Sexual & Reproductive Healthcare 49 (2026) 101262

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

Full Length Article

Building birthing confidence in practice: Insights from community-based doula focus groups in New York State

Yookyeong Park [a,b], Elana S. Marton [a], Vanessa L. Threatte [a], Yan Wu [a,*]

[a] New York State Council on Children and Families, Rensselaer, NY, USA
[b] Department of Educational & Counseling Psychology, University at Albany–State University of New York, Albany, NY, USA

ARTICLE INFO

Keywords:
Community-based doula
Medicaid
Maternal healthcare
Workforce development
Hospital collaboration
Barriers and facilitators

ABSTRACT

Objective: This study aimed to understand the perspectives of community-based doulas in New York State regarding the opportunities and challenges facing the profession. Specifically, it explored their experiences, perceived barriers, and recommendations prior to the implementation of Medicaid reimbursement.
Methods: Five in-person focus groups were conducted with 22 community-based doulas in four regions of New York State between October and November 2023. Discussions explored participants' pathways into doula work, training experiences, professional practice, collaboration with healthcare providers, and perspectives on Medicaid reimbursement. Data were analyzed using reflexive thematic analysis.
Results: Five themes were identified: (1) pathways and motivation for doula work, (2) training and certification, (3) role recognition and hospital collaboration, (4) client outreach and recruitment, and (5) Medicaid reimbursement and implementation readiness. Across themes, participants described community-based doulas as providing community-rooted support while facing persistent structural barriers to professional recognition, financial sustainability, and integration within maternal healthcare systems. Participants emphasized the need for stronger professional support, greater public awareness, and more collaborative relationships with healthcare providers.
Conclusion: Findings suggest that expanding Medicaid reimbursement alone may not be sufficient to support the community-based doula workforce. Sustainable integration of community-based doulas into maternal healthcare systems will also require investments in workforce development, improved public awareness and referral pathways, and stronger collaboration between doulas and healthcare providers.

Introduction

Experiences of pregnancy and childbirth take place within broad social and structural contexts that have implications for maternal and infant health. It is therefore not surprising that persistent racial inequities are reflected in disproportionately poorer maternal health outcomes among Black, Indigenous, and other marginalized birthing persons [1]. Although New York State has implemented several statewide initiatives to address systemic racism in maternity care [2–5], including the New York City Standards for Respectful Care at Birth developed in 2018 [6], racial inequities persist.

Black, non-Hispanic women experience pregnancy-related mortality at more than five times the rate of White, non-Hispanic women [7,8]. Although patient-reported care has improved overall, these improvements have not extended equally to Black respondents' reports of being treated with dignity (NYSDOH, personal communication, March 3, 2026). These inequities highlight the need for culturally responsive and person-centered perinatal support.

Doulas—also referred to as labor, birth, or childbirth coaches—are positioned to provide support through sustained, non-medical care during pregnancy, childbirth, and the postpartum period. A growing body of research has documented associations between doula support and improved quality of care, as well as better perinatal experiences and outcomes, particularly among populations that have historically faced barriers to respectful maternity care [9]. States across the United States have increasingly invested in the doula workforce and policies to support access to doula services by, for example, providing Medicaid coverage for doula services [10].

Community-based doulas are a distinct segment of the doula workforce, serving birthing people at greater risks of maternal morbidity and

* Corresponding author at: New York State Council on Children and Families, 52 Washington Street, West Building, Suite 99, Rensselaer, NA 12144, USA.
E-mail address: Yan.Wu@ccf.ny.gov (Y. Wu).

https://doi.org/10.1016/j.srhc.2026.101262
Received 2 April 2026; Received in revised form 31 July 2026; Accepted 7 August 2026
Available online 8 August 2026
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mortality. Unlike privately hired doulas, they are typically trained through community organizations, share cultural and linguistic backgrounds with the communities they serve, and are supported through public funding such as Medicaid [5]. Their work frequently extends beyond individual client interactions to include advocacy, care coordination, and sustained community engagement [11].

Community-based doulas describe their roles as encompassing both emotional support and advocacy for birthing people within hospital and community settings and view this work as central to meeting clients' needs [12]. For example, a quality improvement project led by the SisterWeb San Francisco Community Doula Network found that their daily work also includes extensive office work, community engagement, logistical coordination, advocacy, and emotional support—many of which are rarely compensated or formally recognized [13,14].

Despite the breadth and complexity of these responsibilities, existing literature has largely focused either on birthing individuals who receive doula support or on program-level evaluation [15–17]. Although recent studies have begun to examine aspects of the doula workforce—including mentorship, professional development, and organizational support [14,18]—these studies primarily have evaluated specific organizations or workforce experiences. Less is known about how multiple structural, organizational, and policy conditions collectively relate to the experiences of community-based doulas. Understanding these experiences is essential for sustaining implementation of community-based doula programs.

This project was conducted during a period of statewide activity consisting of efforts to strengthen and expand community-based doula services in New York State (see Table 1 for a timeline of major policy developments). As part of this broader initiative, the findings were intended to inform public awareness efforts to improve understanding of community-based doulas and improve access to their services.

Method

All procedures of focus group adhered to ethical standards for protecting participants' rights and privacy. The focus groups were originally conducted to gather stakeholder perspectives, amplify the voices and visibility of community-based doulas, and inform program and policy improvements. Because these focus groups were conducted for programmatic rather than research purposes, they were not submitted for Institutional Review Board review. Prior to each focus group, facilitators reviewed the purpose of the initiative, informed participants that the session would be audio-recorded for transcription, and obtained participants' written consent. Participation was entirely voluntary, and participants were informed that they could decline to answer any question or withdraw at any time.

Table 1
New York State's timeline regarding doula services.

Calendar Year	Policy Context
2019	- Doula pilot program launched in Erie and Kings Counties in March to target maternal mortality and reduce racial disparities in health outcomes. - New York State Council on Children and Families (NYSCCF) supports interns at two health centers that promote doula care.
2022	- Citywide doula initiative launched in New York City to improve health outcomes for birthing people. - NYSCCF supports training of doulas in the Capital District.
2023	- Report and recommendations released in March based on Public Hearing on Doula Care by New York State Senate Health and Mental Health Committees. - New York State Governor Hochul signs law establishing a statewide Doula database in November.
2024	- New York State Department of Health (NYSDOH) report on pregnancy-associated deaths recommends that hospital systems and OB providers engage community resources (e.g., doulas) during prenatal care and hospital discharge planning to support high-risk people with chronic conditions in March. - Medicaid coverage expanded to cover doula services in March.
2025	- Standing order for doula services issued for all pregnant, birthing, and postpartum New Yorkers, by NYSDOH commissioner in June.

Participants and procedures

Five in-person focus groups were conducted with community-based doulas in four regions of New York State—Albany, Buffalo, New York City, and Syracuse—between October and November 2023. Two focus groups were conducted in NYC. One region (Buffalo) was part of the 2019 Medicaid pilot program, while the others represented non-pilot areas. A total of twenty-two doulas participated.

Each focus group lasted approximately two hours. Sessions were facilitated by three staff members from the NYSCCF. At the beginning of each session, doulas were asked to sign a release permitting the use of de-identified quotes in reporting and to complete an optional demographic questionnaire. Participants were notified that discussions were recorded solely for internal reference. Each doula received a $50 gift card, and meals were provided. Recruitment was conducted through outreach to community-based centers serving high-need urban areas. Flyers containing meeting details were disseminated through regional email lists in collaboration with community-based organizations. A semi-structured protocol was used for all focus groups, including a facilitator guide, recording procedures, and a set of interview questions. The complete interview guide is provided in Appendix A, with the full set of questions listed in Appendix B.

Data analysis

An inductive reflexive thematic analysis was conducted following the six-phase guidelines outlined by Braun and Clarke [19,20]. This approach was selected for its flexibility and suitability for exploring participants' experiences and perspectives.

Audio recordings were transcribed, and transcripts were reviewed for accuracy. The first author, who was not involved in facilitating the focus groups, independently reviewed all transcripts and conducted coding of the complete dataset. During theme development, the first author also reviewed the preliminary analytic work conducted for an earlier white paper based on the same focus-group data. This earlier analysis served as an interpretive resource rather than as a fixed coding framework. Coding decisions and emerging theme interpretations were discussed with additional members of the research team. Through this iterative and recursive process, codes were organized, refined, and developed into final themes.

Consistent with the interpretive nature of thematic analysis, inter-rater reliability was not calculated. Although respondent validation was not undertaken, analytic credibility was supported through the first author's independent coding of the full dataset, repeated engagement with the original transcripts, consideration of the earlier analysis, and collaborative discussions with members of the research team throughout theme development.

Results

A total of twenty-two doulas participated in the focus groups. Participants varied in years of professional experience ($Mean = 5.14$, $SD = 4.98$, $Min = 0$, $Max = 20$). All doulas identified as female; 90% identified as Black or African American, and 10% as another race. Ten percent reported Hispanic/Latinx ethnicity, and most participants (90%) spoke English as their primary home language. Household income varied, with half earning less than $49,999 (see Table 2).

Theme 1. pathways and motivation for doula work

Participants traced their pathways to a combination of lived

Table 2
Demographics of doula participants.

Focus Group	Count	%	Income	Count	%
Albany	4	18.18	Less than $49,999	11	50
Buffalo	3	13.64	$50,000 to $74,999	5	22.73
NYC	7	31.82	$75,000 to $99,000	1	4.55
Syracuse	8	36.36	$100,000 to $149,999	5	22.73
Race	Count	%	Hispanic	Count	%
Black/African American	20	90.91	Yes	2	9.09
Other	2	9.09	No	20	90.91
Gender	Count	%			
Female	22	100			

experience, community involvement, and professional exposure to maternal healthcare systems. Specifically, they described how personal experiences, including their own births or those of family members, motivated them to pursue doula work. One participant reflected on how her experience as a teen mother shaped her commitment to supporting clients in navigating the hospital system.

"I went through the training to become a doula to help the women who cannot stand up for themselves and cannot handle all the control and stress and will say yes to anything they want to do and sign any paper. There is injustice on Black women especially if coming from a different country." (Quote 1).

"I started doing birth work because I was a teen mom. As a teen mom, the experience was not good. … It would have been helpful to have someone who was better informed in the birth world and how to navigate the hospital system." (Quote 2).

Some participants also described exposure to childbirth through family or community networks, which made entry into birth work feel culturally grounded. Despite the diverse pathways into the profession, participants described these personal, professional, and community experiences as important sources of motivation that sustained their work.

"I wanted to do maternal health and as a Black woman I wanted to dive into maternal inequities. … I know with us we are very vulnerable." (Quote 3).

"Saw the issue and problem, and that it's a problem for me as a young Black woman." (Quote 4).

"I knew having a doula was so expensive as a Black woman. … I couldn't afford it and had to do my own research to have the birth I wanted." (Quote 5).

Theme 2. training and certification: barriers and supports

Participants emphasized that existing training and certification pathways often do not adequately prepare community-based doulas for the realities of their work. Several participants described training programs as insufficiently addressing the complex medical, social, and trauma-related needs of the communities they served. As a result, many reported relying on self-directed learning and practical experience to develop the skills.

"Some of the stuff they trained with was good, but they didn't address things going on in my area like health issues like diabetes, or the trauma some people may experience giving birth or what it would take to support a client who has been sexually assaulted or has no support and maybe who wasn't even working." (Quote 6).

"I feel like a lot of stuff is self-taught on the job on the go." (Quote 7).

Participants also identified financial and logistical barriers to obtaining training and certification. Training programs were described as expensive, geographically not easy to access, and requiring substantial personal financial sacrifice. One participant explained having to rely on a cash advance to cover training costs, while another described the lack of affordable local training opportunities. Despite these challenges, some participants viewed certification as a valuable learning experience that revealed important knowledge gaps and strengthened their professional preparation.

"Cost. We had to get very creative when paying for it. Got no interest cash advances because of good credit." (Quote 8).

"In 2019 right before COVID, I started to research places to get certified... I found they were very expensive, not affordable, there were none right here in Albany, had to go down to the city or do it online." (Quote 9).

"I got certified and that was interesting—it was like going back to school, having to take tests and study. It was nice because I didn't realize how much I was missing, how much I didn't know despite doing this so long." *(Quote 10).*

Theme 3. role recognition and hospital collaboration

Participants reported limited public and institutional understanding of their role. They described being frequently confused with midwives, a misunderstanding that sometimes led medical staff to delegate clinical tasks outside doulas' scope of practice, creating tension and frustration. More broadly, this lack of understanding contributed to doulas not being treated as integral members of the care team. At the same time, participants emphasized that providers who understood the doula role and viewed doulas as members of the maternity care team created more positive experiences for both doulas and birthing people.

"They assume a doula and a midwife is the same thing. I do not catch babies…. Doulas provide the support and advocacy and care that you need as a birthing person." (Quote 11).

"They are going to confuse doulas with midwives because Medicaid is paying them. It needs to be clear that this is what doulas do: resources, emotional support, family support, but separate it from the midwife." (Quote 12).

"Some doctors are stuck in the past and will tell women (birthing people) they don't need one (doula)." (Quote 13).

"I've never seen a doula with a doctor and nurse in the room. … I have not seen a doula as part of the team. We are not being shown as part of the team in the hospital setting." (Quote 14).

"The barrier is when you can't walk into a hospital or birth center and feel welcomed or safe." (Quote 15).

"Value me as a doula… we do a lot." (Quote 16).

"*I try not to bring up that I'm an RN, but one time I had to because I was being given a hard time by the hospital. They were very apologetic, but I shouldn't have had to do that.*" *(Quote 17).*

Several participants described experiences of racial bias, noting differential treatment between Black doulas and White doulas. One Black participant shared that she was repeatedly questioned about her credentials, while White doulas were allowed to enter without verification.

"My biggest barrier comes down to race. Realistically, I hate that it's like that. … It's one of the craziest things I've ever felt because you still need to be professional." (Quote 18).

"As a Black woman who is navigating a world where you are mistreated, when you have a doula people see what humanizing pregnant people looks like. They see the value in it because you are modeling what community care looks like." (Quote 19).

Theme 4. client outreach and recruitment

Participants reported a lack of established referral or outreach infrastructures that made client recruitment challenging. In the absence of formal referral pathways, many relied on informal community networks, such as word of mouth, personal contacts, and social media, to connect with potential clients.

"Social media hashtags work. That's how people find me. It's a lot of work." (Quote 20).

"Had a client and she gave my information to friend." (Quote 21).

"I had one close friend from high school as a client." (Quote 22).

"*I think that sometimes social media doesn't work because of lack of awareness of what is a doula. Maybe they ignore the message because of*

that." *(Quote 23)*.

Participants explained that increasing visibility required sustained outreach within the communities they served, including attending local events and partnering with trusted community spaces.

"*We have to be more in the community at churches and local events we could spread the word more. We do good but we do it as volunteers and it takes a lot of work.*" *(Quote 24)*.

Although these recruitment efforts were often labor-intensive, participants described community relationships as one of their greatest strengths for connecting with clients. Word-of-mouth referrals, trusted relationships with previous clients, community organizations, and personal social networks frequently served as particularly valuable because they fostered trust and credibility within the communities they served.

Theme 5. medicaid enrollment and implementation readiness

Participants expressed apprehension about enrolling as Medicaid providers during the early implementation of New York State's Medicaid doula benefit. Many also described uncertainty surrounding enrollment requirements, documentation, reimbursement procedures, and expectations for practice.

"*While it sounds great, we want to know… what is the process?*" *(Quote 25)*.

"*What does Medicaid expect from doulas? It needs to be clear.*" *(Quote 26)*.

Several participants expressed concern that reimbursement policies might not reflect the realities of community-based doula work. Some worried that low reimbursement rates and administrative demands could make serving Medicaid clients financially unsustainable. Despite these concerns, participants viewed Medicaid coverage as an important opportunity to expand access to doula services for underserved communities.

"*I did sign up for it when they tried to do the pilot for certain zip codes. My only issue was that amount being reimbursed, … so I had to decide I would only take 2 Medicaid clients and the rest would be private.*" *(Quote 27)*.

"*Recently did another training that wanted us to be prepared for the Medicaid aspect. I am still going to support my community and if this is going to help me take on more clients in the community, because I know a lot of people have Medicaid and how could they afford doula services? People with disabilities, single parents, teenagers, use Medicaid.*" *(Quote 28)*.

"*City initiative is not city wide. Medicaid initiative will allow everyone in different demographics who need it to participate in doula services.*" *(Quote 29)*.

Discussion

This project demonstrates that community-based doulas in New York State occupy a meaningful yet structurally constrained position within the maternal health system. Similar themes emerged across focus groups. Across all five themes, participants described entering community-based doula work through lived experiences with maternal health inequities, yet they also reported facing persistent barriers related to workforce development, institutional recognition, public awareness, and Medicaid implementation. Rather than representing isolated challenges, these findings suggest that the sustainability of community-based doula care depends on strengthening the systems that support doulas throughout their professional pathway.

Community-based doulas as a lived-experience workforce

One of the most notable findings was that participants rarely described becoming doulas as simply a career choice. Instead, many shared that they entered the profession after personally witnessing inequities in maternity care or experiencing barriers themselves, particularly as Black women or members of historically marginalized communities (see Quotes 1–4). These experiences appeared to shape not only why participants became doulas, but also how they understood advocacy, trust, and culturally responsive care as central components of their professional identity.

This finding suggests that community-based doulas represent a workforce grounded in lived experience and community relationships. Their perspectives reinforce literature emphasizing that community-based doula models extend beyond labor support by addressing broader social, cultural, and structural needs within historically underserved communities [21]. Policies focused exclusively on certification requirements or reimbursement may therefore overlook the relational and community-centered foundations that participants consistently identified as essential to their work.

Workforce sustainability extends beyond reimbursement

Participants described workforce sustainability as dependent on multiple interconnected supports. Although Medicaid coverage for doula services was viewed as an important opportunity to expand access to doula services, participants emphasized that reimbursement alone would not address the practical realities of community-based practice. Concerns regarding administrative complexity, unclear enrollment expectations, reimbursement delays, and financial viability (see Quotes 22–24) suggest that expanding Medicaid coverage may not automatically increase participation among community-based doulas if implementation systems remain difficult to navigate. These findings are consistent with previous studies documenting administrative burden and reimbursement delays as barriers to Medicaid participation [22,23]. They also suggest that successful implementation of the Medicaid benefit for doula services depends not only on reimbursement itself but also on implementation strategies that reflect the realities of community-based doula practice.

Participants similarly described training, mentorship, and client outreach as interconnected opportunities to support workforce sustainability. Limited access to affordable, culturally responsive training reduced opportunities to establish mentorship relationships and professional networks, while the absence of formal referral systems increased reliance on personal and community connections for recruitment (see Quotes 6, 7, 23, 24). These findings are built upon previous research documenting financial and logistical barriers to doula training [24], illustrating how limitations across training, mentorship, and outreach may collectively affect workforce recruitment and retention.

Institutional recognition remains essential for integration

Participants also emphasized that meaningful integration into maternity care depends on institutional recognition of the doula role. Limited public understanding resulted in doulas being confused with midwives, while inadequate recognition within hospital settings contributed to unclear expectations, restricted collaboration, and, for some participants, experiences of racial bias (see Quotes 11–19).

Rather than representing isolated interpersonal interactions, these accounts suggest broader organizational barriers to integrating community-based doulas within perinatal care systems. Previous studies have similarly documented variable acceptance of doulas across hospital settings [25]. The present findings extend this literature by illustrating how participants perceived respectful communication, clear role definition, and collaborative relationships as essential conditions for effective integration.

Strengths and limitations

This project has several strengths. First, this study focused on community-based doulas of color, allowing the perspectives of practitioners from historically marginalized communities to be more fully represented. Second, participants were recruited from both doula pilot and non-pilot regions, providing insight into a range of policy

implementation contexts in New York State. Third, the applied quality improvement framework generated findings with direct relevance to ongoing policy implementation and workforce development efforts, enhancing the study's practical value for policymakers, healthcare organizations, and community-based doula programs.

This study also has several limitations. First, the sample was relatively small and drawn from four regions, limiting the transferability of the findings to all doulas in New York State or to doulas working in different training and practice contexts. Second, because data collection occurred in 2023, prior to the statewide implementation of New York State's Medicaid doula benefit in 2024, participants described anticipated rather than actual experiences with Medicaid enrollment and reimbursement. The findings therefore provide a baseline understanding of workforce perspectives but do not reflect doula's experiences following implementation.

Future study

Future research should examine how community-based doulas experience Medicaid enrollment, reimbursement, and workforce sustainability following statewide implementation. Longitudinal studies will be particularly valuable for understanding how policy implementation influences doulas' practice experiences, retention, and integration within maternal healthcare systems.

Future studies should also examine how doulas navigate these processes in practice, as well as how hospital–doula collaborations evolve over time. Emerging evidence from New York State suggests that intentional hospital–doula partnerships can strengthen integration and access to doula care. For example, the Building HOPE program in New York City demonstrated that formal hospital policies, closed-loop referral systems, and regular communication between hospital leadership and doula organizations were associated with improved institutional alignment [16]. Understanding how doulas experience these partnerships will be essential to refining and scaling sustainable models of collaboration (see Table 3).

Table 3
Key Challenges and Policy Recommendations Identified by Participants.

Challenge	Recommendation	Reference Quotes
• Doulas are often not recognized within hospital settings, are confused with midwives, or experience restricted access to clients.	• Require healthcare systems to provide doula-related training, enforce anti-discrimination policies, and offer financial or accreditation incentives to hospitals that integrate doulas, with public reporting of progress and outcomes.	11–17
• Most clients are reached through word of mouth or social media, with few formal referral pathways.	• Require clinics and hospitals to provide information about community-based doulas and establish referral pathways that integrate doula support into routine prenatal care.	20–24
• Doulas report that Medicaid enrollment processes are confusing and express concern about delayed reimbursement or denied claims.	• Provide clear enrollment guidance, hands-on application assistance, and ongoing technical support through state agencies or community-based organizations.	25–28

Conclusion

This paper demonstrates that community-based doulas in New York State play a critical role in supporting birthing people and strengthening perinatal care, yet their work remains constrained by structural, institutional, and administrative barriers. This study extends the existing literature by centering the perspectives of New York State community-based doulas during a critical period preceding statewide Medicaid coverage for doula services. The study highlights the experiences of the community-based doula workforce and identifies the organizational, relational, and structural conditions that shape successful policy implementation. Participants' experiences point to the need for more accessible and culturally responsive training pathways, sustained mentorship and peer support, improved public and institutional understanding of doulas' roles, and streamlined administrative processes for doulas to participate in Medicaid. Centering doulas' perspectives in policy design and implementation will be essential to ensuring that investments in doula care translate into sustainable and effective support within the maternal health system.

CRediT authorship contribution statement

Yookyeong Park: Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Data curation. **Elana S. Marton:** Writing – review & editing. **Vanessa L. Threatte:** Writing – review & editing, Supervision, Project administration. **Yan Wu:** Writing – review & editing, Supervision.

Consent for publication

All participants gave consent for their data to be used in publications.

Funding

Part of the original project was supported by the Annie E. Casey Foundation.

Declaration of competing interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Acknowledgements

The authors thank the twenty-two doulas who participated in this study and the following sites for hosting the interviews: In Buffalo, Jericho Road and the Erie Niagara Area Health Education Center; in New York City, the Caribbean Women's Health Association and Mama Glow; in Albany, BirthNet and the United State Committee for Refugees and Immigrants; and in Syracuse, the Sankofa Reproductive Health and Healing Center.

Thank you to Cate Bohn, Samantha Gerken, Ocesa Keaton, and Betsey Schuhle for their numerous and valuable contributions to the Doula Project.

Thank you to the New York State Department of Health for supporting the preparation of this manuscript.

Appendix A. Doula Focus Group Protocol

Welcome, everyone. Thank you for taking time out of your schedule to attend today's focus group. My name is [facilitator's name]. I will lead the discussion. This is [note taker's name]. She will observe and take notes. This is [forms coordinator's name]. She will pass out our forms and collect them from you. This is [co-facilitator's name]. She will help ask questions and keep us on time during the discussion. We are researchers from the New York State Council on Children and Families.

You are here as prenatal, birth and post-partum doulas. We are interested in your professional experience as a doula, the process by

which you became a doula. We will also ask questions about what benefits you would pregnant women to know about doulas. We are gathering information for a media campaign to help inform the public and pregnant women about doulas and the new Medicaid benefit to cover doulas services.

We have consent to participate forms that we would like you to read and sign if you are willing to participate in the discussion. We have a demographic informational form, that is optional, you can self-select your race & ethnicity, gender, and age. At the end of the session, we will have another form for you to sign and to gather your email addresses for the $50 gift card distribution.

I'm going to ask you questions, and we may have some follow-up questions too. If you do not feel comfortable answering a question, you do not have to. Your participation is voluntary, so you can leave at any time. There are no right or wrong answers. We appreciate your honesty and your willingness to participate.

In addition to taking notes, today's session will be audio recorded to ensure that we don't miss anything. The recording, along with the notes, helps us catch all the important details. We don't use anyone's name or other identifying information in any of our notes or reports. If something comes up during the discussion that you do not want to be recorded, please let me know and we can turn off the recorder for that portion of the discussion. All notes and recordings will be destroyed at the end of the project. We ask you to keep what is said during this group to yourselves.

Please take a moment to silence your cell phone. If you need to make or take a call at any time, please leave the room to do so and come back when you are finished. Please try not to talk over each other if you can and be patient with all of us. We want to make sure we can get everyone's thoughts and opinions.

Are there any questions before we get started?

Appendix B. Doula Focus Group Questions

1. Let's start with introductions. Please tell us your name and how long you have been a doula?
2. What made you decide to become a doula?
3. What was the process like for you?
4. Were there any barriers or challenges to becoming a doula?
5. How did you find your clients – or pregnant women?
6. What would you want pregnant women to know about the benefits of having a doula?
7. If you were running a media campaign to advertise these services, how would you want doulas to be presented?
8. If you were running a media campaign to advertise these services, what would you want to say?
9. New York State government is proposing to start covering doulas services for pregnant women who are eligible for Medicaid. Would you register with Medicaid if that happens? Why or why not?
10. What is your favorite thing about being a doula?
11. Is there anything else you would like to add?

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