

THE PERINATAL REVOLUTION

New research supports the critical role Community-Based Doula Programs can play in improving maternal and child health in underserved birthing populations.

THE PERINATAL REVOLUTION

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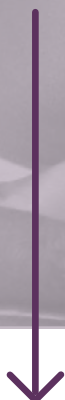


Photo by Helen Dimas

PART ONE EXECUTIVE SUMMARY



New research supports the critical role Community-Based Doula Programs can play in improving maternal and child health in underserved birthing populations.



Photo by Brenda Reyes

I. EXECUTIVE SUMMARY

The Community-Based Doula Program is a unique, innovative program model that provides extended, intensive support to families throughout pregnancy, during labor and birth, and in the early months of parenting in communities that face high risks of negative birth and developmental outcomes. The presence and involvement of the community-based doula at birth distinguishes this program from all other home visiting models. In addition, community-based doulas are of and from the communities being served. This program model combines culturally appropriate peer-to-peer support with a life course approach that focuses on the perinatal year and the early months of parenting, a sensitive period in which families have a unique openness to change, learning and growth. It represents

a new approach to perinatal support: one that makes use of the power of relationships and the power of birth.

This white paper shares recommendations from an Expert Panel regarding the Community-Based Doula Program model as carried out by the Health Resources and



Photo by Flint Chaney

The most compelling data findings were the high breastfeeding rates and low c-section rates achieved by the Community-Based Doula Programs implementing this model.

Services Administration (HRSA) Maternal and Child Health Bureau (MCHB). This document contextualizes the Panel's third-party recommendations (Part V) with background, definitions, and Panel-approved data findings. The Expert Panel was convened in September of 2012 as a result of an inter-agency collaboration initiated by the Centers for Disease Control and Prevention (CDC) and HRSA.

Officially named the "Promotion and Support of Community-Based Doula Programs" Expert Panel, this body was facilitated and staffed by HealthConnect One (HC One), a non-profit agency funded by HRSA as the Community-Based Doula Leadership Institute. The Expert Panel's goal was to review the literature and non-traditional sources and to analyze evidence and outcomes from the four years (2008-2012) of HRSA funding of Community-Based Doula programs. The Expert Panel consists of 20 national experts who evaluated, discussed and identified both key lessons learned and recommendations for moving forward.

The most compelling data findings were the high breastfeeding rates and low c-section rates achieved by the Community-Based Doula Programs implementing this model. Women supported by a high-quality Community-Based Doula Program breastfed their babies at dramatically higher rates, with women in the program sometimes breastfeeding at twice the rate of the comparison group. These data reinforce equally strong findings from the original pilot of this program led by HealthConnect One in Chicago. The fact that community-based doulas work with very disadvantaged populations makes these findings even more significant.

The Panel reviewed the literature and nontraditional sources, examined data and outcomes of Community-Based Doula Program participants, solicited feedback from experienced program staff, supervisors and administrators, and considered the implications of the findings for a variety of health policy issues and systems. On the basis of these deliberations, the Expert Panel provided the following summary recommendations.



THE EXPERT PANEL PROVIDED THE FOLLOWING SUMMARY RECOMMENDATIONS:

- HRSA should continue to promote and expand the Community-Based Doula Program with federal funding, based on the uniqueness of the model, the workforce development implications, and the data analysis which identifies significant and important program outcomes;
- The most compelling data findings were the high breastfeeding rates and low c-section rates; further research funded at the federal level is essential to deepen the evidence base and to clarify best practices;
- High quality implementation of the model is critical to achieve strong positive outcomes; replication sites should seek community-based doula program accreditation to ensure quality programs;
- Sustainability of this model requires integration of the program into a variety of systems and venues.

Detailed recommendations are provided in Part V, on page 37.

A grayscale photograph of a woman with her eyes closed, gently holding a newborn baby. The woman is wearing a light-colored button-down shirt and a large, ornate earring. The baby is wrapped in a light-colored cloth. The image has a soft, ethereal quality with a light purple overlay.

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Photo by Flint Chaney

PART TWO

WHY COMMUNITY-BASED DOULAS MATTER

II. WHY COMMUNITY-BASED DOULAS MATTER



A. What's at Stake?

A Failure to Connect: The United States currently spends more than any other country on health care: both our public and private health expenditures are growing at rates which outpace comparable countries. Despite this higher level of spending, the U. S. does not achieve better outcomes on many important health measures. The World Health Statistics (2010) revealed that compared to the United States, 40 countries had better neonatal mortality rates, 65 had better low-birth-weight rates and 32 had higher rates of exclusive breastfeeding at six months.ⁱ



HOW DOES THIS TRANSLATE INTO DOLLARS AND CENTS?

- The Institute of Medicine concluded that poor birth outcomes cost \$26.2 billion annually or \$51,000 for every preterm infant.^v
- The high use of medical interventions during labor and birth also increases costs. Each avoided C-section provides \$4,459 in medical care savings, and each avoided epidural provides \$607 in medical care savings.
- Given that more than two of every five births in the U.S. are to women on Medicaid, these costs are also significant for state and federal governments.
- Strategies to decrease health care costs should include promoting optimum breastfeeding: the cost of suboptimal breastfeeding is estimated to be \$13 billion per year for pediatric costs and an additional \$18.3 billion per year in maternal health costs.^{vi, vii}

Populations at the highest risk of disease and poor birth outcomes experience tremendous socio-economic challenges and lack of access to health care services. Barriers that constrain underserved populations from connecting with healthcare resources they so urgently need include income, language, education, geography, and culture. These barriers result in shocking disparities in maternal and child health and development. For example:

- Non-Hispanic Black babies were almost twice as likely as Non-Hispanic White babies to be born at low birth weight (< 2500 grams, or 5 lbs., 8 oz.), and two and a half times as likely to be very low birth weight (<1500 grams).ⁱⁱ
- Black babies are twice as likely as white babies to die before their first birthday.ⁱⁱⁱ
- The percentage of Black infants who ever breastfed was 58.9% in 2008, compared to 75.2% among Whites and 80.0% among Hispanics.^{iv}

Despite significant attempts over the past decades to improve the health of low-income communities and populations of color, unacceptable health disparities persist for our most vulnerable families.

The Cost of Waiting: Community-Based Doula Programs connect the dots within an often splintered healthcare environment, connecting one woman at a time with a trained doula from her own community. The program begins before birth to increase the possibility that every baby has an equal chance to live a long, productive life. The ongoing discoveries around early learning and health demonstrate the importance of focusing as early as possible in a birthing family's life course. Support and resources for low-income families during the critical perinatal year (conception through three months post-partum) can profoundly impact the start of life for the child, as well as the future of the whole family. Strengthening health in the prenatal and early childhood periods can reduce chronic disease across the life course, in part by decreasing the number and severity of adverse experiences that threaten the wellbeing of parents and young children. Attachment in the first year of life is critical to social-emotional development and school readiness.

Community Health Workers Can Open the Door: During the past decade, a growing awareness of the social and economic determinants of health, and the increased use of a life-course perspective on health and disease, have led to significant policy shifts. These changes have led to a prioritization of health promotion and disease prevention, a commitment to community-based innovations, and an understanding that investments in pre-conception, pregnancy, birth and early childhood support are essential for the health of our population and our economy.

- Community-based doulas are community health workers (CHWs) – frontline public health workers who are trusted members of the community being served.
- Community health workers have been effective members of healthcare and social service teams since the 1960's in both paid and unpaid positions.
- The total number of trained Maternal and Child Health CHWs is estimated at 40,000 in the year 2000.^{viii}

- Involving CHWs during the birth process has been found to improve health outcomes, reduce hospital stays and increase utilization of preventative and primary care services.
- CHWs are of and from the communities they work in, and therefore represent a valuable resource for their participants as well as for the healthcare teams engaged in providing care in underserved communities.

In the next few years, the Affordable Care Act will begin engaging many new mothers and infants earlier and more comprehensively into America's healthcare system, and supporting them with stronger preventive care services. Including community health workers like community-based doulas and breastfeeding peer counselors in the health care team is an effective and cost-effective way to provide these services. Public health providers across the nation are poised to catch the rising tide of interest in the unique role of community health workers.

B. Why Now: The Need to Seize this Moment & Continue Developing the Community-Based Doula Program

Momentum is Building: The Policy Landscape

Over the last several years advocacy efforts on state and federal levels have succeeded in solidifying and raising the profile of the community health worker (CHW) workforce. In 2010, two major accomplishments accelerated the integration of CHWs into the workforce and pushed policy makers further into the conversation.



Photo by Brenda Reyes

2009

CHWs receive occupational classification from U.S. Department of Labor

2010

ACA is signed and recognizes CHWs as integral part of health care team

2011

U.S. Senate Appropriations Committee Report filed to recommend inter-agency collaboration resulting in Promotion and Support of Community-Based Doula Program Expert Panel

First, in 2009, the U.S.

Department of Labor developed an occupational classification for CHWs (SOC 21-1094); secondly, on March 23, 2010 President Obama signed Public Law 111-148, HR 3590: Patient Protection and Affordable Care Act (ACA). This historic legislation created a new opportunity for health reform to take place at the federal, state and local level and recognized CHWs as an integral part of the health care team. Section 5313, Grants to Promote the Community Health Workforce, amends Part P of Title III of the Public Health Service Act (42 U.S.C. 280g et seq.) to authorize the CDC in collaboration with the Secretary of Health and Human Services

to award grants to “eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.”

The specific reference to community health workers was a victory for CHWs across the country and for the National Community-Based Doula Network, which worked on ACA language with Senator Richard J. Durbin (D-IL), a champion of the Community-Based Doula Program.

Funding established by the Affordable Care Act also made possible the inter-agency collaboration that resulted in the convening of the Promotion and Support of Community-Based Doula Programs Expert Panel. As federal agencies were working to better collaborate and provide less siloed services, a US Senate Appropriations Committee Report was filed on September 21, 2011 (112-84): P. 66 recommending this collaboration:

Breastfeeding.—The Committee is aware of research showing that suboptimal breastfeeding rates are a significant contributor to our Nation’s epidemic of obesity, increasing risks of several acute and chronic diseases and conditions, including diabetes and cardiovascular disease. The Committee supports the Surgeon General’s Call to Action to Support Breast Feeding. The Committee has included funding through the Prevention and Public Health Fund to support hospitals that promote breastfeeding and non-governmental organizations that assist breastfeeding mothers. The Committee urges Centers for Disease Control & Prevention (CDC) to collaborate with the Maternal and Child Health Bureau’s doula best practices initiative.

A Variety of Models are Competing for Recognition

The Community-Based Doula Program’s culturally sensitive and intimate-on-the-ground model is one of several home visiting models. Public health and early childhood leaders, insurers, and policy makers are evaluating a range of possible maternal-child health and early learning solutions. While there is room for many strategies, the growing evidence for community-based doula impact strengthens the case for this model as new funding streams develop.

Medicaid has begun to Fund Low-Cost Prevention-Oriented Interventions

Among the first round of the Centers for Medicare and Medicaid Services (CMS) Innovation Challenge Grant recipients, funded through the Affordable Care Act, 25% are implementing and evaluating models that use community health workers, which will provide lessons learned for implementation of CHW programs. Additionally, CMS issued a 2013 ruling that allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state’s clinical licensure system, so long as the services have been recommended by a physician or other licensed practitioner. This new rule for the first time offers state Medicaid agencies the option to reimburse for more community-based preventive services, including those of CHWs.



Quality Control issues such as CHW Certification and fidelity of home visiting model replication are being debated on the national, state and local levels.

The national program quality conversation in home visiting is shifting from the initial focus on a randomized controlled trial (RCT) as the “Gold Standard” of effectiveness evidence to a more nuanced examination of the process of replication and program fidelity on the ground in diverse communities. A community-oriented lens can illuminate some of the important issues in this debate. Lessons learned from fifteen years of Community-Based Doula Program replication should inform emerging policies around this complex issue.

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Photo by Sandy Schaeffer

PART THREE HISTORY OF THE WORK

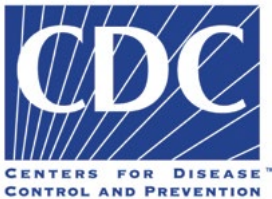
III. HISTORY OF THE WORK

A. Key Players

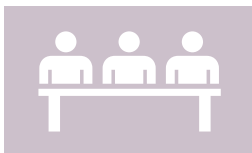


Health Resources and Services Administration (HRSA)

Maternal and Child Health Bureau (MCHB): The Maternal and Child Health Bureau (MCHB) within HRSA provides leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs. Within MCHB, the Division of Healthy Start and Perinatal Services (DHSPS) has been administering the federally funded Community-Based Doula Program since 2008.



Centers for Disease Control and Prevention (CDC): The Centers for Disease Control and Prevention (CDC) develops and applies disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. Within CDC, the National Center for Chronic Disease Prevention and Health Promotion's Division of Nutrition, Physical Activity, and Obesity (DNPAO) is committed to increasing breastfeeding rates throughout the United States and to promoting and supporting optimal breastfeeding practices toward the ultimate goal of improving the public's health. These efforts have most recently been funded through the Prevention and Public Health Fund. This Division collaborated with HRSA on the Promotion and Support of Community-Based Doula Programs Expert Panel.



Expert Panel: The Centers for Disease Control and Prevention (CDC) and HRSA initiated an inter-agency collaboration in early 2012, resulting in the convening of the "Promotion and Support of Community-Based Doula Programs" Expert Panel. The Expert Panel's goal was to review the literature and non-traditional sources (e.g. unpublished program assessments and qualitative description of program staff experiences), and to analyze evidence and outcomes from the four years (2008-2012) of HRSA funding of community-based doula programs. HealthConnect One, which had been funded for four years as the Community-Based Doula Leadership Institute, was asked to assemble a high-profile roster of 20 individuals capable of bringing an informed and impartial eye towards this work, and discussions began in September of 2012. The Panel's charge was to provide recommendations to HRSA regarding:

- Evaluation of Community-Based Doula Program outcomes
- Recommendations for future high quality implementation of the Community-Based Doula Program
- Recommendations for integration of the Community-Based Doula Program and connectivity across systems

The Expert Panel, which included leaders of national maternal and child health organizations, researchers, community-based doulas and program staff, funders and other content experts, met over the course of a year through webinars, conference calls and a two-day face-to-face meeting in Washington, DC to evaluate, discuss and identify recommendations for HRSA and CDC regarding future investment in community-based doula programs. Eleven additional federal public health leaders and administrators brought consultation and content expertise to the discussions. The Panel reviewed the literature and nontraditional sources, examined data and outcomes of Community-Based Doula Program participants, solicited feedback from experienced program staff, supervisors and administrators, and considered the implications of the findings for a variety of health policy issues and systems. See Appendix for a list of members.



HealthConnect One/Community-Based Doula

Leadership Institute (HC One): HC One developed the Community-Based Doula program in a four-year pilot in Chicago, and was awarded funding from HRSA from 2008-2012 as the Community-Based Doula Leadership Institute, providing training, technical assistance, and evaluation to HRSA grantees across the country. HC One also facilitates the Community-Based Doula Leadership Institute Advisory Board. This 25-member board provides guidance to HC One and HRSA regarding program design and replication. The overall composition of the board is: eight doulas/administrators; eleven MCH experts; five government staff (ex-officio) and one private sector funder (See Appendix for full list). Additionally, HC One facilitates the National Community-Based Doula and Breastfeeding Peer Counselor Network, composed of more than 850 maternal and child health stakeholders from across the United States, which provides peer support and collaborative learning to the cohort of HRSA-funded program sites.

Founded in 1986, HealthConnect One is the national leader in advancing respectful, community-based, peer-to-peer support for pregnancy, birth, breastfeeding, and early parenting. HC One partners with direct service organizations to develop programs that connect underserved women to women in their own communities who are specially trained to provide support during the childbearing year. These programs employ women who are of and from the same community as their participants and are thus able to bridge language and cultural barriers in order to meet health needs.



Program Partners: Eight organizations replicating the Community-Based Doula Program across the country contributed data and experiences for this report. They are large and small, urban and rural, and they serve diverse populations -- primarily Hispanic, African-American, and American Indian. Six of the eight organizations received HRSA funding for their programs. (Brooklyn Young Mothers Collective and Mothering Mothers had other public and private funding sources.) The program partners are listed below, with descriptive detail (a full list of organizations with established or developing community-based doula programs can be found in the Appendix).

COMMUNITY BASED DOULA SITES REPRESENTED IN THIS REPORT

Name	Location	Type	Population	Approximate Organizational Budget Size
Migrant Health Promotion	Weslaco, TX	Social Service Agency/Advocacy	Migrant Families in the border region of Texas	\$1,510,000
Families First	Atlanta, GA	Social Service Agency/Advocacy	African-American and Hispanic Teens	\$10,515,000
The Birth Circle (University of Pittsburgh Medical Center)	Pittsburgh, PA	Former FQHC, Current University Hospital	Low Income	\$541,491,000
Birth Matters/ReGenesis Community Health Center	Spartanburg, SC	FQHC (ReGenesis)	80% African-American 20% Hispanic	\$5,461,000
Brooklyn Young Mothers Collective	New York, NY	Cooperative	Primarily African-American Teens	\$60,000
Great Lakes Inter-Tribal Council	WI	Inter-Tribal Council	American Indian Families	\$8,326,000
Healthy Family Initiatives	Houston, TX	Social Service Agency	Hispanic Families referred to HFI for home visiting services	\$1,667,000
Mothering Mothers (Gateway Northwest Maternal and Child Health Network)	Elizabeth, NJ	Medical Center	Hispanic Families served by Trinitas Health Center & Hospital	\$2,264,000

*Data in table is self-reported

B. The Program

What is a Community-Based Doula Program? Beginning early in pregnancy through home visits and center-based activities, a community-based doula supports a participant throughout pregnancy, during the birth and then into the postpartum period. The effectiveness of the program emerges out of the trusting relationship between a community-based doula and her participant, the duration of the relationship, and the continuous presence of the doula during labor and birth.

What communities? Community-based doula peer-to-peer programs reside in vastly different settings, but all serve communities that have been self-defined as underserved. These programs have identified specific priority needs of birthing families that are not being adequately addressed in their community and have chosen the community-based doula program to change their community's outcomes.

What values & methods drive this program? HRSA's funded Community-Based Doula Program requires that grantees implement HealthConnect One's "Five Essential Components" to achieve successful outcomes in improving a community's health, building a workforce and improving health outcomes around the time of birth for women and babies. Replicating this program is time intensive and requires buy-in from a variety of community stakeholders to ensure its success and to evaluate the objectives they set out to achieve. The "Five Essential Components" must be embraced and integrated regardless of the setting. All HRSA-funded Community-Based Doula Programs:

- Employ women who are trusted members of the target community.
- Extend and intensify the role of doula with families from early pregnancy through the first months of postpartum.
- Collaborate with community stakeholders/institutions and use a diverse team approach.
- Facilitate experiential learning using popular education techniques and the HC One training curriculum.
- Value the doula's work with salary, supervision and support.

DEFINING TERMS

A COMMUNITY HEALTH WORKER (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Definition by the American Public Health Association (APHA)

A COMMUNITY-BASED DOULA is a woman of and from the same community who provides emotional and physical support to a woman during pregnancy, birth and the first months of parenting.

Doulas have been supporting other women around the time of birth for centuries. Community-based doulas are of and from the same communities as the participants being served. The trusting relationship with a community-based doula brings families into the program earlier and keeps them longer.

How is a Community-Based Doula Program embedded in a community?

The Community-Based Doula Leadership Institute provides training, technical assistance and multi-site evaluation to program sites. The implementation of the program is tailored to each site and starts by engaging the community.

- Over the first several months of implementation, the lead organization completes a community-needs assessment and holds a Stakeholders Meeting. This meeting provides an opportunity for community leaders, residents, providers, and advocates to discuss community priorities, hear about the program, and provide feedback about objectives, partners, and appropriate outreach.
- Outreach and recruitment for both community-based doula trainees/potential staff and program participants begins at this Stakeholders' Meeting. This meeting also lays the foundation for an active and engaged Stakeholder Advisory Board.
- After the Stakeholders meeting, the Leadership Institute conducts an intensive 2-day Training of Trainers session that develops local competency in the community-based doula curriculum and the popular education training approach.
- The site then conducts the 20-session community-based doula training, and hires the doulas for the program after the completion of the sessions. The sessions include time as a group, homework, journaling, attending birth, and conducting a celebratory graduation. The Leadership Institute co-facilitates and mentors site facilitators during one or two of the training sessions. This popular education approach is core to the program, which supports an experiential learning environment, recognizes that everyone learns differently, and is adapted and tailored to meet the needs of the target population.
- Other components of the technical assistance provided by the Leadership Institute during this "start-up" time include training on the web-based data collection system, support on development of policies and protocols and defining case loads and contact intensity, program quality assessment, National Network webinars, regional meetings and national conferences.

How do doulas work once they are trained? A typical community-based doula attends up to 25 births a year, and most program sites employ two full-time doulas. Because the program supports an extended and intensified role, caseloads should not exceed more than 12 women at one time. HRSA-funded community-based doulas provide support during home visits, medical appointments, at the birth and for at least 6 months postpartum (some up to two years after the birth).

What makes the Community-Based Doula Program model different from other home visiting models?

The presence and involvement of the community-based doula at birth distinguishes this program from all other home visiting models. This is a sensitive period in which families have a unique openness to change, learning and growth, and community-based doulas are committed to helping other women and families in their communities have satisfying birthing and early parenting experiences.

WHY DOES THE COMMUNITY-BASED DOULA PROGRAM WORK?



IT BUILDS HEROES:

Community-Based Doula Program and workforce development strategies are informed by this belief: to improve health status and equity, programs need to focus on a prevention-oriented approach that respects and accesses the existing assets within a wide range of populations.



IT ACTIVATES COMMUNITY HEALTH CARE ENVIRONMENTS:

By developing, supporting and connecting families with resources that exist in their own neighborhoods - right where families live - the program creates an essential fit between individuals and health-care providers. The vision is a web of care, an ecosystem of support, which transforms health-care 'deserts' into thriving neighborhoods poised to surround and sustain children living in poverty.



IT FOCUSES TIGHTLY:

Right Place, Right Time, Right Strategy. By connecting CHWs with vulnerable families at the right place (neighborhood health centers and homes) and the right time (pregnancy through early childhood), the program dramatically improves birth outcomes.



IT SUPPORTS THE CAPACITY OF MOTHERS TO PROTECT THEIR CHILDREN:

Mothers supported by doulas have safer births and better outcomes. And every low-income woman who decides to breastfeed for the first time, or against the odds, or for the first time in several generations of her family, is giving her child the most important protection against disease - giving her child what money can't buy.

Hero icon based on Woman by Gina Rafaella Furnari

"Breastfeeding is a natural safety net against the worst effects of poverty. If a child survives the first month of life, the most dangerous period of childhood, then for the next 4 months or so, exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence. It is almost as if breastfeeding takes the infant out of poverty for those few vital months in order to give the child a fairer start in life and compensate for the injustices of the world into which it was born."

—The late James P. Grant, past Executive Director of UNICEF

C. Timeline: A Chronology of the Development of the Community-Based Doula Program



1996

In 1996, HealthConnect One developed The Chicago Doula Project, a four-year pilot, in collaboration with three frontline Chicago agencies serving pregnant and parenting teens. The pilot was designed to demonstrate that supportive relationships around birth can make a strong impact in health and early learning outcomes by diminishing the fragmentation of the healthcare delivery system, reducing high cost medical interventions, improving breastfeeding rates and strengthening parent-infant relationships in families experiencing significant adversity.

Between 1996 and 2000, the four-year pilot documented that families supported by community-based doulas during pregnancy, at the birth and in the post-partum period had better health and mother-infant attachment. Strong outcomes included high breastfeeding rates (even in agencies where breastfeeding was previously rare), fewer labor and delivery complications, fewer medical interventions, and increased well-being for both mothers and babies served. These outcomes resulted in cost savings at the time around birth. Estimates of reduced costs from decreased c-sections and epidurals alone were approximately \$750 per family, with additional cost-savings possible due to reduced length of stay. Increased breastfeeding also saves families \$500 in the first year and prevents costly illnesses.

2000

In 2000, building upon the success of the robust outcomes in Chicago, HC One began national replication in communities that lacked equal access to healthcare, support and resources to combat the persistent disparities facing mothers and babies. Community-Based Doula Programs have been implemented within Healthy Start programs, Federally Qualified Health Centers (FQHCs), social service agencies, community health centers, hospital systems, and residential addiction treatment centers, in 50 organizations in 18 states. Some programs, including the pilot sites, have been sustained for more than 15 years (in some cases with the original community-based doulas still providing services).

2008

In 2008, as a result of advocacy by the National Community-Based Doula Network and other maternal and child health stakeholders around the country, the first federal funding stream for community-based doula programs was established through the Special Projects for Regional and National Significance (SPRANS) administered by HRSA's Maternal and Child Health Bureau. The Division of Healthy Start and Perinatal Services has overseen the administration of the program since the \$1.536 million in federal funding was established. HRSA has had two funding cycles for two different cohorts of six sites each, and a Leadership Institute providing training, technical assistance, and multi-site evaluation to the cohort of program sites. Two of the initial cohort sites were continued into the second cohort; their data from the first cohort years has been included in the analysis. Data from the other four sites in the first cohort was incomplete and was not included in the analysis.

From 2008-September 2010, through competitive grant application processes, six rural and urban program grantees received two years of funding. HRSA chose HC One to serve as the Community-Based Doula Leadership Institute.

2010

A second cycle of funding began in 2010 with funds to be distributed over three years to three rural and three urban programs and HealthConnect One.

2012

However, in early 2012, due to the fiscal climate and drastic federal budget cuts to maternal and child health programs, the Community-Based Doula Program funding was cut one year early. Most sites were forced to close the program, creating a loss of workforce and program services to the underserved communities the programs were working in.

In 2012, HRSA and the CDC initiated an inter-agency collaboration, resulting in the convening of the "Promotion and Support of Community-Based Doula Programs" Expert Panel in September of 2012. The Expert Panel was facilitated and staffed by HC One. The Expert Panel's goal was to review the literature and non-traditional sources and to analyze evidence and outcomes from the four years (2008-2012) of HRSA funding of Community-Based Doula programs. The Expert Panel consists of 20 national experts who evaluated, discussed and identified both key lessons learned and recommendations moving forward.

Concurrent with these budget cuts, the Affordable Care Act was being implemented, and national discussions in a variety of systems and arenas were focused on evidence-based interventions, promoting early health and early learning, and the high costs of healthcare. This debate pushed a needed and important conversation that intersected with the recognition that community-based doulas could positively impact underserved communities and address some of these issues.



THE PERINATAL REVOLUTION



PART FOUR THE DATA

Photo by Flint Chaney

IV. THE DATA

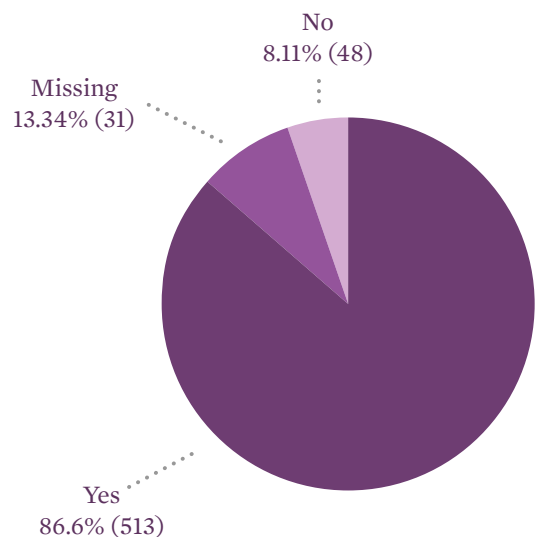
The Expert Panel's evaluation of Community-Based Doula Program outcomes focused on data collected from eight community-based doula programs from around the country, six of which received HRSA funding. Data were collected by community-based doulas, and entered into *Doula Data*, an online, user-friendly systematic and comprehensive program monitoring and evaluation tool. *Doula Data* was launched in 2008 to strengthen the community-based doula program by building the research base behind it. Data from 2008-2012 were used for this analysis.

A total of 592 women benefited from the services of a community-based doula in eight organizations included in *Doula Data* during the period of 2008-2010.

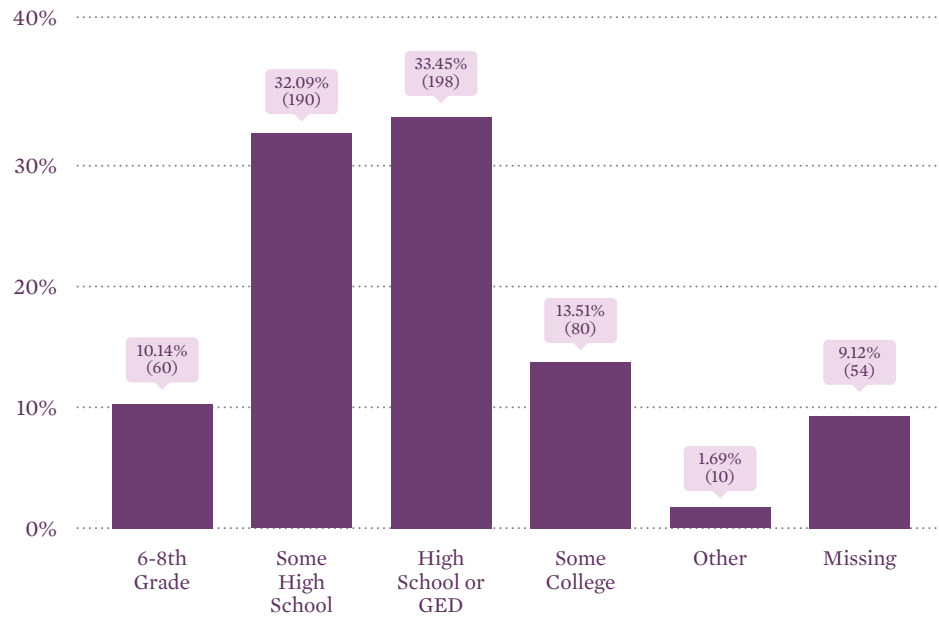
A. The Population

The participants served by the Community-Based Doula Program are typically the highest need families dealing with complicated health and social issues. The communities served in this study were low-income (86.66% WIC eligible), had limited formal education, and faced other challenges that significantly impact birthing outcomes. The participants often experienced barriers accessing and utilizing services and support that they needed most, both medical and social. The majority were Black (33.1%) or Hispanic (47.1%) but also included a small percentage of American Indian (4.6 %) and White (5.2%). Most participants served were young; two-thirds (66.21%) were younger than 25 years old.

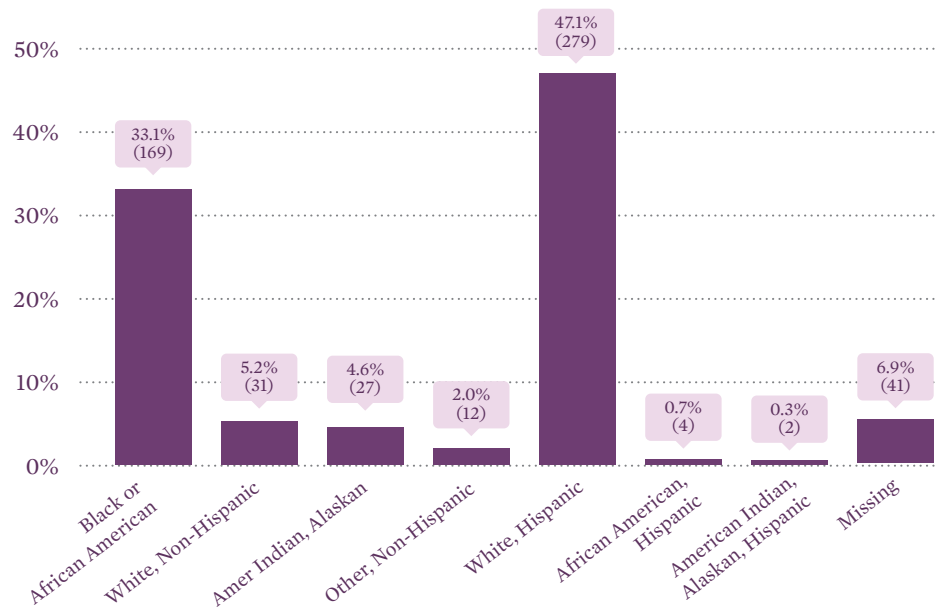
INCOME INDICATOR
PARTICIPANT BY WIC
STATUS (EVER)



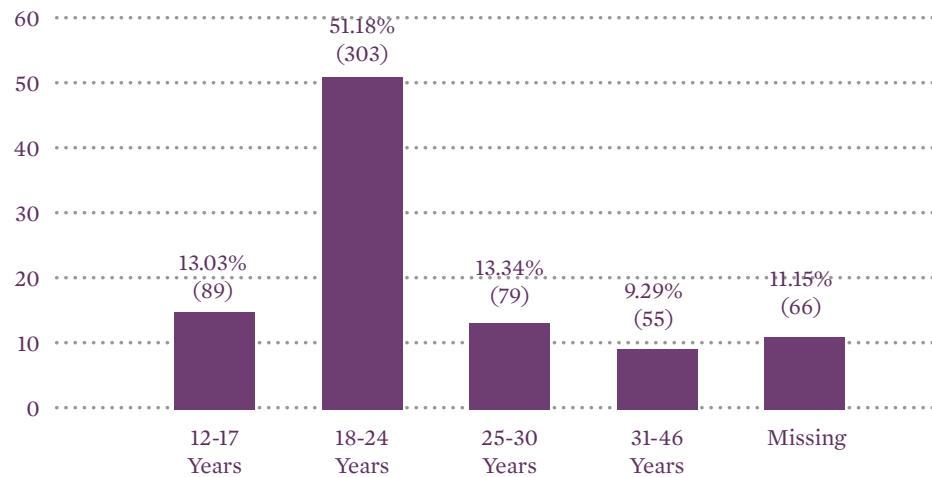
PARTICIPANTS BY EDUCATION



PARTICIPANTS BY RACE & ETHNICITY



PARTICIPANTS BY AGE CATEGORY



A high percentage (42.38%) of participants experienced one or more health conditions that are associated with adverse pregnancy and birth outcomes, including overweight /obesity, diabetes, depression, high blood pressure, heart disease, respiratory illness or asthma and sexually transmitted diseases. Participants were also described as experiencing substantial socio-economic challenges, which can significantly impact maternal and infant health. ***All categories of socio-economic challenges decreased between those described in the prenatal period and those described postpartum.***

Populations with high rates of medical conditions and socio-economic challenges are at a higher risk of adverse birth outcomes, including prematurity, low birth weight, low breastfeeding rates and mental health issues. Each community where a Community-Based Doula Program has been implemented experiences different combinations of risk factors that contribute to poor birth outcomes.

B. Data Sources & Methods

An exploratory data analysis was conducted, which included an unadjusted comparison between 592 participants that were tracked through *Doula Data* and benchmarks from a sample of participants in PRAMS (Pregnancy Risk Assessment Monitoring System) from 2008-2010.^{ix} In spite of limitations in the data,^x results of the analysis were consistent with positive outcomes that were shown in the original community-based pilot.^{xi} This includes much higher breastfeeding duration and exclusivity rates (at 6 weeks, 3 months and 6 months) and much lower c-section rates.

Doula Data is an online, user-friendly systematic and comprehensive program monitoring and evaluation tool. *Doula Data* was launched in 2008 to strengthen the community-based doula program by building the evidence base behind it. The data collection system has 419 variables, which include a variety of topics and questions focused around participant history, prenatal and postpartum contacts and labor and birth.

Although *Doula Data* has the capacity to collect a plethora of information regarding participants served, it was not designed as a research tool. *Doula Data* was designed to monitor program implementation and evaluate program outcomes. The community-based doula is the data enterer, and doulas have to balance both participant support and data entry within their challenging role. Doulas often have to enter similar data into numerous systems. Given the nature of the doula's role and the variation in site-by-site emphasis on data collection, there is some potential for missing and inaccurate data within the system.

C. What the Data Tell Us

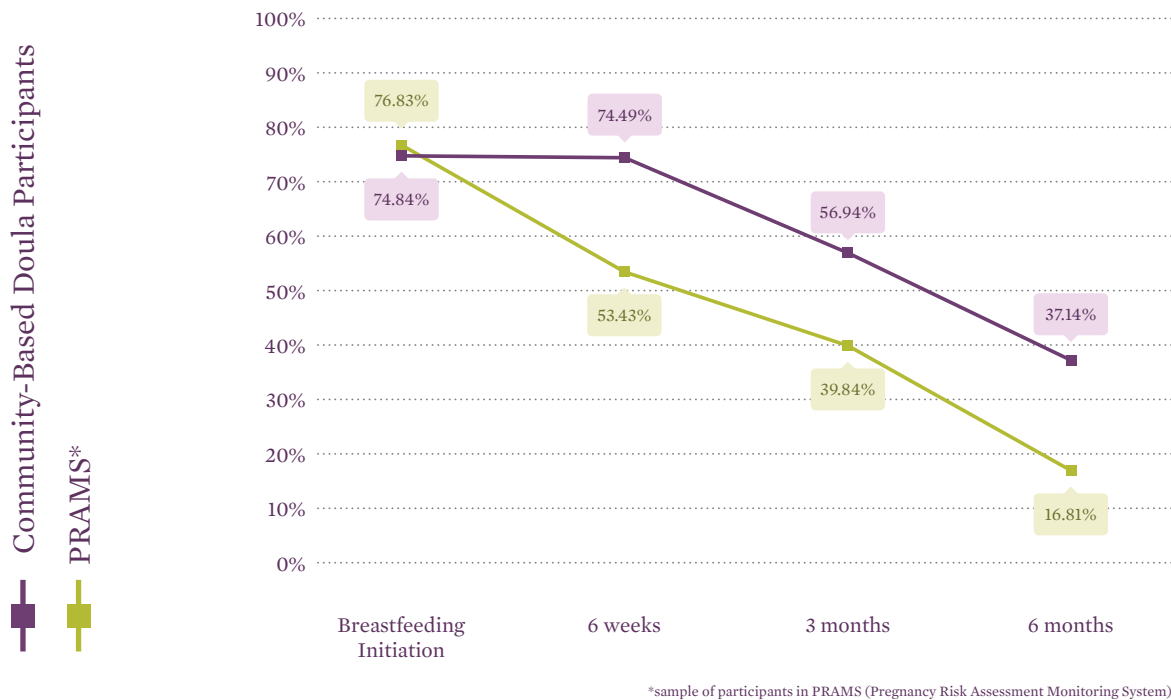
The Importance of Breastfeeding: Extended and exclusive breastfeeding has been well established as the healthiest option for newborn babies and their mothers. Breastfeeding not only provides nutrition to babies.^{xvii} The health benefits are related to the amount of breast milk the baby gets – similar to the dose of a medication.^{xviii} Given the numerous short and long term benefits of exclusive breastfeeding, including the best possible health and development outcomes for infants, exclusive breastfeeding for the first six months of life is endorsed by the American Academy of Pediatrics.^{xvii}

The breastfeeding rates of mothers served by a Community-Based Doula Program are astounding. Not only do mothers breastfeed, they also breastfeed for much longer and much more exclusively than what is typically seen in similar populations. Breastfeeding duration and exclusivity rates among both Black and Hispanic mothers were significantly higher than PRAMS benchmarks. These breastfeeding rates exceed many of the Healthy People 2020 goals for breastfeeding and are extremely impressive given the improvements seen in populations where significant disparities often exist. Rates exceeded the Healthy People 2020 goals for exclusive breastfeeding at 3 months and 6 months (see charts on next page).^{xii}

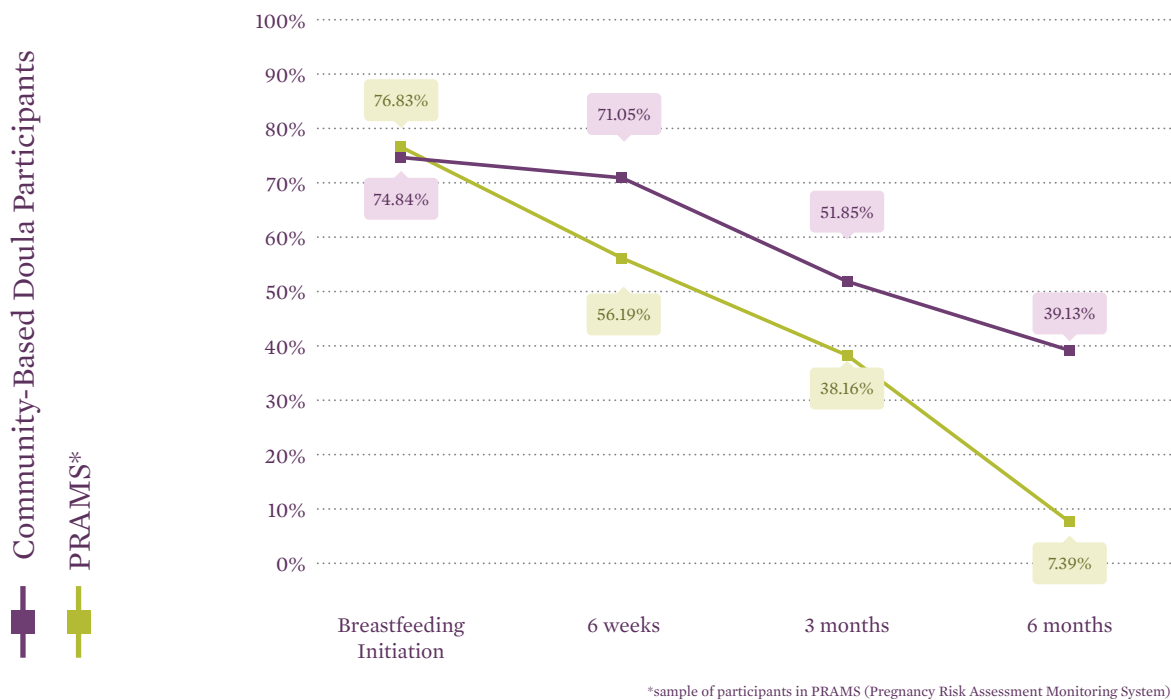


Photo by Flint Chaney

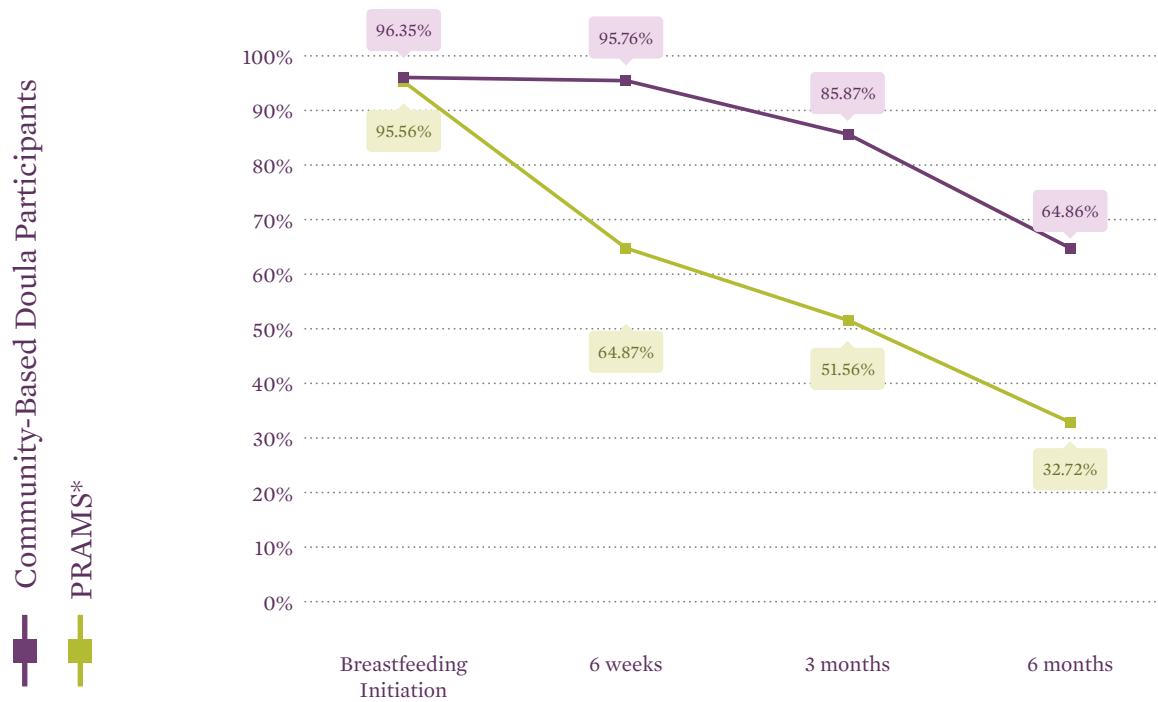
BREASTFEEDING DURATION: BLACK OR AFRICAN AMERICAN MOTHERS



BREASTFEEDING EXCLUSIVITY: BLACK OR AFRICAN AMERICAN MOTHERS

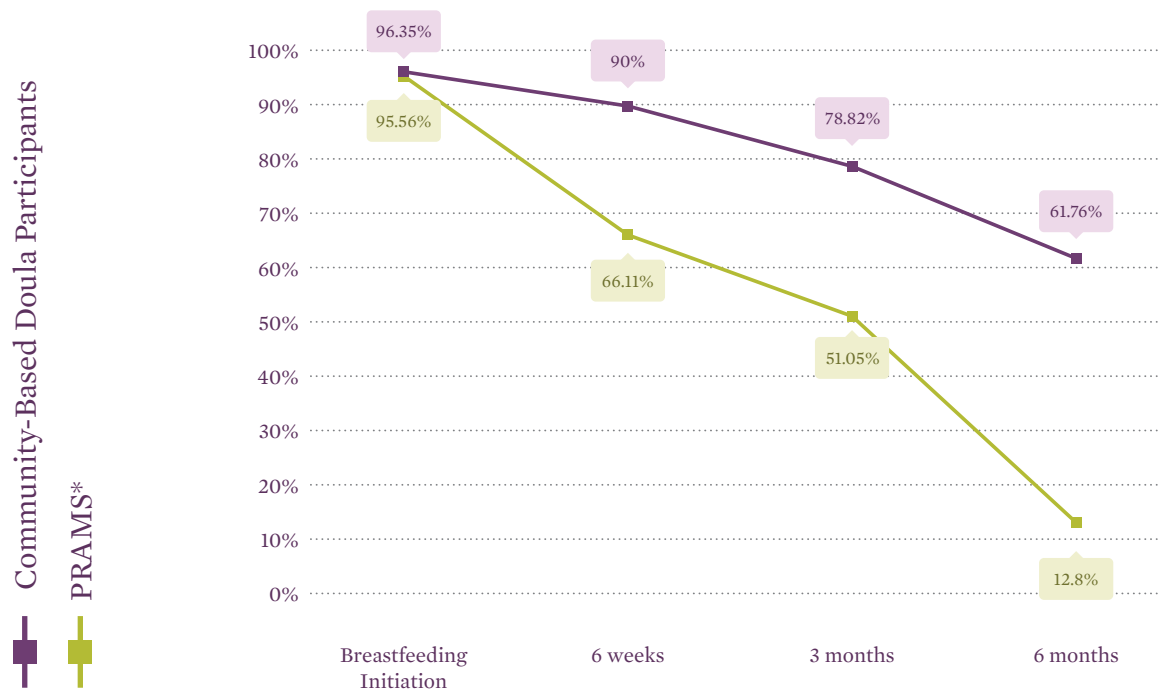


BREASTFEEDING DURATION: HISPANIC MOTHERS



*sample of participants in PRAMS (Pregnancy Risk Assessment Monitoring System)

BREASTFEEDING EXCLUSIVITY: HISPANIC MOTHERS



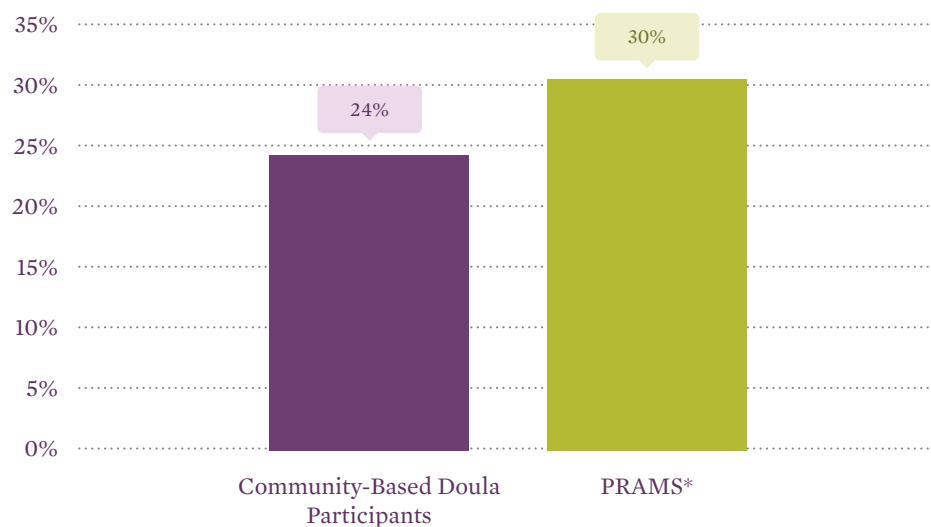
*sample of participants in PRAMS (Pregnancy Risk Assessment Monitoring System)

Impact of Program Fidelity on Breastfeeding Outcomes:

An analysis of associations assessed the impact of quality measures on breastfeeding outcomes. Both the number and the timing of prenatal and postpartum visits (early and frequent) and the doulas' attendance at birth were associated with increased breastfeeding rates. Starting the program sooner, meeting with a doula frequently and having the doula attending the birth all had positive associations with better outcomes. These data suggest that the length and type of relationship between the doula and participant is important for achieving the best breastfeeding outcomes.

C-sections: C-section rates were also lower for mothers in community-based doula programs than in PRAMS benchmarks. C-sections are costly surgeries that are sometimes necessary, but U.S. rates are double the percentage of expected c-sections based on medical need.^{xiii} This over-use leads to higher costs to the medical system and higher risks of adverse outcomes for the mother, along with a longer recovery time. Regional differences in c-section rates have been identified and can be influenced by regional risk factors, provider culture, and policies and protocols established in maternity hospitals. Outcomes in Doula Data demonstrated that having the support of a community-based doula significantly lowered the rate of c-sections. These outcomes are even more important given the barriers faced by grantees. For example, “a barrier in OB practice in the rural community [is that] OBs are in solo practice and tend to induce labors, this includes use of epidural because small hospitals do not have [an] on call anesthesiologist. Research proves that induction increases cesarean rates.”^{xviii}

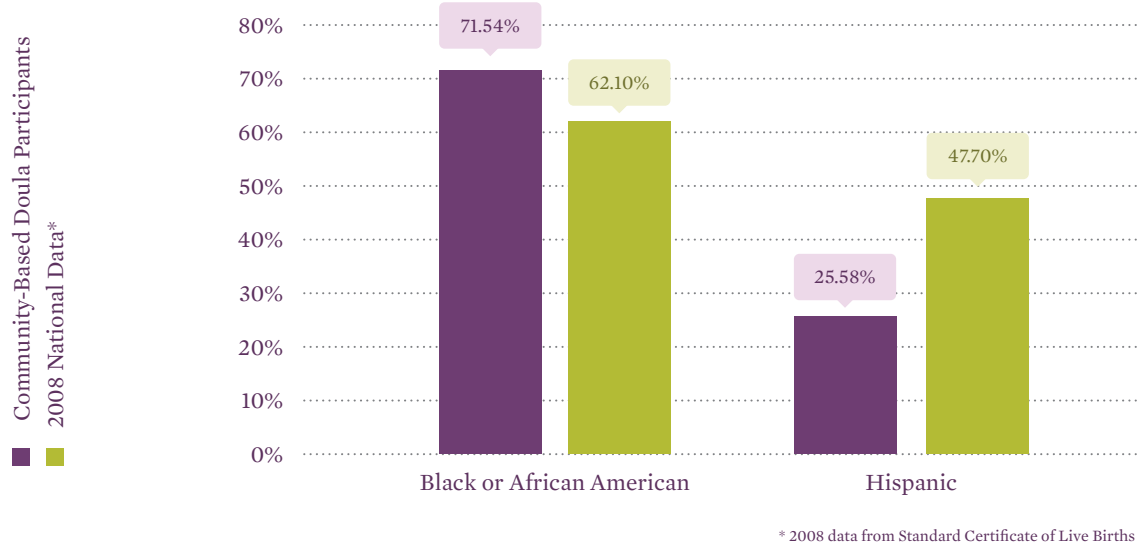
C-SECTIONS



*sample of participants in PRAMS (Pregnancy Risk Assessment Monitoring System)

Other outcomes: Other promising, though not significant, results include high rates of skin to skin contact in the first hours after birth, low epidural rates among Hispanic participants, and increased use of alternative pain management techniques. The data also show that all mothers enrolled with a community-based doula used prenatal care (a median of 8 visits for those enrolled in the first trimester, 6 visits for those enrolled in the second trimester, and 4 visits for those enrolled in the third trimester), and all had at least one maternal and one pediatric visit postpartum (higher median visits with longer postpartum doula services).

EPIDURAL USE (VAGINAL BIRTHS ONLY)



Spotlight on Tribal Communities: A small, but important, number of American Indian participants were served by community-based doula programs in this cohort (4.6%). The community-based doula site at Great Lakes Inter-Tribal Council, which served 4 different Tribal communities, experienced a number of positive health outcomes including high breastfeeding rates and low C-section rates. The breastfeeding initiation rate of 83.9% exceeds the Healthy People 2020 goal of 81.9% and the C-section rate of 25% is lower than the 28.6% American Indian rate in 2012. These results indicate that providing community-based doula services is not only effective in Black and Hispanic communities, but also in Tribal communities.

GREAT LAKES INTER-TRIBAL COUNCIL OUTCOMES

Breastfeeding Initiation Rate	83.9%
Breastfeeding rate at 6 months	28.6%
C-Sections	25%
Epidural Use	75%

Cost Savings: The current outcome analysis provides limited but useful information on cost savings for community-based doula programs. The variability in size of the programs, size and complexity of host organizations, quality of program implementation, and use of funding, as well as the short program duration, hampered the ability of the Expert Panel to arrive at definitive estimates of return on investment. Nevertheless, program outcomes demonstrate some immediate cost savings and suggest additional long-term costs savings in the following areas:

- Higher breastfeeding rates lead to both short and long term cost savings for both mother and baby in the form of avoided illness and chronic disease. Over the long term, the cost of suboptimal breastfeeding in the U.S. is estimated to be \$13 billion per year for pediatric costs and an additional \$18.3 billion per year in maternal health costs.^{xiv xv}
- Each avoided C-section provides \$4,459 in medical care savings (Medicaid costs).
- Each avoided epidural provides \$607 in medical care savings (Medicaid costs).

Limitations of Comparison Data: The comparison data used for the analysis of outcomes of the Community-Based Doula Program were useful for benchmarking the outcomes shown in *Doula Data* but also included a number of limitations. The participants served by community-based doulas experience complex health and social challenges that are known to increase adverse birth outcomes. The PRAMS comparison data, even with populations restricted to Black and Hispanic mothers eligible for WIC, might not be the most appropriate data for this population. Future comparison data (e.g. Medicaid data) should include mothers with a more similar set of challenges.

Given the important and significant outcomes identified in this small data set, continued research on the Community-Based Doula Program is recommended in order to better understand the positive impact of the program, potential opportunities to take the program to scale, and identification of cost savings.

D. Beyond Data: The Story on the Ground & Three Case Studies

The Community-Based Doula Program relies upon active collaboration between the Leadership Institute and program sites, and between program sites and community stakeholders. This reciprocal and respectful relationship empowers local leaders, and builds capacity. Although this asset-building can be hard to measure, any description of the program's benefits must include these factors. In particular:

- **Partner Capacity-Building:** The Leadership Institute provides extensive technical assistance to support Partner Sites. This work is devoted to empowering local champions, building organizational capacity and enabling long-term sustainability. Through the course of the work described in this report, a total of eight nonprofits received approximately 5700 hours in direct support from the Leadership Institute (site visits, meetings, Training of Trainers, etc.).
- **Workforce Development:** A total of 156 women received training during the period covered by this report, and an estimated 40 women were employed as Community-Based Doulas.
- **Community Change:** The Community-Based Doula Program, which brings partner organizations together with their constituencies in authentic Stakeholder Meetings, is often a catalyst for change.

The testimonials on the next three pages provide brief case studies illustrating these benefits.





Transforming Communities over Time

“I just think that if we didn’t have this opportunity... we would still be stuck.”

- Jennifer Bouley, Program Coordinator and Community-Based Doula with the Red Cliff Band of Lake Superior Chippewa Community-Based Doula Project (Wisconsin) 2012.

“

I am from the Bad River Band of Lake Superior Ojibwe. However, I work and reside at Red Cliff Band. I am a community-based doula and program coordinator. The Red Cliff Band and Bad River Band were two of the four sites that were convened as a consortia of tribes to implement the community-based doula program. . . . There is a historical animosity and mistrust that has developed over the years between these two bands.

We ended up with a really good core group of 13 [women to be trained as community-based doulas]. That 20 week journey was really like birth. It started -- everyone was excited and happy and excited about the work -- then it got harder. Then people started to resist a little bit, challenges came, barriers were there. This group and this curriculum and the circle that we created really afforded the opportunity for these women to hash it out and get down to the nitty gritty and say what is it that we are holding onto. Was it tough? Yeah, it was really tough. Were there tears? Heck yeah. Lots of tears, especially on my part, but those tears were healing tears ... and it was necessary to go through that to get beyond it, to get to a place of light and hope and to really see where we stood as sisters on the circle.

And so our experience was really necessary... I can’t tell you how valuable it’s been and what types of connections and relationships that have born out of the process and we really have a deeper connection and deeper respect. I just think if we didn’t have this opportunity through HRSA and HC One, we would still be stuck.

”



Developing a Workforce

“The impact of the Community-Based Doula Program is not always easy to see when you look at the numbers.”

- Molly Chapell-McPhail, Director and Supervisor, BirthMatters, ReGenesis (FQHC, urban/rural communities – South Carolina) 2012.

“ The impact of the Community-Based Doula Program in the two communities [urban and rural] is not always easy [to see] when you look at the numbers. A good example is when we ... provided the Breastfeeding Peer Counselor training to the community-based doulas to enhance their information around breastfeeding, and we included two mothers we have served to attend this. They were big advocates for breastfeeding, had babies in our program and were very interested in receiving the training. As a newly trained Breastfeeding Peer Counselor, a mom was hired by the local WIC office to provide breastfeeding support to her peers. This story does indicate how impactful this program is on the community, the mothers, babies and the larger community. This graduated mom is now a board member for BirthMatters and she remains employed at the local WIC office.

”

BirthMatters/ReGenesis results confirm that this approach is working: 80% of their mothers initiate breastfeeding, and 32% are still exclusively breastfeeding at 6 months.





Connecting the Dots: Fostering Integrated Solutions

“We now have two [medical] providers very supportive and supportive of the program and [who] allow our doulas to provide prenatal education while waiting to be seen.”

- Lizette Pacheco, Program Supervisor,
Migrant Health Promotion (South Texas) 2012.

“ I oversee the doula program in South Texas, right next to the border. We have had the doula program for seven years and through this HRSA funding, we were able to provide services to first-time moms. ... [Providing] doula support services in the valley [is] not very common or known in the area, so we established very good relationships with providers. We now have two providers very supportive and supportive of the program and [who] allow our doulas to provide prenatal education while waiting to be seen – a way for doulas to identify patients that would benefit from the services as part of our outreach services beyond the door-to-door approach in the rural colonias. The providers are supportive and know what the doula goals are and program outcomes. They are helpful and they have provided letters of support and whatever we need from them. It has been a great blessing because when we started, we didn’t have that support from providers. This can all be obtained by being persistent and really enjoying the work that you do, which is what my staff and I have for the work of the doula and the needs of the community. ”



THE PERINATAL REVOLUTION



Photo by Flint Chaney

PART FIVE

EXPERT PANEL RECOMMENDATIONS & NEXT STEPS



V. EXPERT PANEL RECOMMENDATIONS & NEXT STEPS



THE HRSA/CDC “PROMOTION AND SUPPORT OF COMMUNITY-BASED DOULA PROGRAMS” EXPERT PANEL PROVIDES THE FOLLOWING SUMMARY RECOMMENDATIONS:

- HRSA should continue to promote and expand the Community-Based Doula Program with federal funding, based on the uniqueness of the model, the workforce development implications, and the data analysis which identifies significant and important program outcomes;
- The most compelling data findings were the high breastfeeding rates and low c-section rates; further research funded at the federal level is essential to deepen the evidence base and to clarify best practices;
- High quality implementation of the model is critical to achieve strong positive outcomes; replication sites should seek community-based doula program accreditation to ensure quality programs; and
- Sustainability of this model requires integration of the program into a variety of systems and venues.

Detailed recommendations are made in three major areas:

(1) Data/Evaluation, (2) High Quality Program Implementation, and (3) Systems/Sustainability.

(1) Data/Evaluation Recommendations

Program Evaluation

Future implementation of community-based doula programs should include an external evaluation process that starts from the inception of cohort replication.

COMPARISON DATA FOR EVALUATION

- Appropriate comparison data should be identified early in the evaluation process that matches the characteristics of the target populations served.
- Obtaining Medicaid data to be used as comparison data should be considered a priority given it offers the best potential for an appropriate comparison with the populations served.

Future evaluation should include qualitative methods in order to further tell the stories of community-based doula programs and capture community impact.

The potential for community-based doula to meet additional MIECHV (Maternal, Infant, and Early Childhood Home Visiting) benchmark areas beyond “improved maternal and newborn health” (such as “improvements in

the coordination and referrals for other community resources and supports” and “child abuse, neglect, or maltreatment”) should be explored in future research and evaluation of the program. A current Maternal, Infant, and Early Childhood Home Visiting (MIECHV)-funded randomized controlled trial of community-based doula integrated with approved home visiting programs in process in Illinois may provide some of this information. Home visiting programs are an important system for integration, which is recommended in more detail on page 43 of this document.

Other areas for further research and evaluation include workforce development and cost savings.

Quality Improvement and Program Monitoring

HRSA and the Leadership Institute should collaborate with program sites to employ continuous quality improvement activities and program monitoring throughout the implementation process.

The Community-Based Doula Accreditation Program (CBDAP) should be used to assess the quality of implementation at sites, as the CBDAP has developed standards and indicators for high-quality programs through a collaborative process involving experienced program representatives over two years.



Future evaluation should include an analysis of the relationship between meeting Accreditation standards and indicators, and health outcomes.

Doula Data, a web-based data collection system developed specifically for community-based doula programs, should continue to be required to be used by sites in order to collect universal, comparable data on program process and outcomes for evaluation and monitoring purposes. HRSA’s grant-funded community-based doula programs have been required to use this system for the past two years in order to enable multi-site evaluation of consistent and comparable data.

Program Cycle Length

Length of the program cycle should be greater than two years, determined by a number of considerations including but not limited to:

- Sites’ past and current experience in providing direct services/support to pregnant and parenting families; and
- Location of site (rural vs. urban) – rural sites may take longer to reach the same number of participants served as urban sites.

(2) High Quality Program Implementation Recommendations

High quality implementation of community-based doula programs is critical to achieve strong outcomes. Recommendations include guidelines for both replication sites and for the technical assistance and support provided to those sites.

Site Requirements

1. The Community-Based Doula Program should serve low-income, underserved populations in both rural and urban areas. The target population should include but not be limited to first time parents, a limitation which had been required in the first four years of HRSA funding. Participants should also include those identified by the community which may include teen parents and families facing substance abuse, intimate partner violence and other adverse challenges.
2. Community-Based Doulas must be full-time salaried employees with benefits who are hired from the community that will be served by the program,^{xvi} in order to optimize program outcomes and limit turnover.
3. Every attempt should be made to hire a supervisor from the target community and/or from the “birth community.”
4. Training for supervisors and administrators of the program includes but is not limited to:
 - Participation in the Training of Trainers (TOT)
 - Training/awareness of the communities and cultures the program will serve
 - Training or exposure to what occurs at the time of birth to better support doulas and their work at hospitals
 - Supervision strategies for helping doulas manage their non-traditional hours
 - Team building exercises between doulas and supervisors
5. All sites are expected to use an approved curriculum, specifically developed for community-based doula training, to include:
 - a. A popular education/experiential learning approach,
 - b. Requirements for pregnancy, birth and postpartum observation experiences for trainees including:
 - Medical provider visits
 - Home visits
 - Labor/Birth training course
 - Breastfeeding training course
 - Labor, birth, recovery
 - c. Information on the following topics:
 - Standards and Limitations of Community-Based Doula work
 - Communication, family involvement, and home visiting
 - Goal setting

- Pregnancy and prenatal doula work
- Labor and delivery
- Doula support during labor and delivery
- Obstetrical routines and interventions
- Loss and unexpected events
- Infant health and development
- Maternal health
- Breastfeeding
- The context of community-based doula work

In consultation with the Leadership Institute, sites will adapt the curriculum to ensure it is culturally appropriate for the target population being served while maintaining fidelity to the model.

6. All prospective and chosen sites should understand that working towards Accreditation is an expectation and will ensure the highest quality outcomes for the staff, families and community served.

Program Technical Assistance and Support

1. A Leadership Institute to provide training, technical assistance, and cross-sited evaluation is critical for high quality implementation of the model. HRSA should select the Leadership Institute prior to site selection. The Institute should provide guidance and expertise to HRSA in choosing sites.
2. Readiness is an essential component that prospective sites must assess in order to understand how replication or expansion fits into the service delivery system of health and early learning in their community and how it connects to their mission. Prospective sites, HRSA and the Leadership Institute need a clear understanding of how ready a site is prior to it being selected. Therefore it is strongly recommended that this process happen during the application process and sites are not chosen without a comprehensive readiness assessment. This should be included in either the Letter of Intent or in the Request for Proposal process. Planning grants should be considered for sites who have demonstrated community need and a commitment to replicate, but who need time to build capacity and infrastructure.
3. HRSA and the Leadership Institute need to provide technical assistance during the planning process and implementation of the Community-Based Doula Program in order to prepare sites for obtaining Accreditation, to achieve optimum program outcomes. Funded partly by HRSA, the Community-Based Doula Accreditation Program (CBDAP) was developed in a two-year collaborative process to identify standards and indicators for high-quality program implementation. HRSA should provide clear guidelines on how funding can be spent for obtaining Accreditation.

(3) Systems Integration/Sustainability Recommendations

The Community-Based Doula Program, which exists at the intersection of health promotion, health care delivery, and early learning, should similarly be integrated and expanded in more than one system. There is not one “best” system or venue for integration of the community-based doula model, in part because it spans siloed systems, and in part because its community-focused approach requires more than one option to meet individual community need and community capacity. However, it is recommended that strategies for expansion and sustainability be focused primarily on the opportunities afforded by innovations and policy change driven by the Affordable Care Act, and secondarily on more immediate opportunities. The Affordable Care Act creates opportunities for long-term integration and sustainability in efforts to improve the delivery of health care. While discretionary, grant-funded programs are important, integration of community-based doula programs with mandatory programs may lend itself to a more long-term solution. Given the current fragmented delivery systems and fragmented funding streams, implementation of health reform is an important opportunity to offer the Community-Based Doula Program as a solution to meet multiple objectives, including increased access to care, improved health outcomes, and systems integration.

1. Integration of the Community-Based Doula Program within the overall implementation of the Affordable Care Act is strongly recommended as a key long-term strategy for sustainability, particularly through community health centers, home visiting and the promotion of community health workers.

COMMUNITY HEALTH CENTERS (CHCs), expanded with ACA funding, are poised to play an essential role in the implementation of the ACA by emphasizing coordinated primary and preventive services, or a “medical home” that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations using a health care team approach. Community-based doulas are currently integrated into a number of CHCs, providing the opportunity to share best practices. The outcomes of the Community-Based Doula Program support the maternal and child health objectives promoted via CHCs.

Federal Agency Implementation Co-Leader

The HRSA Maternal and Child Health Bureau (MCHB) should work with the HRSA Bureau of Primary Health Care (BPHC) to:

- Recommend and support the incorporation of community-based doulas into the healthcare team, in the context of a team approach with clinical and community expertise and strong reflective supervision.
- Recommend the use of community-based doulas to extend the work of the healthcare team outside of the walls of the clinic (into the home and into the hospital) and to assist in the integration of additional services at the CHC (e.g. breastfeeding support, perinatal depression screening).



- Provide Community-Based Doula Program funding as a supplement to each CHC and part of startup funding for new grantees, with clear guidelines on how money is to be spent and how the program is to be integrated in the CHC. This language should be included in the guidance, and sites should be expected to implement the program, in the same way that they are expected to integrate dental and mental health.
- Require sites to follow the attached recommendations for high quality implementation of the Community-Based Doula Program.

Federal Funding

In addition to providing clear guidelines on the ability of CHCs to use federal grant (“Section 330”) funding for the Community-Based Doula Program, the HRSA MCHB and BPHC should also work with the Centers for Medicare and Medicaid Services to allow CHCs to bill Medicaid for Community-Based Doula Program services.

Public/Private Partnerships

The HRSA BPHC should work with the National Association of Community Health Centers to promote public/private partnerships in support of integration of the Community-Based Doula model in CHCs.

HOME VISITING EXPANSION, including HRSA’s Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), and the Administration of Children and Families (ACF) Home Visiting Program, represents a core investment in early learning by the ACA. The outcomes of the Community-Based Doula Program support the early learning objectives promoted by MIECHV. Opportunities for integration of community-based doula programs in home visiting systems should be maximized.

Federal Agency Implementation Co-Leader

The HRSA MCHB should work with the HRSA Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), as well as the Administration of Children and Families (ACF) Home Visiting Program to:

- Incorporate community-based doulas into the home visiting team, in the context of a team based approach with clinical and community expertise and strong reflective supervision. Community-based doula programs sit at the intersection of early health and early learning: for MCH programs they add support for early parenting and attachment; for early learning programs they add MCH promotion (e.g. breastfeeding support and family planning).
- While awaiting results from the MIECHV-funded randomized controlled trial of the Community-Based Doula Program, promote integration with the following approved MIECHV programs:
 - a. Early Head Start
 - b. Parents as Teachers
 - c. Healthy Families
 - d. Nurse Family Partnership
- Consider integration with additional approved MIECHV programs that are also at the intersection of early health and early learning.

Federal Funding

HRSA and ACF should provide clear guidelines to states encouraging the use of MIECHV funding to integrate community-based doula programs in approved home visiting programs, with detail on how funding can be spent and how the program is to be integrated into the home visiting team. HRSA and ACF should work with CMS to allow for Medicaid reimbursement for community-based doula services within home visiting programs.

Public/Private Partnerships

HRSA and ACF should encourage relationships with private funders to complement federal funding for incorporation of community-based doula programs into home visiting teams.

COMMUNITY HEALTH WORKERS (CHWs). Given that community-based doulas are CHWs, and given that Section 5313 of the Affordable Care Act (ACA) authorizes CHWs in the Public Health Service Act, including a definition of a perinatal role, HRSA should explore and understand the opportunities and challenges of CHW certification and promotion. Sustainable federal funding for CHWs is at an early stage; new initiatives within the Centers for Medicare and Medicaid Services, CDC, and HRSA are promising, and should be considered within this context.

2. Other innovative health care delivery structures

including Accountable Care Organizations, Community Care Organizations, and a health care team approach, will have long-term implications for Medicaid and other reimbursement systems. Though the process of development is young, these systems are important to the future of Community-Based Doula Program sustainability, as are the expansion of population-based health promotion strategies.

OTHER INNOVATIVE HEALTH CARE DELIVERY STRUCTURES

Federal Agency Implementation Leader

The Centers for Medicare and Medicaid Services (CMS) should lead, organize and fund a research study of community-based doula integration in Accountable Care Organizations, Community Care Organizations, and other innovative health reform systems. Health Care Innovation Grants funded by CMS currently include CHWs, providing an opportunity to share lessons learned.



POPULATION BASED HEALTH PROMOTION

Federal Agency Implementation Leader

The Centers for Disease Control and Prevention should request that the National Center for Chronic Disease Prevention and Health Promotion explore community-based doula integration in population-based health promotion systems, including Community Transformation Grants and other opportunities for innovative systems integration. Community-based doula programs integrate chronic disease prevention using a life course approach addressing health promotion and cost savings for mothers and babies beginning in the reproductive period.

Federal Funding

- CDC should integrate community-based doula programs in initiatives to promote breastfeeding.
- CDC should develop appropriate guidelines and funding mechanisms.

3. Maternal and Child Health Bureau grant-funded programs have led the development of community-based doula programs. MCHB has been the clear leader for this program, and should continue to integrate community-based doula into relevant grant-funded programs.

Federal Agency Implementation Leader

The MCHB within HRSA should:

- Provide grant funding for Community-Based Doula Program implementation within Title V, Healthy Start, and other infant mortality initiatives.
- Require sites to follow the attached recommendations for high quality implementation of the Community-Based Doula Program.

Federal Funding

The MCHB within HRSA should

- Specify in the guidance for Title V and Healthy Start that funding may be used for Community-Based Doula Programs.
- Designate funding for continued research on Community-Based Doula Program effectiveness given promising early outcomes.

Public-Private Partnerships

MCHB should work with the Association of Maternal and Child Health Programs and the National Healthy Start Association to promote public private partnerships for Community-Based Doula Program expansion.

A close-up, slightly low-angle shot of a baby's face. The baby is wearing a dark-colored beanie with a light-colored geometric pattern. They are wrapped in a thick, textured knit blanket. The baby's eyes are wide open, looking upwards and slightly to the right. The background is out of focus, showing what appears to be a wooden railing or fence.

THE PERINATAL REVOLUTION



Photo by Brenda Reyes

PART SIX

CONCLUSION: THE WIDER PERSPECTIVE
& MOVING FORWARD

VI. CONCLUSION: THE WIDER PERSPECTIVE & MOVING FORWARD

The recommendations of the Expert Panel mark a milestone in the development of the Community-Based Doula Program. This is the first new multi-site data analysis since the evaluation of the Chicago Doula Project in 2001, and it documents important health outcomes, similar to those in the original pilot. The consistency of the high breastfeeding rates in particular – across the board, regardless of the setting and the population served – is a striking validation of the effectiveness of the model. This is also a moment of tremendous innovation in the field of early health and early learning. The implementation of the Affordable Care Act has opened up a reevaluation of health care delivery systems. The new public health focus on a life course perspective and on the social determinants of health is building the case for investments in community-based health promotion models, and for national investment in maternal and child health and early learning. There is a growing understanding that investments in pre- and inter-conceptional, pregnancy, birth and early childhood support are essential for the health of our population and our economy.

It has been said that the newest idea is 5,000 years old. The Community-Based Doula Program brings forward the ancient practice of women of and from the same community helping other women, this time in a new context, at a time when health care delivery is changing dramatically – and is open to innovation to an unprecedented extent. This country is recognizing that the current system is too expensive and not effective, that disparities in health and development must be decreased, and that if we don't act now, the burden of obesity and chronic disease will limit our national productivity and our economy for generations to come.

The community-based doula is a role that makes use of social capital and of the power of relationships to improve health and development in communities facing huge challenges. The Community-Based Doula Program integrates community experience with systems of care at a powerful moment in the life of families.

The Expert Panel recommends to HRSA that it continue to promote and expand the Community-Based Doula Program with federal funding, due to the uniqueness of the model, the significant and important outcomes demonstrated in this analysis, and the substantial community impact of the program.

The time is now; there is much work to be done.



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Photo by Flint Chaney

PART SEVEN REFERENCES & ENDNOTES

VII. REFERENCES AND ENDNOTES

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- ix. Outcomes for c-sections, epidurals, skin-to-skin contact, alternative pain management techniques, breastfeeding, premature births, low birth weight, and health care utilization were analyzed using *Doula Data*. Outcomes for c-sections and breastfeeding were compared with PRAMS benchmarks. Outcomes for epidurals were compared with 2008 data from Standard Certificate of Live Births. Skin-to-skin contact was compared to the CDC National Survey of Maternity Practices in Infant Nutrition and Care (mPINC)–2011. There were no similar comparisons available for alternative pain management techniques and health care utilization. PRAMS include data from states where community-based doula sites were located (TX, GA, PA, WI, NJ, NY) with the exclusion of South Carolina (data did not meet the threshold). PRAMS data were not available from Texas for 2008 on breastfeeding initiation or from NY state for 2009 on breastfeeding initiation. Data on breastfeeding duration and exclusivity at 3 and 6 months is information from the state supplemental PRAMS surveys; and a smaller subset of data from 6 states (TX, GA, PA, WI, NJ, NY) was used in the analysis. Given that the majority of doula participants were Black (33.1%) and Hispanic (47.1%), data was analyzed for these two race/ethnicities. Since the majority (86.6%) of doula participants received WIC, PRAMS data was also restricted to WIC participants. WIC was used as an indicator for low income.

- x. *Doula Data* includes 7 sets of twins which could skew the data in such a small sample. PRAMS data is weighted by state but *Doula Data* is not. Some outcomes vary significantly by state. Limitations in the data include a small data set from eight diverse settings, variations in the quality of implementation of the doula program over short time frames and in a variety of settings, and the quality of comparison data sets that were available for the analysis within a short time frame. The short funding periods (2 years) and variations in the length of follow-up with participants at each site contributed to the inconsistent amount of follow-up data.
 - xi. Altfeld, S. (2001). *The Chicago Doula Project Evaluation final report*. Chicago: The Ounce of Prevention Fund.
 - xii. The short funding periods (2 years) and variations in the length of follow-up with participants at each site contributed to the small size of participants that had available data for breastfeeding at 3 and in particular 6 months. In addition, the rate of initiation in the PRAMS data is not consistent with other national statistics for breastfeeding, which are generally reported as being much lower than PRAMS data suggest, for both Black mothers (59.7±2.9) and Hispanic mothers (80.6±2.4).
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 - xvi. There is ongoing conversation and some controversy in the CHW/ Promotores community about the definition of CHWs. The Community-Based Doula Program has defined a CHW as “a trusted member of the community being served,” while some use a broader definition similar to “a health professional who applies his or her unique understanding of the experience, and/or culture of the populations he or she serves.” (Community Health Workers: Essential to Improving Health In Massachusetts, Massachusetts Department of Public Health, 2005.)
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PART EIGHT

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VIII. APPENDIX

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50 National Community-Based Doula Program Sites as of 2014

AZ	PHOENIX	Tanner Community Development Corporation
CA	EL SEGUNDO	South Bay Center for Counseling
	MERCED	Healthy House in a MATCH Coalition
CO	DENVER	The Haven & the University of Colorado Irving Harris Program in Child Development and Infant Mental Health
GA	ATLANTA	Families First & Georgia Campaign for Adolescent Pregnancy Prevention
IL	CHICAGO	There are 22 sites in Chicago and Illinois, including UCAN, Access Community Health Network+
IN	INDIANAPOLIS	IPN MOM Project
	BLOOMINGTON	Bloomington Area Birth Services
MI	DETROIT	Focus: Hope; Community Health and Social Services Center (CHASS); Black Mothers Breastfeeding Association
MN	MINNEAPOLIS	University of Minnesota Harris Center
	ONAMIA	Mille Lacs Band of Ojibwe
MO	ST. LOUIS	Queen of Peace Center
MS	TUPELO	Northeast Mississippi Birthing Project
NM	ALBUQUERQUE	New Mexico Community Health Workers' Association
	ESPANOLA	Tewa Women United
NJ	ELIZABETH	The Partnership for Maternal and Child Health of Northern New Jersey
NY	BROOKLYN	Brooklyn Young Mothers Collective
PA	PHILADELPHIA	Maternity Care Coalition
	PITTSBURGH	The Birth Circle
SC	SPARTANBURG	Birth Matters, ReGenesis Health Center
TX	FORT WORTH	The Natural Way Birthing Project
	DALLAS	Migrant Health Promotion
	HOUSTON	Healthy Family Initiatives
WA	SEATTLE	Open Arms Perinatal Services, teaming with Thrive by Five
WI	BELOIT	Rock-Walworth CFS, Early Head Start
	LAC DU FLAMBEAU	Great Lakes Inter-Tribal Council, Inc



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