Ohio Journal of Public Health, Vol. 8 Issue 1 ISSN: 2578-6180

COMMENTARY/POLICY

Perinatal Care Providers Should ask Their Patients if They Would Like a Doula

Ozi Ojukwu

Kent State University

Corresponding Author: Ozi Ojukwu, 700 Hilltop Drive, Kent, OH 44242, oojukwu@kent.edu

Submitted May 5, 2025 Accepted June 16, 2025 Published December 18, 2025 https://doi.org/10.18061/ojph.6409

ABSTRACT

In the last few years, Ohio's infant mortality rates have been consistently higher than the United States' own as well as the Healthy People 2030 goal. Given that it is known that clinical approaches to solving the problem have been found lacking, a public health approach is warranted. It has been hypothesized that doulas may be able to reduce or mitigate infant mortality outcomes. Based on an extensive review and discussion of the literature on doulas, the pregnancy experience, and pregnancy outcomes, this article argues it is prudent for perinatal care providers to ask their patients if they would like a doula for support.

Keywords: Health care provider; Doulas; Infant mortality; Labor support; Obstetrics

INTRODUCTION

The infant mortality rate refers to the number of deaths of infants younger than 1 year per the total number of live births in a given year. It is considered an important signifier of the health status of a community given that structural factors leading to infant deaths also affect other members of the community.[1] While in the United States the most recent infant mortality rate was 5.6 deaths per 1000 live births in 2022, Ohio's infant mortality rate was 7.1 deaths per 1000 live births, which represented an increase from the 2020 infant mortality rate of 6.7 deaths per 1000 live births. A report from an advocacy organization described Ohio's infant mortality rate over the last 10 years as stagnant and demonstrates that clinical approaches are not sufficient to reducing the rate, highlighting broader access to preventive services as an effective solution to reducing the infant mortality rate in the state.[2] Doulas may be an innovative solution to the infant mortality crisis in the state. Doulas are companions who provide physical, emotional, and informational support to clients throughout the perinatal period, including in the postpartum period. They can also provide support in the context of pregnancy loss, including miscarriage and abortion. An evidence review by Knocke and colleagues indicated that doulas were effective at enhancing the birthing (labor and delivery) experience and, among the Medicaid population, were effective at increasing rates of breastfeeding initiation and in reducing rates of preterm birth and cesarean section.[3] The finding that doulas are effective at increasing rates of breastfeeding initiation is important as breastfeeding is known to be a protective factor for sudden infant death syndrome (SIDS), a cause of infant mortality in Ohio. This article will highlight data from a practicum project, a narrative review demonstrating that doulas are effective at improving the birth experience and pregnancy outcomes. It will then use this evidence to argue that perinatal care providers should ask their perinatal patients, as a matter of standard practice, if they would like a doula.

Evidence Review

While doula support has received discussion recently in popular media,[4] doula research in the United States extends back into the 1990s,[5] although earlier research exists in Guatemala.[6] The first randomized control trial by Kennell and colleagues (1991) found that doula support in a public Texas hospital was associated with less epidural usage and less use of cesarean section during labor. Per Kozhimannil and colleagues, doula support was associated with fewer preterm births as well as a 22% reduction in the odds of preterm birth.[7] Given that preterm birth is the greatest cause of infant mortality in Ohio, it is especially meaningful that Ohio has passed legislation that permits doulas to be paid through Medicaid. While this is a laudable step to realize the prevention of infant mortality, recent legislation in Ohio Substitute House Bill (HB) 96 has been proposed that would limit Medicaid reimbursement for doulas to the 6 Ohio counties with the highest infant deaths. Given that doulas—in their unique provision of physical, emotional, and informational support—have been demonstrated to

reduce preterm births, it would be in the interest of the state to permit doula services to receive reimbursement in all counties so the state's health can improve.[8] Thus, an amendment to the legislation is justified. Such a policy would not require that doulas apply for Medicaid certification but leave the option to them. By amending the legislation, it would be possible for doulas to provide valuable support to low-income populations throughout the state. Evidence of the support doulas provide is outlined below.

In their 2008 randomized control trial assessing doula impact on cesarean section births for middle-class couples in Ohio, McGrath and Kennell found that doula support was associated with significantly lower rates of epidural and cesarean section birth, including for induced labor (echoing the 1991 study).[9]

In addition to the objective evidence that doula support is associated with less pain during the labor and delivery process, perinatal patients also report a subjectively improved pregnancy experience when doula support was added. In several studies analyzing the impact doula organization Birthing Beautiful Communities had on its clients, Rice and coauthors uncovered a positive influence. Birthing Beautiful Communities is a nonprofit doula organization serving Black clients in Cuyahoga County and Summit County (both in Ohio) in recognition of the racial disparities in infant and maternal mortality rates for this population.[10] In a 2024 study, the authors found that Birthing Beautiful Communities' doulas addressed the social determinants of health needs their clients had as needed, including by providing free Uber rides so their clients could get to medical and nonmedical appointments. Furthermore, the organization also helped provide brief financial assistance to ameliorate housing instability, another key social determinant of health.[11] While doulas were limited in their support during the COVID-19 pandemic, clients in the program described their relationship with the doula as a sisterhood,[12] and in an earlier 2021 study, Collins et al found that clients in the program described the relationship they had with their doulas as one of love.[13] Per a personal communication via email (May 16, 2025) with H. M. Rice, PhD, Birthing Beautiful Communities has a 99.2% infant survival rate and a 92% full-term birth rate starting at 37 weeks gestation, along with an 86% to 88% breastfeeding initiation rate depending on the time of year.

Furthermore, Bihn-Coss and Egbert completed a study on Ohio birth doulas' perceptions on their advocacy role. Doulas promoted self-advocacy among their clients as they gave birth, and they also provided physical, emotional, and social support in the labor and delivery processes. Examples of physical support included loaning comfort items and providing space for the client (including leaving her alone when necessary). Examples of emotional support included the provision of empathy including listening to and sometimes praying for the patient. Finally, in providing support throughout the entire perinatal period, doulas provided social support. Doulas also maintained lists of other helpful resources including grief and bereavement resources in the case of miscarriage.[14]

When we expand the scope of analysis from Ohio to other Midwestern states, we also find beneficial outcomes for patients. In a 2009 ethnography looking at postpartum doula competencies and roles in Michigan, McComish and Visger found that doulas helped integrate the new baby into the larger family unit, and they also helped mothers learn how to breastfeed (important to the prevention of sudden infant death syndrome). In addition, postpartum doulas encouraged fathers to be more involved in family life, and they encouraged mothers to practice self-care.[15]

In a 2016 qualitative article, Kozhimannil and colleagues found that, similar to Bihn-Cross and Egbert's study, doulas in Minnesota empowered their clients to interact with their health care providers. Patients also believed that doula support and presence would help promote autonomy in decision-making in the process of giving birth. In addition, doulas also fulfilled their informational support role by providing their clients information about the physiological process of pregnancy. Furthermore, doulas also provided social support and decreased isolation for women with limited support networks.[16]

In a series of studies from Illinois, Hans et al found that doula support was associated with a host of beneficial outcomes. Edwards and colleagues found that intensive doula support throughout the perinatal period was associated with significantly higher rates of hospital-based breastfeeding attempts and later introduction of cereal and other solid foods compared to the control group. While doula support was not significant with breastfeeding length at 3 different time points (less than 6 weeks, 6 weeks, and more than 4 months), the relationship between doula support and breastfeeding duration represents a new area of research and public health practice.[17] In another study assessing doula support and mother-infant relationships, Hans and authors found that intervention mothers encouraged their infants more than those in the control group. Intervention babies were also less likely to have long periods of distress in video recordings that researchers used to understand parenting behavior, demonstrating doulas have health-promoting effects.[18] Finally a randomized control trial by Hans and colleagues in 2018 indicated no differences between the doula intervention and control groups in preterm birth outcomes. However, those in the doula group had higher chances of attending a childbirth education class in pregnancy and had lower chances of using pain medication (including epidural) in labor. Those in the doula group also were more likely to practice the safe sleep behavior of placing their infant to sleep on their back and to always place their baby in a car seat when traveling by car, behaviors key to the prevention of sudden infant death syndrome, another cause of infant mortality.[19]

In addition, in a 2024 qualitative study, Herriott et al reported that doulas collaborated with other birth workers and also provided continuity of care by filling in gaps.[20] A 2015 study by Shlafer and colleagues found that doulas fulfilled their roles in providing physical, emotional, and informational support to women in a Midwestern prison in the United States, although special considerations were applied. For example, doulas provided emotional support to their clients as they returned to jail

and had to leave their babies behind, and they also recorded the birth experience when family members could not.[21] Also, in their qualitative study on African American women's experiences of pregnancy in Chicago, Norcott and colleagues found that some of their sample population received information about perinatal health disparities from doulas.[22] Finally, a retrospective cohort study from Pennsylvania by Lemon and colleagues demonstrated that the University of Pittsburgh Medical Center's (UPMC) hospital-based doula program was associated with reductions in preterm birth outcomes for both spontaneous preterm birth (-3.8 to -4.0 preterm births) and indicated preterm births where the baby is born by cesarean section given maternal or fetal illness (-2.2 to -2.7 births).[23] While Pennsylvania is not a Midwestern state, and this study assesses a hospital-based doula program in contrast to independent or community-based doula services, the study provides further evidence that doula care is associated with reductions in preterm birth, increasing the likelihood that doulas are associated with reductions in infant mortality and thus promote the public's health.

PUBLIC HEALTH IMPLICATIONS

Given the clear benefits described above associated with doula support throughout the perinatal period, it should be a matter of standard practice for prenatal and postpartum care providers to ask their pregnant and postpartum patients if they would like a doula, either prenatally or in the postpartum period. Such providers would include obstetrics and gynecology (OB/GYN) physicians, certified nurse midwives (CNM), women's health nurse practitioners (WHNP), pediatricians, pediatric nurse practitioners (PNP), neonatal nurse practitioners, and their physician assistant counterparts. Since doulas are associated with improved infant health outcomes, including the reduction of preterm births, it is likely that connections to doula support would be associated with reduced infant mortality rates. Thus, the health status of the entire community would be improved. Furthermore, beyond asking, if possible, providers should refer their interested clients to community-based doula services to ensure actual receipt of services to see improved outcomes in public health. Finally, given that preterm birth (birth before 37 weeks) is the greatest cause of infant mortality in Ohio, the high rate of full-term birth (92%) associated with this intervention provides reason to implement programs similar to Birthing Beautiful Communities, in areas Birthing Beautiful Communities does not serve, and for perinatal care providers in Summit County and Cuyahoga County to refer their pregnant patients to this program if feasible..

REFERENCES

1. Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Infant mortality. NIH. October 29, 2021. Accessed April 16, 2025. https://www.nichd.nih.gov/health/topics/infant-mortality
2. Groundwork Ohio. Infant mortality in Ohio: a ten-year look at the impact of policy changes and opportunities for the future. Accessed April 18, 2025. https://www.groundworkohio.org/resources
3. Knocke K, Chappel A, Sugar S, De Lew N, Sommers BD. Doula Care and Maternal Health: An Evidence Review. (Issue Brief No. HP-2022-24). Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. December 2022. https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf
4. Gupta AH. You can now get virtual doula care for pregnancy. Does it work? The New York Times. June 8, 2024. Accessed April 16, 2025. https://www.nytimes.com/2024/06/08/well/family/virtual-doula-care.html
5. Kennell J, Klaus M, McGrath S, Robertson S, Hinkley C. Continuous emotional support during labor in a US hospital. A randomized controlled trial. *JAMA*. 1991;265(17):2197-2201. https://doi.org/10.1001/jama.1991.03460170051032
6. Sosa R, Kennell J, Klaus M, Robertson S, Urrutia J. The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *N Engl J Med*. 1980;303(11):597-600. https://doi.org/10.1056/NEJM198009113031101
7. Kozhimannil KB, Hardeman RR, Alarid-Escudero F, Vogelsang CA, Blauer-Peterson C, Howell EA. Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth*. 2016;43(1):20-27. https://doi.org/10.1111/birt.12218
8. Britton T. Medicaid trigger language, doulas, kids' continuous coverage: interested party testimony. Center for Community Solutions. May 6, 2025. Accessed June 3, 2025. https://www.communitysolutions.com/resources/medicaid-trigger-language-doulas-kids-continuous-coverage-interested-party-testimony
9. McGrath SK, Kennell JH. A randomized controlled trial of continuous labor support for middle-class couples: effect on cesarean delivery rates. *Birth*. 2008;35(2):92-97. https://doi.org/10.1111/j.1523-536X.2008.00221.x
10. Birthing Beautiful Communities. Accessed April 18, 2025. https://www.birthingbeautiful.org/
11. Rice H, Collins C, Cherney E. Beyond birth work: addressing social determinants of health with community perinatal support Doulas. *Clin Nurs Res*. 2024;33(5):316-325. https://doi.org/10.1177/10547738241244590
12. Rice HM, Collins CC, Singh M, Cherney E, Hercbergs D; Birthing Beautiful Communities. The impact of Covid-19 on community perinatal doula support services for Black women. *Matern Child Health J*. 2024; 28(5):858-864. https://doi.org/10.1007/s10995-023-03858-3
13. Collins CC, Cherney E, Brown PL, et. al. Experiences of Black women during pregnancy: the meaning of perinatal support. *Am J Orthopsychiatry*. 2021;91(5):589-597. https://doi.org/10.1037/ort0000557
14. Bihn-Coss G, Egbert N. Supporting in solidarity: an examination of social support, advocacy, and barriers among birthing doulas. *Commun Q*. 2023;71(3):243-267. https://doi.org/10.1080/01463373.2022.2164737
15. McComish JF, Visger JM. Domains of postpartum doula care and maternal responsiveness and competence. *J Obstet Gynecol Neonatal Nurs*. 2009;38(2):148-156. https://doi.org/10.1111/j.1552-6909.2009.01002.x
16. Kozhimannil KB, Vogelsang CA, Hardeman RR, Prasad S. Disrupting the pathways of social determinants of health: doula support during pregnancy and childbirth. *J Am Board Fam Med*. 2016;29(3):308-317. https://doi.org/10.3122/jabfm.2016.03.150300

17. Edwards RC, Thullen MJ, Korfmacher J, Lantos JD, Henson LG, Hans SL. Breastfeeding and complementary food: randomized trial of community doula home visiting. *Pediatrics*. 2013;132 Suppl 2:S160-166. https://doi.org/10.1542/peds.2013-1021P

18. Hans SL, Thullen MJ, Henson LG, Lee H, Edwards RC, Bernstein VC. Promoting positive mother-infant relationships: a randomized trial of community doula support for young mothers. *Infant Mental Health J*. 2013;34(5):446-447. https://doi.org/10.1002/imhj.21400

19. Hans SL, Edwards RC, Zhang Y. Randomized control trial of doula-home-visiting services: impact on maternal and infant health. *Matern Child Health J.* 2018;22(Suppl 1):S105-113. https://doi.org/10.1007/s10995-018-2537-7

20. Herriott AL, Etling S, Hans SL. Community-based doulas' roles within the birth support system: young Black mothers' perspectives. *J Midwifery Womens Health*. 2024:69,33-40. https://doi.org/10.1111/jmwh.13570

21. Shlafer RJ, Hellerstedt W, Secor-Turner M, Gerrity E, Baker, R. Doulas' perspectives about providing support to incarcerated women: a feasibility study. *Public Health Nurs*. 2015:32(4),316-326. https://doi.org/10.1111/phn.12137

22. Norcott C, Mbayiwa K, Ilyumzhinova R, Sroka AW, Hipwell AE, Keenan K. Listening to the perspectives of Black women on perinatal health disparities: reversing the tide and improving outcomes. *J Racial Ethn Health Disparities*. 2024:1-8. https://doi.org/10.1007/s40615-024-02181-z

23. Lemon LS, Quinn B, Young M, Keith H, Ruscetti A, Simhan HN. Quantifying the association between doula care and maternal and neonatal outcomes. *Am J Obstet Gynecol*. 2025;232(4):387.e1-43. https://doi.org/10.1016/j.ajog.2024.08.029