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DOULAS AS CHILDBIRTH PARAPROFESSIONALS: RESULTS FROM A NATIONAL SURVEY

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Fourteen randomized trials have demonstrated that continuous caregiver support during childbirth can lead to shorter labors and decrease the need for intervention. In response, there has been a significant increase in the number and use of doulas as paraprofessionals who provide social and emotional support to women during labor/birth for a fee. We conducted a mailed survey of a nationally representative sample of certified and certification-in-process doulas in the United States (n = 626, 64.4% response rate) to gather some descriptive information on their sociodemographic backgrounds, practice characteristics, and beliefs/attitudes on a number of salient issues. The survey results suggest that, in 2003, doulas were primarily white, well-educated married women with children. The majority of certified doulas worked in solo practice and provided childbirth support services on average to nine clients per year. Very few doulas were earning more than $5,000 per year from this work, and only 10% of certified doulas reported receiving third-party reimbursement for their services. Thus, while almost all doulas found their work emotionally satisfying, only one in three saw their work as financially rewarding. Doulas also reported challenges in getting support/respect from clinicians and in balancing doula work and family life. In addition, one in four doulas reported that they were preparing for a career in midwifery. Doulas can play an important and unique role in the childbirth process and reap many personal rewards engaging in this type of work. However, a number of financial, personal, and professional challenges present significant obstacles to the growth of doulas as childbirth paraprofessionals in the United States.

Background

One of the many changes in childbirth in the United States during the 20th century was a decline in the presence of family members or friends providing support to a woman during labor and birth (Leavitt, 1999; van Teijlingen et al., 2000). Over the past two decades, however, there has been renewed interest in the use of "supportive caregivers" during childbirth (Hodnett et al., 2003; Klaus & Kennell, 1997). A critical component of "supportive care" is providing continuous support during the labor and birth process, never leaving the laboring woman alone. The benefits of continuous support are well documented in the research literature, as more than 14 randomized trials have shown that such support has no known risks and can reduce the length of labor, the need for pain medication, and the rate of cesarean sections and other types of invasive interventions (Hodnett et al., 2003; Zhang et al., 1996). The authors of a recent review conducted by the Cochrane Collaboration's Pregnancy and Childbirth group concluded that "continuous support during labour should be the norm, rather than the exception. All women should be allowed and encouraged to have support people with them continuously during labour" (Hodnett et al., 2003).

A significant aspect of this renewed interest in continuous support during labor is the emphasis on the use of a uniquely trained support person or

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"doula" instead of a family member, friend, or health care provider. Doulas are different from midwives and obstetrical nurses who provide clinical care and are focused on both the medical and psychological needs of women during the birth process (Thorton & Lilford, 1994; Zhang et al., 1996). A doula (deriving from a Greek word meaning "woman caregiver of another woman" or "woman servant") provides social support and assistance in the nonmedical or nonclinical aspects of labor and birth (Klaus & Kennell, 1997; Klaus, Kennel, & Klaus, 1993). The types of physical, emotional, and social support doulas provide include assistance regarding positions and breathing, massage, words of encouragement, coaching, education, a continuous presence, and other types of comfort and support (Klaus, Kennel, & Klaus, 1993; Hodnett & Osborn, 1989; Thorton & Liliford, 1994; Simkin, 1995).

The notion of women providing support to other women during childbirth is certainly not new. What is newly emerging, however, is the role of specific training and credentials for women who provide this type of service for a fee. No longer is a doula simply a female friend or community member who volunteers her knowledge and experience regarding childbirth to others with whom she already has a relationship. Rather, doulas have become a new type of "paraprofessional" (or someone with a lower level of training and/or credentials who works in tandem with another professional) with a specialized role and an interest in finding clients who will hire them for their services. As such, doulas (who are also called labor assistants) represent a new addition to today's maternity care team. Survey estimates suggest that, in 2002, 5% of women giving birth in the United States used a doula for childbirth support (Declerq, Sakala, & Corry, 2002).

At the present time, there is very little sociological or health services research regarding doulas or how they are practicing. Given the growth in the number of doulas in the United States and the lack of research literature on this phenomenon, we conducted a descriptive study on the emergence of doulas as paraprofessionals. Our study had the following objectives: 1) to conduct the first national survey of doulas in the United States, with the goal of gathering descriptive information on their sociodemographic and practice characteristics; 2) to compare the background and practice characteristics of certified and not-yet-certified doulas to identify similarities and differences; 3) to document attitudes and perspectives among doulas regarding salient aspects of their work; and 4) to identify important questions for future research.

Although doulas may go through a certification process, there are no regulations in any state requiring that doulas or labor assistants be certified or registered. In fact, the certification process requires work experience as a doula, thereby expecting that services will be provided prior to certification. As a result, many doulas are "practicing" when they are in the process of certification; in addition, some doulas start but do not finish certification, and some never even begin the certification process. The latter group is quite challenging to identify in a systematic fashion. Thus, this study focuses on doulas who have completed certification and those who started the process but had not yet completed it in the summer of 2003.

Our work represents the first survey of a representative sample of doulas in the United States. An increased descriptive understanding of the emergence of doulas as paraprofessionals is important from several perspectives. First, the growth of doulas is occurring in a context when there are renewed debates regarding the continued and increased use of medical technologies and interventions during childbirth. While many of the advances in obstetrical and neonatal medicine have had positive health impacts, the approach taken to labor/delivery in the United States continues to be criticized as overly "medicalized" (Davis-Floyd, 1992; Arms, 1994; Wertz & Wertz, 2004). Many changes have been made to standard childbirth practices in the United States in response to this critique of medicalization, including the use of midwives, the design of birthing centers, the childbirth education movement, and the inclusion of fathers in the preparation and labor/delivery process. As such, doulas can be viewed as an important current aspect of an ongoing movement attempting to "demedicalize" or "humanize" childbirth (Hodnett et al., 2003; Fox, 1990; Arms, 1994). Second, to date, there is no published research regarding the sociodemographic characteristics of doulas, the range of services they provide, who their clients are, and how they interface with health care systems and medical professionals. Each year, approximately 4 million babies are born in the United States, with childbirth being the most common cause of hospitalization (Anonymous, 2002). Thus, from a health services research perspective, doulas represent an interesting yet understudied phenomenon in an important component of the health care system.

Methods

This study was a cross-sectional survey of doulas in the United States and was approved by the Health Sciences Institutional Review Board at the University of Michigan. The study population included all doulas listed as certified or as having started but not yet completed certification by five professional doula associations: 1) Association of Labor Assistants and Childbirth Educators (ALACE); 2) Birth Works; 3) Childbirth and Postpartum Professional Association (CAPPA); 4) Doulas of North America (DONA); and

5) International Childbirth Educators Association (ICEA). The first professional association for doulas, DONA (which was recently renamed DONA International), was started in 1992, offering an educational process by which someone can become a certified doula. Certification through DONA includes 12 hours of childbirth preparation education, 16 hours of doula training by a certified instructor, experience working as a doula, client and health care provider evaluations of the services provided, and completion of an essay regarding the role of doulas and labor support. Since the premier of DONA, a number of other professional associations and training programs for doulas have emerged; and according to their records, the number of trained doulas in the United States has increased greatly over the past decade, exploding in the past 5 years. Although the certification process is generally similar between the various organizations, some important variations do exist, primarily related to the scope of practice for a doula and the addition of limited clinical skills in the educational preparation.

The five organizations in our sample agreed to provide mailing lists of all current members who were residents of the United States and who were either certified doulas or had started the certification process. These five organizations provided the names/address of 2,400 certified and 2,709 certification-in-progress doulas, bringing the potential study population to a total of 5,109. Based on sample size calculations, a random sample of 1,000 doulas (stratified by professional organization) was selected from the total list, with an oversampling of certified doulas. The selected sample included 700 certified and 300 not-yet certified doulas. Anticipating a response rate of 60–65%, a sample size of 1,000 was considered adequate to estimate differences between certified and not-yet-certified doulas with confidence (alpha = .05) and to estimate the prevalence of specific variables in the certified sample at 50 ± 3% (alpha = .10).

In June 2003, study participants were requested to answer a mailed questionnaire using the Dillman method for mailed surveys (Dillman, 1978). This included mailing the survey with a return, postage-paid envelope, sending a reminder postcard 2 weeks later, and sending another letter, survey, and return envelope to nonrespondents 4 weeks later. A small gift of a zippered vinyl notebook with the study name on the front cover accompanied the first mailing as a token of appreciation and as an incentive.

Eight study subjects were identified as duplicates (on more than one organization list), and 20 surveys were returned as undeliverable, leaving 972 doulas in the sample. Surveys were completed by 626 study participants, for an overall response rate of 64.4%. The response rate among certified doulas was 70% (n = 471) and 52% (n = 155) among doulas whose certification was in progress. Several subjects in the not-yet-certified subsample called or e-mailed to report that they were not comfortable completing the survey because, even though they started the certification process, they had never practiced as a doula (and were not intending to in the future) and thus had no experience base from which to answer the questions. Although we considered these people to be nonresponders in the response rate calculation, this helps to understand the lower response rate among uncertified doulas.

The survey instrument was developed by the research team after review of various professional organization materials, existing literature regarding the role of doulas, and consideration of discourse regarding doulas in the popular media and in on-line doula discussion groups. The survey instrument was pilot tested by a sample of local doulas. The instrument gathered information on participants' sociodemographic characteristics and family profiles, practice setting and characteristics, the number and sociodemographic characteristics of clients, and scope of practice/policy issues. In addition, attitudes regarding practice issues (including attitudes regarding who can be a doula and satisfaction with different aspects of doula work) were assessed using survey questions with five-point Likert scales (response categories ranging from strongly agree to strongly disagree).

Data from the returned surveys were single-entered into the Statistical Package for the Social Sciences, which was also used for analysis. Basic descriptive statistics were used to analyze the survey data, including frequency distributions and contingency table analysis (to investigate differences between certified and not-yet certified doulas). The questionnaire also included open-ended items that asked respondents to list "the two biggest challenges you face in your work as a doula/labor assistant" and the two "aspects of your work as a doula/labor assistant that bring you the most satisfaction." A process of open coding as described by Strauss (1987) was conducted by two members of the research team to analyze responses to the open-ended survey questions. The open codes were then collapsed by two of the study authors through a process of content analysis, as described by Flick (1998). This allowed for data reduction by collapsing the open codes into categories that emerged from the data, as defined and standardized in a codebook.

Results

This sample of doulas is comprised of 471 (75.2%) certified and 155 (24.8%) yet-to-be certified doulas. The majority of doulas reported their ethnicity as white (93.8%), and respondents ranged in age from 20 to 71, with a mean age of 40.3 years. In addition, the

majority of doulas were married (81.6%) and had given birth themselves (87.8%). Compared to certified doulas, not-yet-certified doulas were significantly younger, less likely to be white, and less likely to be married or have given birth. Other general characteristics of the total sample and by certification status are presented in Table 1.

As a group, doulas in the United States come from households with high levels of income and have a high degree of formal educational attainment (Table 1). Only 6.6% of the sample had a high school education or less; approximately one-half reported that they had a college degree or more. The majority of respondents reported additional training/credentials related to medicine, childbirth, or women's health. For example, 15.7% were nurses, 4.6% were midwives, and 9.9% were massage therapists (Table 1). Over one-third reported that they had training in some type of childbirth preparation instruction. Interestingly, 27.2% of respondents claimed that they were planning to become either a direct entry or certified nurse midwife in the future.

The survey included questions regarding the sociodemographic characteristics of the last three doula clients, to which respondents provided information regarding 1,586 clients. The average age of the respondents' most recent clients was 30.2, ranging from 14 to 49 years. About one-half (54%) of these clients were giving birth for the first time, and 84% were married. In terms of ethnicity, doula clients were 84% white, 6% African-American, 7% Hispanic, and 3% other ethnicities.

Information regarding salient practice characteristics is reported for certified doulas only. The results (Table 2) suggest that the vast majority (79.9%) are in solo practice, with another 17.8% in group practices of various sizes, and only 3.6% in a hospital- or clinic-based practice. The mean number of labor/birth clients served over the course of respondents' careers to date was 60, with a range of 0 (8% of respondents) to 1,000 (one respondent). On average, respondents reported that during the past 12 months they had served 11.3 prenatal clients, 9.3 labor/delivery clients, and 4.1 postpartum clients. When asked about how their client load compared with their preferred number of clients each month, 39.0% indicated that they had fewer clients than preferred, 47.2% indicated they had the actual number they preferred, and 8.0% said they had more than preferred (Table 2). Several respondents (8.6%) reported that they did not plan to have any more clients in the future. The most common reasons offered included lack of time due to family obligations and/or employment-related responsibilities.

Nearly all certified respondents (96.2%) reported that they strongly agreed or agreed with the statement "my work as a doula or labor assistant has been rewarding to me on a personal or emotional level" (Table 3). In contrast, however, only 37.5% reported that they strongly agreed or agreed with the statement "My work as a doula or labor assistant has been rewarding to me on a financial level." As reported in Table 2, the mean gross income from doula work during 2002 (among certified doulas) was $3,645, with almost one-half of doulas reporting that they made less than $1,000. Only 10.3% of certified doulas reported making $10,000 or more during 2002. Almost three out of four respondents (71%) reported that they have paid jobs in addition to their doula work, working on average 24.5 hours per week at these jobs.

The majority but not all certified doulas indicated that their role as a doula is respected by physicians who provide labor/delivery care (69.6%) and labor/delivery nurses (75.6%) (Table 3). Respondents also expressed a number of attitudes regarding essential characteristics of doulas/labor assistants. As shown in Table 3, 76.2% of respondents believed that it is essential for a doula to be female, while 44.6% believed that it is essential for a doula to have given birth herself. In addition, 49.1% of certified respondents indicated it is essential for a doula to be certified, and 42.9% indicated it is essential for a doula to have medical knowledge.

Regarding some key policy issues, the majority of certified doulas (89.4%) believed that there should be third-party reimbursement for doula services. Among certified doulas, 10% reported that they have received such reimbursement for services (usually under the auspices of providing "labor support" or "prenatal educational services"). In addition, 28.3% believed that doulas should have malpractice or liability insurance, with another 11.1% believing this is important only in certain circumstances (e.g., if a doula attends home births). Approximately one out of five certified doulas (18%) reported that they do have liability insurance, with the average annual premium for this coverage approximately $100. This insurance is not meant to cover doulas who get into legal trouble regarding medical care (e.g., for practicing medicine without a license). Rather, this insurance provides coverage for legal fees (e.g., a consultation with an attorney) should a doula who attended a labor that resulted in a lawsuit against an obstetrician or midwife get subpoenaed or otherwise incur some type of legal expense.

Both certified and not-yet-certified doulas reported a wide array of perspectives on the challenges and benefits of their work in the open-ended survey items (Table 4). The most frequently cited challenges included: 1) lack of support or respect from clinicians and other members of the medical community (41.6%); 2) balancing doula work with other jobs and with life in general, and the emotional or stress response that happens when things are off balance

Table 1. Descriptive characteristics of doulas in national sample by certification status (n = 626)

Variable	Total Sample	Certification Complete	Not Yet Certified	Significance (P)
Number	626	471	155	
Age (years)				
<30	17.0%	13.0%	29.4%	
30–39	34.6%	35.6%	22.5%	
40–49	29.7%	30.9%	26.1%	<.001
50+	18.7%	20.5%	13.1%	
Mean	40.3 years	41.4 years	37.1 years	
Ethnicity				
White	93.8%	95.3%	89.0%	
African-American	2.6%	2.1%	3.8%	<.05
Hispanic	2.2%	1.5%	4.5%	
Other	1.4%	1.1%	2.6%	
Marital status				
Married/partnered	81.6%	83.8%	74.8%	<.001
Not currently married	18.4%	16.2%	25.2%	
Birth history				
Given birth	87.8%	91.7%	76.1%	<.001
Mean no. of children	3.27	3.20	3.49	
Household income				
<$40,000	26.6%	24.0%	34.2%	
$40,000–$74,999	40.2%	40.6%	39.0%	NS
$75,000–$99,999	15.9%	16.6%	13.7%	
$100,000 or more	17.3%	18.7%	13.9%	
Education				
High school graduate	6.6%	6.6%	6.6%	
Some college	43.5%	42.3%	47.4%	NS
College graduate	38.2%	40.0%	32.9%	
Graduate degree	11.6%	11.1%	13.2%	
Prior medical training				
Medical assistant	7.5%	7.4%	7.7%	NS
Nursing (LPN/RN)	15.7%	16.3%	13.5%	
Midwifery	4.6%	5.0%	3.8%	
Other training				
Bradley instructor	5.8%	7.2%	1.3%	<.01
Lamaze instructor	9.0%	10.6%	3.9%	<.01
Other childbirth instructor	29.8%	33.6%	18.1%	<.001
Massage therapist	9.9%	9.1%	12.3%	<.05
Planning to become midwife in future (direct entry or certified)	27.2%	27.6%	25.8%	NS

(32.9%); 3) balancing doula work with family demands and obligations, particularly childcare (23.4%); and 4) being on call and other aspects of the work related to its unpredictable and unscheduled nature, including sleep deprivation (22.9%).

Doulas also reported aspects of their work that they find satisfying; and there was a great deal of convergence in the themes that emerged from the qualitative data. The most frequently cited satisfying aspects of doula work included: 1) supporting, nurturing, or empowering new mothers and instilling them with confidence regarding their ability to birth and be a mother (49.0%); 2) helping women to have a positive birth experience and helping families have the kind of birth they desire (48.2%); and 3) being part of the birth process (often described as "a miracle"), and 4) witnessing a family bond with a new baby (29.7%). There were few differences in the challenges and rewards cited by certified and not-yet-certified doulas (comparative results not shown).

Discussion

It is difficult to estimate the number of doulas in practice in the United States. What is clear, however, is that the number of people who are seeking certification and who are offering doula services for a fee or as part of a hospital-based maternity care team is growing (Meyer, Arnold & Pascali-Bonaro, 2001; Morton, 2002). This article presents some basic descriptive information gathered from a national sample of doulas working as paraprofessionals in the United States in 2003. The results can be generalized to certified doulas or those who started training with one of five major professional organizations. Doula services can

Table 2. Characteristics of practice situation and clients for certified doulas (n = 471)

Characteristic	Percent or Mean
Type of practice	
Solo practice	79.9%
Group practice with two to four doulas	12.8%
Group practice with five or more doulas	7.0%
Hospital-based practice	1.8%
Clinic-based practice	1.8%
Client load	
Mean number of clients past year	
Prenatal clients	11.3
Labor/delivery clients	9.3
Postpartum clients	4.1
Number of clients per month	
Fewer than preferred	39.0%
Actual number preferred	47.2%
More than preferred	8.0%
Don't know	5.8%
Income from doula work in 2002, mean	
(SD) gross income	$3,645
<$1,000	49.8%
$1,000–$4,999	29.9%
$5,000–$9,999	10.0%
$10,000 or more	10.3%

Table 3. Attitudes of certified doulas regarding practice and policy issues (n = 471)

Attitudinal Statement	Strongly Agree or Agree (%)
My work as a doula/labor assistant has been rewarding to me on a personal or emotional level.	96.2
My work as a doula/labor assistant has rewarding to me on a financial level.	37.5
My role as a doula/labor assistant in childbirth preparation is respected by physicians who provide prenatal care to my clients.	55.6
My role as a doula/labor assistant in labor and delivery is respected by physicians who also provide care to my clients.	69.6
My role as a doula/labor assistant is respected by nurses who provide labor/delivery care.	75.6
It is essential that a doula/labor assistant be a woman.	76.2
It is essential that a doula/labor assistant has given birth.	44.6
It is essential that a doula/labor assistant be certified.	49.1
It is essential that a doula/labor assistant have medical knowledge.	42.9
There should be third-party reimbursement for doula services.	
Yes	89.4
No	2.3
Don't know	8.3
Doulas should have malpractice or liability insurance.	
Yes	28.3
Only in special circumstances	11.1
No	54.3
Don't know	6.3

be provided without certification, but it appears that the vast majority of practicing doulas (especially those providing services in exchange for a fee) are certified. Thus, the results of this survey very likely reflect the characteristics of the majority of doulas practicing in the United States in 2003.

The survey results suggest that doulas as a group are primarily white, well-educated married women with children and household incomes well above the median in the United States. Their clients are a bit more diverse. Very few certified doulas are earning significant income from this work. Thus, while almost all doulas find their work emotionally satisfying and rewarding, only about one out of three certified doulas describe their work as financially rewarding. These financial strains and challenges do not bode well for future growth of doulas as paraprofessionals. In addition, as approximately one out of four doulas are using doula work as preparation for a career in midwifery, it appears that a significant number of women practicing as doulas are doing so only temporarily and as a stepping-stone to a career in midwifery. As long as there continues to be new women who pursue this pathway into midwifery, the supply of doulas could be maintained.

It is likely that doula work will not become more financially lucrative or appealing unless more people are willing to pay for these services and/or third-party reimbursement becomes more common. Some advocates are using the results of the randomized trials described above (Hodnett et al., 2003; Zhang et al., 1996) to make "cost-saving" arguments regarding the worth of doulas (e.g., the cost of hiring a doula is more than offset by the reduction in costs associated with longer labors with more medical interventions and thus should be covered by insurance). Our survey results suggest that the vast majority of certified doulas believe that insurance reimbursement for doula services is desirable. Some doulas, however, do not want insurance companies to reimburse for doula or labor support services. Information from doula listservs and the popular press suggest that one reason some doulas do not support third-party reimbursement is because they fear this would result in undesirable restrictions or limitations on their scope of practice or what they can and cannot do for their clients.

Our results also suggest that a significant number of doulas do not feel supported or respected by physicians, obstetrical nurses, other clinicians, and health care administrators. The professional roles and relationships between doulas and other members of the maternity care team have not been systematically explored. It is clear, however, that there is significant

Table 4. Aspects of doula work most frequently reported as challenging and satisfying (n = 626)

Most frequently cited challenges of doula work	
Lack of support or respect from medical community/clinicians	41.6%
Balancing doula work with other jobs/life in general/good health	32.9%
Balancing doula work with family demands and obligations	23.4%
Being on call/unpredictable nature of hours/sleep deprivation	22.9%
Low pay/low financial rewards/no job benefits (e.g., retirement, insurance)	14.9%
Finding clients	13.8%
Most frequently cited aspects of doula work that are satisfying	
Supporting/nurturing/empowering new mothers; instilling confidence in clients	49.0%
Helping women to have a positive birth experience; helping clients to have the births they want; helping different types of clients	48.2%
Being part of and witnessing the birth process; seeing mother's and family's reaction to new baby; being part of a miracle	29.7%
The relationships developed with clients and families; bonding with clients and families; developing relationships with medical staff	14.4%
Receiving gratitude and appreciation from clients; receiving positive feedback	14.2%

potential for overlap (real or perceived) in roles, for challenges to team members' relative authority and expertise, and for perceptions of encroachment into each others' "territory" in the health care arena (Hwang, 2004; Enkin et al., 2000). The doula as a paraprofessional is a relatively new phenomenon, thus it is not surprising that there are some tensions and conflicts regarding "turf" or professional territory, unique roles, and authority. This is a common occurrence when an emerging profession undergoes social definition and experiences the sociological process of professionalization (Abbott, 1988).

Debates regarding what constitutes a quality childbirth experience are ongoing in the United States (DeClerq, Sakala & Corry, 2002; Davis-Floyd, 1992, Arms, 1994). While everyone values healthy mothers and babies, the degree to which medical interventions are overused is a serious point of contention. Important issues currently being discussed include home births, the routine use of epidurals and episiotomies, and elective C-sections. Midwives and doulas play an interesting and increasingly important role in these debates (van Teijlingen et al., 2000; Wertz & Wertz, 2004; Morton, 2002). Additional research in these debates and other areas of concern is needed to better understand the unique role and contributions of doulas/labor assistants to maternity care teams in the 21st century. Areas requiring further research include: 1) comparative evaluation of the models of care/scope of practice guidelines used by different doulas and promoted by different professional associations, and their impact on doula behavior; 2) research regarding organizational or practice models, including the positive and negative implications of moving doula practices from the community to hospital-based settings (as has happened with childbirth education); 3) research regarding women's experiences with doulas and their responses to this emerging paraprofession; and 4) policy research evaluating the costs and benefits of doula care and investigating issues related to the professionalization of doula work, including training and certification processes and legal/regulatory issues (Goer, 1995; Gordon et al., 1999; Morton, 2002; Hwang, 2004).

The future of doulas in a health care system that is highly specialized and in a culture in which birth is significantly medicalized is unclear. While the majority of American women report satisfaction with the care they receive related to childbirth, a significant number also express dissatisfaction with many aspects of the process and concern regarding the high use of medical interventions (Declerq, Sakala, & Corry, 2002). Doulas play an important and unique role in the childbirth process and reap many personal rewards engaging in this type of work. Nonetheless, our survey findings suggest that a number of challenges—personal, financial, and professional—also present significant obstacles to the further growth of doulas as childbirth paraprofessionals in the United States.

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