informed about pregnancy and birth, helped ensure that patients were treated fairly and listened to by medical providers. One doula reflected:

> If things are being discussed, or interventions mentioned, the dad or the client will look at me and I'll give them a thumbs up. Or I'll be able to reword and clarify, instead of them just listening to what the doctor says, and then they just go, "Okay, I guess if you're saying it's good for the baby," instead of feeling competent, like "I understand what is happening."

Doulas who work with low-income, minority and other underserved populations felt a larger responsibility to help patients advocate for their birth decisions. One doula shared,

> I see women of color being disregarded and their pain level being not taken seriously. I've definitely seen the disparity in Black maternal health outcomes. Even those who are highly educated and of [high] socioeconomic status that you think wouldn't be discriminated against, I still have seen huge discrimination.

Doulas noted how advocating for birthing people of color was more difficult to do when they could not physically be in the birthing room. One doula who worked with predominantly Black clientele shared, "A big piece of my work is helping clients advocate for themselves and have their questions and their issues heard. It's definitely difficult to do virtually."

Technological limitations could make it seem like a doula is not even present. As one doula reflected, "There have been some hospital settings where no one acknowledged my presence — the little head on the laptop on a table somewhere."

Provider attitudes about doula care matter during a pandemic—While constant readjustment to ever-changing hospital policies put stress on both doulas and their clients, many doulas noted that providers who were more receptive to doula care and made an effort to interact with doulas virtually enhanced the overall birth experience for the client. As one doula stated:

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> Nurses who come over to the camera and introduce themselves and get to know me, are the ones who are going to really enhance the client's experience. Because that client has chosen to have me there as a support person.

In general, before the pandemic, negative provider attitudes toward doula care could make the birthing experience more stressful. One doula commented:

> If they [providers and staff] are not really supportive of your presence, it can affect how you're able to support your client. They can affect how your client is perceiving the situation, because it can make things stressful for them. If they're [patient] noticing that there's negative energy in the space, it can impede the birth experience for them.

Several doulas reported that they try to improve relationships with providers and repair staff perceptions of the doula profession through actions like shaking hands and introducing themselves. However, when a doula is restricted from entering hospitals, it is more difficult to connect with medical providers in this way. One doula remarked, "I can't smile … to sort of make that person-to-person connection. When you're a head on a computer, it makes it more difficult to make that connection."

Miscommunication about doula services from providers and hospitals—Many hospital policies regarding doula support were miscommunicated during the pandemic. Some doulas reported many of their clients did not hire a doula initially because they were told by providers doulas weren't allowed in their hospital:

> [I discovered that] people were not looking for doulas, because their providers told them you can't have a doula with you. And they didn't say "but your doula might be able to call in with you or video in" or something like that. So, it wasn't even an option they felt like they could have because their provider told them "no doulas allowed in person."

Furthermore, providers may not be up to date on rapidly changing hospital policies and may provide inaccurate information regarding doulas to their patients. Another doula noted,

> They [clients] still relay back what their doctor says to me, and a lot of the doctors who are not staying abreast of the constant changes in policy are still [incorrectly] telling my clients that we weren't allowed in the hospital.

Adapting and Coping as a Doula During COVID-19

Adapting to virtual communication—Some doulas increased use of diagrams and other visual aids to better explain birthing techniques and comfort measures virtually. One doula said, "I have been trying to give my clients better tools to be by themselves because I'm not always guaranteed in the birthing space… sending them infographics or articles has helped bridge that gap of when I can't be there." Although using visual aids was new to most doulas in our sample, participants were becoming more comfortable finding and using these tools:

> I have gotten very good at sending a client a good picture of what I'm talking about. For breastfeeding health … at the beginning, I thought, "Man, this would

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> just be easier if I could show you with my hands." But once I knew the keywords to Google, I was able to just send a screenshot [of a diagram] to my client and I can highlight it and show "Okay, this is what you need to fix."

Some doulas also focused on more in-depth education so clients could conduct physical interventions themselves during birth. One doula shared,

> I changed my second prenatal that I do to be more in depth, where I showed the partners all of the maneuvers and moves, and told them what they were and said, "If I say, we're going to do a sideline release, this is what you would do."

Coaching partners to provide support—When doulas were not allowed in hospitals, they trained partners to provide support in their place. Frequently, doulas discussed the pressure partners felt when doulas could not be in the birthing room. As one doula noted,

> I think [clients'] partners are frightened, because partners get their heads around, "Okay, I don't have to remember everything, I won't be by myself, and I won't be the only one to provide support."

As a result, doulas who had to coach partners used their teaching skills more extensively:

> Now if I'm going to be attending you virtually, it's going to be more about coaching a partner about what to do and using my voice a lot. Using my voice in labor is something that I typically do, I've just learned to do it more in a virtual setting.

A growing interest in doula telehealth services—Some doulas were able to work with clients outside of their local community through non-traditional telehealth services (i.e., Zoom, Facetime) during COVID-19. One doula shared that two doulas at her practice were hired to support the labor of a person in a city about 2,000 miles away, which she described as "pretty amazing." Other doulas witnessed their colleagues virtually support people with similar racial and ethnic identities, and some have been able to connect people with doulas that share similar identities outside of their community.

Although most doulas agreed that virtual support was inferior to in-person support quality-wise, they also noted that the accessibility of virtual support and improved work-life balance for doulas makes it a worthwhile tool to integrate into their practice. Some doulas expressed interest in continuing telehealth services through a hybrid model after the pandemic:

> As it relates to prenatal visits and birth support, in general, I really like the model of doing virtual visits for the first couple of visits and then doing it in person. So, I plan to figure out some sort of hybrid moving forward, because it does allow me to better manage my time.

Virtual doula education to raise awareness about inequity—Many doulas shared that they saw a larger interest within the doula community, which has historically been predominantly White, in understanding medical racism, diversity, equity and inclusion (DEI) issues and supporting BIPOC communities. Some doulas partly owed this to the 2020 Black Lives Matter protests that coincided with the start of the pandemic. As more doulas have

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become comfortable with using virtual platforms, they have attended virtual trainings to learn more about health disparities as it relates to their work. One doula shared,

> I've seen more interest from … mostly the white doula population, in understanding more about diversity equity inclusion issues, learning more about how to support their BIPOC clients. People take anti-Black racism classes because they're available and online. It used to be what was happening in your area … or wherever you were willing to travel.

Although doulas shared they have seen a larger interest in learning more about anti-Black racism, training and awareness does not always result in different outcomes or treatment for Black patients. One doula, who is a person of color, noticed that "a lot of the training organizations really cater to affluent white families, and providing services to those families," highlighting a persistent systemic issue in community birth support that cannot be addressed only through awareness.

Discussion

The purpose of this study was to investigate communication challenges for doula care during the COVID-19 pandemic (RQ1) and the strategies they have employed to cope and help their clients cope (RQ2). We also explored doulas' perceptions of how these changes to birth support during the pandemic offer perspective on maternal health inequities (RQ3). We review the main contributions of the study below, with particular attention to the potential of promoting equitable maternal healthcare through doula support.

Our findings suggest that doulas have experienced a massive challenge establishing personal connections while providing support to birthing people — in particular, tangible and emotional support during labor and delivery (Castañeda & Searcy, 2021). Outside of doula-client relationships, doulas faced communication challenges with hospitals and labor and delivery healthcare professionals during the pandemic regarding changing hospital policies. However, simply increasing the amount of communication between doulas and healthcare workers will not mitigate this communication barrier if healthcare workers themselves are not informed of rapidly changing hospital policies. More effective coordination among hospital leadership, healthcare workers, and doulas—along with policies and incentives that support such efforts—would be beneficial.

We also found that provider attitudes towards doula care impact patient wellbeing and the birthing environment during COVID-19. Doulas who work with primarily birthing people of color take on advocacy as a large part of their work because their clients are susceptible to medical racism and discrimination. With the transition to virtual care, the physical presence that doulas perceive as an important part of their advocacy is lost. Providers who acknowledged doulas or made an effort to meaningfully interact with doulas virtually, made doulas and their clients feel more comfortable and supported.

In response to RQ2, the findings of the present study show that doulas have found ways to cope and preserve the intimacy of their work. They provided more in-depth informational support during the prenatal period to increase clients' and partners' self-efficacy and

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incorporated visual aids. Most notably, doulas coached partners during COVID-19 to carry out tasks that doulas themselves would typically do, such as offering physical interventions and providing emotional support to the birthing person. Some doulas have always included partners in their prenatal education; our findings suggest the effects of the pandemic extended those efforts. At the same time, a doula's presence helps to ease partners' anxieties and since partners may be interacting with and supporting other family members, birthing people may seek out a doula who solely supports them. For this reason, the physical presence of a doula remains important. However, our findings suggest if doulas maintain similar levels of partner education after the pandemic, this may increase overall partner engagement and have positive effects on the health experiences of birthing people. Future research should examine the sustainability and outcomes of these patterns.

Changes to doula care during COVID-19 highlight both obstacles and opportunities for increasing doula access and providing birth support to populations who face maternal and infant health disparities. Based on our findings, a lack of physical presence in the birthing space can make it more difficult for doulas to support and advocate for patients who are at risk for medical discrimination. Birthing people of color and low SES birthing people are often in most need of advocates and strong support systems to maintain patient autonomy and ensure they are being treated fairly in a hospital birthing space. Without physical presence, some doulas found it harder to recognize if their client was in an uncomfortable environment and more difficult to intervene if a client was treated unfairly.

Despite challenges with virtual support, it also provides opportunities to potentially address maternal health inequities. Our findings indicate doula telehealth can occur through nontraditional channels, such as Zoom, without relying on formal healthcare delivery services. This had some benefits. For example, doulas were able to connect clients with other doulas who could better racially or culturally identify with them and support their needs despite living at a distance. From this, we speculate that the increasing comfort with technologically-mediated communication might enable doulas to gain experience working with more diverse patient populations and make it more normative for people to locate services that are a better fit for them. These are important empirical questions that are beyond the scope of the present study but will be worth examining in the future.

Doulas of color and doulas of low SES status have a unique opportunity to support communities they identify with and communities who need doula support most, but high costs of certification or training and the rigorous demands of the work make it difficult for doulas to offer free or low-cost services. Doulas could offset their own costs by offering remote or virtual pre-birth sessions, which may increase the financial flexibility of doulas to offer lower-cost services to socially and economically disadvantaged communities. The significant interest among doulas to incorporate telehealth services such as virtual birth education into their practice after the pandemic may improve doula accessibility in certain communities (Rivera, 2021). However, the hybrid model of doula care is not a panacea. Technology barriers may prevent this option for low-income people and people who live in areas with low internet bandwidth speeds (Gajarawala & Pelkowski, 2021).

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Lastly, we found an increase in virtual anti-racist trainings among doula communities. With the simultaneous rise of virtual connection during the pandemic and a heightened awareness of racism in America with the 2020 Black Lives Matter protests, doulas cited both a motivation for learning about racism in healthcare and a way to easily access this information through virtual trainings. Both opportunities limit excuses for not learning more about racial issues in birth and healthcare and increase the potential for a more educated and aware doula community, although further research should explore this.

Limitations and Conclusion

Our study examined birth doula support and communication during COVID-19 through the perspectives of doulas. It will be worthwhile to examine how birthing people view the birth doula support they received during COVID-19 pandemic. Future research that centers the perspectives of birthing people at risk for poor birth outcomes will inform how doula care can help mitigate health disparities. It will also be important to extend and triangulate the findings of the present study, for example, by examining longitudinal data on how doula services during the pandemic may actually correlate with health outcomes for birthing people, babies, and families.

This study contributes to literature on doula care during the pandemic by highlighting the perspectives and experiences of doulas providing support in the U.S. Some limitations of this study include self-report methods and volunteer sampling, which may have introduced bias. Given the design and sample size, our findings were not meant to be generalized to all doulas practicing in the U.S.; however, our study may guide some future studies on doula care during COVID-19. Our findings may also connect with research examining how doulas and healthcare teams for birthing people cope with other stressors, including future pandemics, natural disasters, or crises that affect municipalities and their services. It is clear that doulas utilize both in-person and virtually mediated communication to provide support to birthing people, and they have been creative in implementing new communication strategies during the pandemic. While this shift has presented challenges for the doula community and their clientele, it has also uncovered new opportunities for doulas to expand their work to a virtual format and increase doula support in BIPOC and low-income communities.

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