

Doulas as Community Health Workers: Lessons Learned from a Volunteer Program

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ABSTRACT

Doulas, women who primarily provide social support during childbirth, have been associated with a number of positive health outcomes. Because the primary model of practice for doulas is a fee-for-service model in which families privately hire a doula, many expectant women who could benefit from doula support are unable to access the service. The Doulas Care program, located in Ann Arbor, Michigan, represents one model in which doulas provide services without charge. As a result of their extended role in the community, doulas who work with the Doulas Care program have unique educational needs. Through the use of focus groups with the program's volunteer doulas, educational needs related to overcoming barriers to being a doula working in the community were identified. Recommendations for education and training are made to improve the support doulas offer as community health outreach workers.

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The maternity care team in the United States has expanded in the last decade with the addition of doulas, who represent a growing group of paraprofessionals. The work of doulas is most commonly focused on providing social support solely during labor and birth. In the broadest sense of the role, a doula is a community health worker who provides skilled and intimate continuity of care throughout the childbearing year. This includes support during pregnancy, labor, and birth, as well as assistance during the transition to parenthood in the initial postpartum period. A doula does not perform clinical tasks or provide medical care; instead, she focuses on emotional and social support for the childbearing

woman and her family. The use of doulas is an innovative option to address complex health problems during pregnancy (e.g., preterm labor, low birth weight, and postpartum depression) that have multiple contributing etiologies beyond biological factors. For example, doulas may provide education, logistical planning, and social support to help reduce stress associated with preterm labor. Stress has been shown to be associated with preterm labor, but it is not something that can be reduced when family support is limited or home responsibilities are demanding. Thus, a doula's support can be vital.

To date, the most widely used model of doula care has been a fee-for-service model (Lantz, Kane Low,

Varkey, & Watson, 2005). In 1999, the Doulas Care program was initiated by a community-based, non-profit organization located in Ann Arbor, Michigan, to address local disparities in women's access to social and emotional support that may contribute to poor health outcomes during pregnancy and childbirth. The program model matches socially and medically at-risk women with volunteer doulas who provide support during pregnancy and the birth process and into the immediate postpartum period. The doulas of the Doulas Care program are trained for their role using the national standards for doula education, as set forth by Doulas of North America (DONA International). However, most of the training is primarily focused on the birth process and does not address the expanded role that doulas may play as community outreach workers in this program. Thus, in order to develop the Doulas Care program, it was necessary to identify the unique educational needs to fulfill the role of a volunteer community-based doula. This article describes the results of focus groups conducted with Doulas Care volunteer doulas to assess what education they would need to perform their role as community-based doulas.

BACKGROUND—LITERATURE REVIEW

Doula is from the Greek word meaning “woman caregiver of another woman,” “servant to the mother,” and “mothering the mother.” The term *doula* is now commonly used to specify a supportive labor companion who is not a friend, loved one, or kin, and who is frequently professionally trained by DONA International standards to provide nonclinical labor support (DONA International, 2005a). The doula does not have any medical responsibilities; she is present at a birth in addition to a midwife, nurse, and/or medical doctor. The doula is also described as an advocate for the woman in labor. Because the doula's role encompasses the nonclinical aspects of care, doulas can be present with their clients in the entire range of birth settings, from a scheduled or emergency cesarean section to unmedicated home births (Gilliland, 2002).

Fourteen randomized clinical trials have documented numerous positive benefits of the use of doulas during the childbearing year, as summarized in a meta-analysis by Hodnett, Gates, Hofmeyr, and Sakala (2003). Positive effects include enhanced maternal and neonatal outcomes, increased psychosocial benefits, and valuable impacts on the health-care system such as cost savings, reduced resource utilization, and increased patient satisfaction. Despite

the health and cost effectiveness of doula care, in one national survey only about 8% of women have had doulas present at their births (Sakala, Declercq, & Corry, 2002), but this number has been increasing substantially in the last decade (Lantz et al., 2005).

Educational preparation for most doulas consists of a classroom training course or program that emphasizes a wide range of topics such as the anatomy and physiology of labor and birth, the stages of labor, comfort techniques, and breastfeeding support. Doulas may also learn about routine interventions, medical terminology, pain medications, and cesarean surgical procedures. Although the range of support varies, an emphasis is placed on promoting a physiological approach to childbirth and reducing the medicalization of the birth process (DONA International, 2005b).

With a wide variety of models of practice for doulas, access to the support of a doula may be limited by geographic location, ability to pay, or type of insurance reimbursement. Despite the positive health benefits associated with doulas, the women who have the least amount of resources and are most likely to benefit from doula care are the least likely to receive doulas' services (Lantz et al., 2005). As a result of this disparity, the Doulas Care program was formed in an attempt to provide doula support to socially and medically at-risk women at no charge.

SETTING

The Doulas Care program is a community-based, volunteer support service and part of the program offerings of the Center for the Childbearing Year, which is a nonprofit, charitable, and educational corporation established in October 1999 in Ann Arbor, Michigan. Additional programs offered by the center include childbirth education classes, health professional continuing education, and breastfeeding and infant-care education programs.

The goal of Doulas Care is to improve the maternal and child health outcomes of at-risk populations by meeting the emotional and physical health needs of culturally diverse populations of low-income women and adolescents with at-risk pregnancies. To accomplish this mission, Doulas Care matches women who are low-income and pregnant and who are socially and/or medically at risk with a volunteer doula who will provide education and support throughout pregnancy and childbirth and into the postpartum period. The doula services provided include the following:

For more information on DONA International, visit the organization's Web site (www.dona.org) or call toll-free 888-788-3662.

Other organizations that certify doulas include the International Childbirth Educators Association (<http://www.icea.org/doulas.htm>), the Association of Labor Assistants and Childbirth Educators (<http://www.alace.org/>), and the Childbirth and Postpartum Professional Association (<http://www.cappa.net/labordo.asp>).

For more information on the Center for the Childbearing Year, visit the organization's Web site (www.Center4cby.com) or call 734-332-8070.

- transportation to prenatal visits;
- accompaniment to prenatal classes;
- prenatal home visits;
- answers to questions about pregnancy, childbirth, and parenting;
- education to promote healthy behaviors throughout pregnancy;
- support during labor;
- assistance with breastfeeding, if needed;
- home visits during the postpartum period; and
- availability by phone for any questions.

Women do not pay for any of these services; rather, support for the program has been a combination of grants, donations, and revenue from the education programs offered by the Center for the Childbearing Year.

Demand for the program’s services grew remarkably after the first 2 years, and both the number of doulas required and the complexity of the matching process expanded. In order to respond to the growing demand for Doulas Care doulas, a program evaluation was conducted to assess the training and education doulas need to best meet the needs of the women they serve. This article presents the results of that program assessment and describes the development of the educational model for the volunteer doulas within the Doulas Care program.

METHODS—DATA COLLECTION

Focus groups were conducted with volunteers from the Doulas Care program in April 2002. Two focus groups were conducted, with 6–8 participants in each group. The University of Michigan’s institutional review board approved the study. Out of 24 possible participants, a convenience sample of 14 doulas participated in the groups. Study participants were recruited through phone calls and e-mails to all the volunteers in the program, and two dates were provided for the focus groups. Conflicts with the timing of the focus groups were the main rationale for nonparticipation, not a negative response to the process of conducting the focus groups. It should be noted that the doulas did not come together or meet outside of the initial training program they attended to become a doula. Thus, the focus group forum became a reunion for some who had attended the training sessions together, but the majority of participants did not know each other. Each participant received a \$25 gift certificate to a local store in recognition of her participation.

Following the process of informed consent, the focus groups began by having each individual intro-

duce herself and describe what brought her to the Doulas Care program. This open introduction was then followed by asking group members a series of five questions related to the challenges, benefits, barriers, and needs they encountered as doulas in the Doulas Care program. Participants also completed a demographic survey that asked for more personal information such as educational level, income level, and contact information.

Each focus group lasted 2 hours and was taped and transcribed verbatim. The first author of this article and two research assistants individually reviewed the transcripts. Line-by-line coding, as described by Strauss (1987), was applied to the transcripts, followed by the application of content analysis, as described by Flick (1998). These procedures reduced the codes to groups of themes in order to identify issues related to the challenges and rewards of being a doula in the Doulas Care program. A goal of the process was to identify potential barriers to being a doula that were unique to this community-based volunteer program. All members of the analysis team reviewed the themes and achieved 100% agreement on the themes that were identified.

RESULTS OF THE FOCUS GROUPS

Demographics

The demographics of the study participants are detailed in Table 1. The participants represented a highly educated population, generally with economic advantage. Each participant had volunteered with Doulas Care for at least 3 months before participating in the focus group, with the most experienced doula having been with the program for 3 years. The average duration of volunteering for Doulas Care was just less than 1 year. All of the participants had provided services for at least two

TABLE 1
Demographics from Focus Groups (*N* = 14)

Age	Range: 25–48 years old Average: 34 years old
Marital status	12 married 2 single
Number of children	Range: 1–3 children
Education	8 with some college education 6 with college degree
Income	4 reporting <\$20,000 4 reporting >\$50,000
Profession	9 considered themselves stay-at-home mothers

Doulas Care clients, with an average of 4.5 referrals per doula. In addition to their role as volunteers for the program, six of the doulas had had the experience of being hired as a doula, and all of the doulas except one wanted to work on both a volunteer and a fee-for-service basis. Being a volunteer was viewed as a means to gaining more experience, which was necessary for both certification and their résumé to be hired as a doula. All participants expressed a commitment to increasing access to the services of doulas for all women and viewed the Doulas Care program as an essential way to provide this access for women with limited resources.

Career Growth Opportunities

All of the doulas in the focus groups expressed a commitment to helping others. For half of the participants, becoming a doula was a career step toward nursing or midwifery, with three others considering a career in midwifery or nursing within the next 5 years. Ten participants wanted to have a successful doula business in 2–5 years. They expressed a desire for some form of national certification beyond the locally recognized program offered by the Center for the Childbearing Year. They identified the example of receiving DONA International certification as a necessary step toward a successful doula practice, as well as having the skills to run a private business. To that end, the study participants expressed the desire for forms of education and training that were free or low-cost so that they could gain the business skills and knowledge needed to run their own practices in addition to conducting their volunteer work. The demographics and career aspirations identified in this study are congruent with a national survey of doulas that noted one third of those surveyed aspired to become either nurses or midwives in the future (Lantz et al., 2005).

Strengths and Challenges

When asked to comment on the most important strengths a woman needs to be a successful doula, the focus group participants reported patience, education, and support ($n = 7$), respect or love of the birth process ($n = 3$), and experience with birth ($n = 2$). The most significant personal challenges of doula work reported were conflicts with childcare, work, or family ($n = 4$), fear of failure or doing something wrong ($n = 2$), supporting women's choices that the doula personally felt were negative or harmful ($n = 2$), the pressures of being in a hospital setting ($n = 2$), and others' misunderstanding

of the value of the doula ($n = 2$). For example, one doula commented on her fear of failure with a particular client:

I feel like she really needs somebody in her corner, but I just don't know what I should be doing sometimes, and I'm just, like, okay, is that right or is this wrong? I don't know if I'm—by responding to some of the things she does—am I making the situation worse?

Although the challenges raised by the doulas in the focus groups are congruent with the challenges raised nationally by doulas in a variety of roles, the fear of failing or not being able to meet the unique needs of the clients served by this community program were particularly salient. The concerns were rooted in limited knowledge about community resources to address the complexities of living with restricted resources. Additionally, the doulas felt challenged by what they called “unhappy pregnancies,” which they said they had not experienced before being hired. These differences were described as new considerations regarding the role of doulas working in a community-based capacity compared to being hired by an individual family. Typically, the person hiring a birth doula is focused on the hallmark value of the doula—providing support during the process of childbirth. Referrals to the volunteer program occur for a variety of reasons extending beyond the focus on labor and birth. These broader reasons may include difficult social situations or challenges that can be addressed through social support but may present challenges to doulas with limited training.

Barriers to Being a Doula

Two key themes emerged from the focus groups related to barriers to working as a doula. The first grouping of themes was situated around internal dilemmas of being a doula, and the second grouping concerned institutional barriers to being successful as a doula.

Internal dilemmas. Throughout the discussions, a repeated issue noted was balancing the passion for being a doula and desire to help others with the personal demands of the doulas' own families. One doula related an experience with a particular client:

She calls me all the time. . . . I don't mind talking sometimes, but I have a family of my own and I can't just sit there and talk to her on the phone

all the time. She calls me early in the morning and late at night. . . I never know if it's really going to be an emergency or if it is not.

As the discussions continued, the group shared strategies and offered assistance to each other for childcare or backup coverage for clients. For instance, a monthly peer group was suggested.

Other dilemmas of being a doula included confusion about the doula's role and fears of failure. One participant stated:

Doula is such a grey area. Being a pregnant mother is black and white, being a physician is black and white, and being a midwife is black and white, but being a doula is like this little gray area of what it is and why we're there and it's just kind of fuzzy.

This ambiguity of the doula's role contributed to conflicts between the doula and the woman's partner. Conflicts between the father and the doula regarding the role of "labor coach" were often cited by volunteers as the woman's rationale for either not calling the doula when she was in labor or asking to see the doula at sites other than her own home. The doulas described explaining their roles as complementary to the other support people who would be with the woman, but the doulas noted that this was the most difficult aspect of negotiating their role with a woman. Three of the doulas cited instances in which the woman stated a strong desire to have doula support, but her partner denied her the opportunity to have the doula present at her labor. This challenge was unique to their role as a volunteer, compared to being hired by a couple in their other capacity as a "doula for hire." One doula demonstrated this tension with the woman's husband by stating that dealing with couples was difficult "because the idea of a doula is so new and there's not really a clear-cut line." Another doula stated:

I've attended probably about 30 labors, but only four of those were through volunteer work, and there's a big difference because when I shifted over to doing it as a business, people became more clear about what my role was. But. . . with some of the earlier volunteer work, the husband and wife were not on the same page about why they had a doula, and they hadn't necessarily talked about it other than somebody had just suggested it. And that was a problem.

Institutional barriers. Within the focus group, discussion moved from the theme of challenges and

barriers to identifying the unique role the doulas played "in the community" and listing specific challenges or experiences the doulas had within the Doulas Care program. Similar to the discussion regarding role conflict with a woman's partner, the experiences were framed as "client challenges"—meaning that the doulas were challenged in their role or by their limited knowledge in working with childbearing women and adolescents who had the circumstances or situations described below.

Complex histories. The doulas discussed being surprised by the complex socioeconomic situations of their clients. Rather than having to deal with single health-risk factors or segmented risk histories, the doulas in the Doulas Care program were challenged by the complexities of the women's needs. For instance, lack of health insurance, limited housing, lack of or limited social support, and immigration status and language barriers are common to women who are referred to Doulas Care.

In addition, most of the doulas working in the program were not experienced in addressing concerns related to unintended or potentially undesired pregnancies. Doulas reported they felt confident in talking about pregnancy and childbirth, but they were unprepared to handle more important realities of securing housing and transportation. The complex situations of a majority of Doulas Care clients represented a new area of knowledge needed by the doulas. One doula commented:

I think the clientele is probably a lot different. I had two clients that didn't call. And actually, in that respect, it didn't surprise me at all, but I think that because the Doulas Care program attracts certain people—lower income, without partners—having to also call a doula can be like another bump in the road.

Range of age. Working with women at extremes of their lifespan represented a level of anxiety for the doulas. Many felt prepared to work with the age range of 25–35 years old, but the doulas felt less prepared to work with adolescents. They also felt challenged in developing working strategies to be successful with particular clients. They could not always transfer the information they shared with one client to another when the strategy worked once with an adolescent but the next client was someone at the other end of the childbearing age continuum.

With adolescents, the doulas felt they had to do more for the Doulas Care clients in terms of support and talking on the phone than for clients who hired them privately.

Although the study participants were not always clear in describing why they felt this difference, many articulated that a client who hires their services participates in a process of negotiating a “contractual” relationship focused on the doula’s role during childbirth, compared with Doulas Care clients, who are encouraged to call the program by their social worker or health-care provider. The doulas felt that some of the program’s clients were unclear on the role of a doula and, as a result, had varied expectations. As one doula said:

Many of the clients are often really young. . . , and this one girl talked with me for hours. I was like, “Okay, she just needs more care and that’s fine, that’s what I’m here for”. . . . She has no idea what she wants for her birth, so it’s just lots of care and attention and helping. . . , which is great and what I love to do, but you really do get more involved than when someone hires you.

This greater involvement is specifically what the program had targeted as its mission; however, the match between the doulas’ sense of mission and the program’s were not necessarily congruent in the initial years of the program. Many of the volunteers were more focused on gaining experience with birthing women than on the community outreach goals of the program.

Risk behaviors. The doulas described a level of discomfort or limited experience in assessing women for risk behaviors or when they suspected that a risk behavior or situation might exist. Particular concerns were related to drug abuse and domestic violence. Several of the doulas discussed their experience of not knowing whether to ask about the suspected issue or just ignore their suspicions. One doula described the experience of always having to walk around the block and talk with her client because the woman claimed her husband did not want her to bring people into the house. The client walked and talked with the doula for up to 2 hours at a time and was always concerned if they were in sight of her house. The doula suspected issues of domestic violence, but she was not trained in how to address the topic in this context. All of the doulas described a desire for more education related to this issue.

Varied uses of the doulas. Setting and maintaining boundaries were challenges for the doulas. Depending on the manner in which clients entered the program and on their expectations, some of the doulas felt their clients were using them inappropriately. They discussed having difficulty in identifying manipulative behavior versus a true need for assistance. Receiving numerous phone calls or being expected to come to the client’s home at all hours of the day or night raised questions for the doulas about what was or was not an appropriate role or boundary to set. As one doula reported:

She [the client] calls me all the time. She’s gotten a lot better. We talked about what I can and cannot really do. But she calls me at night and she says she needs me and I go, but then when I get there everything is okay, she is not in labor. But she is really depressed, and that is important too, just different than what I expected.

Thus, the doulas desired greater knowledge about possible resources that could support clients with depression.

Challenges and rewards. After discussing these personal and client challenges, the doulas also shared how they felt rewarded for their volunteer work. To maintain a volunteer endeavor, the program’s executive director recognized the need to expand the support for the doulas in order to retain them in the program. The participants were asked, “What can Doulas Care do for you to support your role as volunteers for the program?” Then, they were instructed to list specific needs or desires they had for support. Table 2 lists the items that were identified by the group. Although many of the items were previously identified in the discussions, the list also includes more specific examples of educational needs that had only been alluded to in the earlier conversations.

Despite the challenges of being a volunteer, the doulas cited many examples of the rewards inherent in being part of the Doulas Care program. For example, one doula commented on how she first attended births of friends and found it so rewarding she continued with being a volunteer doula:

I kept reflecting on being with my friends at their births and how rewarding that was for me. I walked away from the first one just sobbing with joy because

TABLE 2

Specific Needs Identified by Volunteer Doulas

Increased support	<ul style="list-style-type: none"> • Support groups for the doulas to share their experiences and problem-solve • Phone access to the trainer/program director as a resource
Increased education	<ul style="list-style-type: none"> • Ongoing education programs on specific topics, as well as continuing education to develop their skills for labor support (e.g., “advanced doula skills”) • Specific education topics suggested included: women with history of sexual abuse, substance abuse, and domestic violence; and resources for women with limited incomes, limited or no health insurance, and housing difficulties • Increased cultural sensitivity and knowledge; specifically, ways to address language barriers primarily for Spanish-speaking immigrants
Greater resources	<ul style="list-style-type: none"> • Development of center space for the doulas to use for study • Web-based resources • Books, videos, materials
More doulas	<ul style="list-style-type: none"> • Scholarships for women who cannot afford the cost of doula training • More frequent doula trainings
Orientation to the volunteer program	<ul style="list-style-type: none"> • A specific orientation to being a volunteer of the Doulas Care program compared to being a “doula for hire” • Education about community resources for pregnant women and their families
Infrastructure support	<ul style="list-style-type: none"> • Phone cards to cover the cost of long-distance calls • Tracking and follow-up procedures for all women who call the program • Evaluating mechanisms to assess how the doula is doing • Increased funding to cover out-of-pocket expenses such as parking

it was just the most beautiful thing I had ever seen, and you tell that to somebody that’s never been at a birth and they’re, like, “Yuck.” They don’t get it, and it really, it was just the best thing.

Being helpful and making a difference was described as a major reward in itself. As one doula commented:

I didn’t really feel like I was being [helpful], but afterwards [the client] was like, “I couldn’t have done it without you,” and she’s still calling me, and her baby was born over 6 months ago and so I know, obviously, that I made an impact on her.

Personal benefits can also come from working within a structured program. As one doula noted, “I think that getting [program] support...you know...that is a pretty equal give and take. If in payment for my volunteer services I got a peer group out of that, that’s equal to me.”

DISCUSSION—LESSONS LEARNED AND IMPLICATIONS

The focus groups provided important information for program planning to develop additional infrastructure support and training for the Doulas Care program. Training needs were identified,

and a continuing education program was a critical priority for the doulas to prepare them for the unique role they would play within the community of women the program served. The doula-training component of the program was highly successful, according to the course evaluations and doula feedback. However, the doulas reported that they needed additional information to support the women referred to the program in the form of resources, referral options, and assessment of risk factors to promote improved outcomes for the mothers and babies in the program. The gaps identified in the doulas’ education that needed to be addressed in a volunteer orientation training were particularly in the areas of education, support, and resources. Based on the focus group results, if these areas were addressed, the capacity of the program could increase because the doulas would feel better supported in their volunteer role.

Increased Doula Training

In response to the focus group information, the Doulas Care program moved from providing a self-designed, doula-training program to instituting the nationally recognized DONA International curriculum, which provides a pathway to national certification as a doula. The program also added a separate

“Introduction to Childbirth” class to fulfill one of the requirements of DONA International certification, so that a woman who wants to be a doula can complete all of her training at one site.

Volunteer Orientation Program

Doulas Care then implemented a volunteer orientation program. A separate volunteer program orientation to Doulas Care was developed to follow the standard 3-day doula training. Initially, the second orientation was a 1-day, 7-hour program, but it later expanded into a two-phased training session: 1) a 3-hour orientation to the administrative aspects required to become a volunteer with Doulas Care, and 2) an additional 7-hour outreach education training required for volunteers within 6 months of becoming a volunteer.

Part I of the orientation addresses the goals and objectives of the Doulas Care program, standards for practice, process of initial client assessment, and data recording and maintenance. Through this initial orientation, the volunteers become more aware of the breadth of needs experienced by the women served by Doulas Care. This also allows for greater clarity and match between the mission of the program and the volunteers. In an effort to build a sense of program identity and association for the doulas, volunteers receive tote bags, t-shirts, and nametags with the Doulas Care logo. Further steps toward developing a sense of community include the addition of a quarterly doula newsletter that provides updates on the program, new information from research about childbirth, and stories shared by the doulas about their experiences. Volunteers are also provided with contact information so they can access one another directly. In addition, a group e-mail system was implemented to promote communication.

Part II of the orientation addresses community outreach issues, including client assessment, working with pregnant adolescents, cultural assessment and awareness, identification of risk behaviors such as substance abuse and domestic violence, identification of health risks during pregnancy, identification of postpartum depression, accessing community resources and referrals, role-playing exercises, and doula community building. Volunteers receive a \$25 gift card for attending the orientation. Since their initiation, the orientation sessions have been rated as being very effective (averaging 4.5 or greater each session on a 5-point Likert scale) in addressing the educational needs of the doulas.

Additional Support for Doulas

The doulas wanted a doula support group, better phone access to the doula trainer for emergency questions, education on specific topics suggested by the doulas, and a wider range of educational materials available in a resource center and on the program’s Web site. A monthly support group for doulas was implemented, and a quarterly continuing education session was developed that provides a lecture by a community expert on one of the topics suggested by the doulas. In the first year of implementing this program, topics included working with women with a history of sexual abuse, grief and loss during the childbearing year, postpartum depression, and preterm labor. A drop-in resource center was created at the Doulas Care office that has a lending library of books and videos, computer access, consumer education resources, and space to meet with a client. A volunteer coordinator was hired to offer support and to be a mentor to the volunteers. Continuing education classes have been added to the Center for the Childbearing Year’s curriculum, such as “Business Development Training,” “Ensuring Breastfeeding Success,” and “Advanced Doula Training,” all of which extend what is learned in the initial doula training program.

CONCLUSION

The focus groups provided important information for program development. Additional infrastructure support and training for the Doulas Care program was implemented. Training needs were identified, and a continuing education program was developed in response to the doulas’ feedback. This was a critical priority for the doulas in preparing for their unique role within the community of women the program served. Increased recruitment and support of volunteers from the same communities the program serves have also been addressed. The gap in educational needs for the doulas appeared to be based on their unique volunteer doula role within the community, compared with being hired by women for their services.

Limitations of this study’s findings include the lack of representativeness of the doulas in the focus groups and the homogeneous nature of their past educational training as doulas. It is possible that other educational needs would be identified for doulas working in a community-based setting, depending on their representativeness of the community, educational level, and past experience as

a community outreach worker. The combination of the roles of community outreach person and birth doula is congruent with the model of doula care advocated by national organizations such as DONA International. If doulas are going to expand their role and value within varied communities, it will be important to assess their learning needs in order to promote their individual success with clients, as well as the sustainability of community-based outreach models.

The value of the findings of this study is in their application by other organizations that may be interested in developing community-based doula programs. Community outreach workers or paraprofessionals working as community advocates have been shown to have a positive effect on outcomes for selected populations of childbearing women (Norr et al., 2003). Models promoting the combination of these roles have received little research attention in the literature, but they represent an opportunity to maximize the positive effect of social support as an intervention to promote positive health outcomes for childbearing women and adolescents. An organization is emerging, with leadership provided by the Chicago Health Connection (the originators of a community-based doula model), to bring greater attention to community-based doula programs and the extended role they can play in improving outcomes for all childbearing women. Yet, clearly, a need exists for expanded educational offerings for doulas who combine the roles of community outreach and doula support. Other programs provide community-based doula models; however, to our knowledge, this is the first discussion of the development of an educational program as a result of feedback from community-based doulas.

Overall, the volunteer doulas are committed to the Doulas Care program and view it as a positive opportunity for them, personally and professionally. As the program model is expanded and the Doulas Care program serves more women, continued research to evaluate the success of these changes will be necessary. Subsequent steps also include the transition from focusing on the process of providing services under the Doulas Care model to evaluating the outcomes of the program's clients.

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Examples of programs supporting community-based doula efforts are the Chicago Health Connection (<http://www.chicagohealthconnection.org/doula/doul.htm>), the Indiana Perinatal Network (<http://www.indianaperinatal.org/about-what-partnerships-ad-community-based-doulas.aspx>), and the Philadelphia Alliance for Labor Support (<http://dolphin.upenn.edu/~doulas/index.html>).

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