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Negotiating boundaries in birth

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Introduction

Doula work involves a physical, emotional, and advocacy relationship between women and others. Doulas are birth companions who work with laboring women and, often alongside, other care professionals including obstetricians, midwives, and nurses whose responsibilities, unlike doulas, center on clinical tasks. Doulas often describe their work as “holding the space,” their community as a “sisterhood ministry,” and their presence at a birth as “an honored guest.” Doulas wipe foreheads, share supportive words, and hold hands with laboring women, and when they walk away from a woman and her newly delivered baby, they carry personal knowledge and information about that woman.

Doulas have no clinical training and are non-medical professionals but a growing body of research suggests that the presence of a doula supports physiological birth and healthier outcomes for mothers and babies (Hodnett 2002; Hodnett et al. 2011; Gruber et al. 2013). The very nature of doulas’ intimate labor provides a unique analytic to engage the often contentious debates around reproductive care. Doulas move in and out of private and public places and build relationships that traverse families and institutions. Doulas also provide a way to think through the complexities surrounding reproduction precisely due to their ability to navigate between and across boundaries.

The term doula entered academic literature in 1973, when medical anthropologist Dana Raphael used the word in her book The Tender Gift to describe the importance of supporting a new mother for successful breastfeeding results. Raphael continued her research on doulas and their relationship with midwives through her focus on breastfeeding outcomes. In her 1981 article, “The midwife as doula: A guide to mothering the mother,” she described a doula as “the caring person” who helps make breastfeeding successful, “someone who literally mothers the new mother and offers continuous encouragement. Too little mothering, and no doula, means not enough milk” (Raphael 1981: 13). In the decade following Raphael’s work, pediatricians Marshall Klaus and John Kennell, along with their co-authors, published extensively about doulas (1991, 1992, 1993, 1997, 2002). Kennell and Klaus (1997) conducted clinical trials on maternal-infant bonding and determined that the continual support of a doula not only benefited bonding but also decreased complications. They published The Doula Book (2002), along with Phyllis Klaus, which targeted a non-academic audience and drew on their previous decade.
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of research to define a doula as a “woman experienced in childbirth who provides continuous physical, emotional and information support to the mother before, during and just after childbirth” (Kennell et al. 2002: 3). In their work, Klaus and Kennell highlighted the emotional and physical impact of keeping mothers and babies close together in those first critical hours after birth. As later scholars would cite, this study validated “the power of relationship-centered care within childbirth … and greatly influenced the development of the humanistic dimension of labor support—the doula” (Morton 2014: 76).

Doulas in their current form arose in the US from the 1970s women’s health movement. But across cultures and time, other women have been present during birth to support birthing women. Prior to the medicalization of birth in industrialized countries, women supported each other during their childbirth and postpartum periods (Raphael 1973; Leavitt 1986; Morton 2014). As midwives were pushed out of birth practices in North America, and obstetricians and hospitals became the standard of care for women giving birth, the practice of women attending to each other sharply declined (Leavitt 1986). The women’s health movement in the 1970s drew critical attention to highly medicalized births and clinical practices around reproduction (Phillips 1973; Morgen 2002). Scholars like Barbara Katz Rothman (1982) and Robbie Davis-Floyd (1992) drew on the work of the women’s health movement to outline different models of care that articulated two models of care: A dominant technocratic or medicalized model and the midwifery model. The practices of homebirth, midwifery, childbirth education classes, and a return to women–supported labor emerged out of and in response to the women’s health movement. The women’s health movement responded to the patriarchal nature of biomedicine by advocating for relationship-centered healthcare (Sharma 2019).

On the heels of the women’s health movement, professional doula organizations began to form. The first, Doulas of North America (DONA) International, was founded in the United States in 1992 by childbirth educators and physicians including Penny Simkin, Phyllis Klaus, Annie Kennedy, and Kennell and Klaus (DONA 2019). As women recognized the positive impact continuous emotional and physical support could bring to women in labor, more women came to work as doulas, and professional organizations rose up to create training and certification. The professional doula movement was founded by and served an overwhelming majority of women who identified as White, heterosexual, married, and college-educated. As the movement has expanded, there is increasing diversity, including a push towards expanding the role of community doulas who support specific socioeconomic, racial, and nonbinary communities. Today dozens of doula certifying organizations exist around the world. Doulas are self-employed entrepreneurs, members of collectives, employed by hospitals or clinics, and serving their own communities. As professional labor support, doulas have even entered the mainstream media appearing in TV shows and in major national newspapers, despite the fact that they attend only 6% of births in the US (Declercq et al. 2013). And while this chapter focuses specifically on birth doulas, the doula role also includes a full spectrum of reproductive services (Castañeda and Johnson Searcy 2015). Doulas now identify in multiple ways including as specialists in birth, postpartum, adoption, abortion, and death. Some doulas see themselves as active agents or part of the “the birth justice wing” (Ross 2016: xv) and they seek to apply a social justice lens to maternity health. These doulas work for reproductive justice, pushing for comprehensive sex education, reproductive rights to contraception, the right to give birth, the right not to give birth, and the right to safely parent (Mahoney and Mitchell 2016). As doulas roles expand, so do the spaces they work; doulas now work in homes, birth centers, hospitals, clinics, and prisons.
Doulas around the world

The majority of research on doulas cited in this chapter was conducted in the United States, yet we know that a global doula phenomenon now exists as evidenced by the increasing understanding that a witness at birth contributes to better outcomes for mothers and babies. For example, the 2015 World Health Organization Safe Childbirth Checklist made birth companions one of the recommendations. Of the six items recommended for safe childbirth number five on the list includes, “Encourage birth companion to be present at the birth” (WHO 2015). By encouraging birth companions, WHO’s Safe Childbirth Checklist acknowledges the critical role of supportive nonmedical companions at birth. This emerging validation from large international public health organizations, like WHO, bolsters the position of doulas entering clinical spaces who can encounter negative perceptions from nurses and doctors (Roth et al. 2016; Papagni and Buckner 2006). In an effort to legitimize their presence in medical institutions, doulas use training and certification programs.

Doula training now exists in many countries around the world, varying from a few days to several months. For example, Doulas of North America (DONA), the world’s first and largest certifying doula organization, cites certification of over 13,000 doulas in 56 countries. This push towards the professionalization of the doula role is connected to the increased medicalization of birth as well as an attempt by doulas to gain legitimacy when working within medical institutions. While we identified nearly 50 training and certifying organizations, the majority of these organizations are based in North America, with some expanding to international settings. Research supports the act of a woman accompanying another woman in labor as rooted in historical traditions across cultures (Morton 2014), yet the formal doula role has been incorporated to different degrees around the world.

Context, and in particular the type of healthcare system, matters when assessing doula presence. No research exists looking at global doula trends but some general patterns emerge. In places like the United States, with overly medicalized private health systems, doulas developed in response to the emotional and social gaps for women in labor. In state-sponsored public healthcare systems of many non-industrialized countries, where women have very few options, birth companions are not typical. Where maternity care takes place in industrialized countries with health systems that rely on midwifery, doulas have only recently begun to practice as the importance of continuous care becomes a focus. For example, in the United States doulas emerged in the 1980s as a response to the overmedicalization of births, and they provide “a consumerist and woman-centered response to the need for emotional and informational support during this significant life transition” (Morton 2014: 99). Women in the United States lacked midwifery care options, so doulas served as emotional advocates in a system that lacks emotional accountability, however, in other parts of the world with more rooted midwifery-based models of care, we find fewer women using doulas, reflecting models that prioritize relationship-based care.

In Mexico, and throughout many Latin American countries, births are highly medicalized especially at public hospitals, and child-bearing women are not familiar with doulas. Vania Smith-Oka’s work in a public hospital in Mexico identifies the inconsistencies in birth systems between Global North and South countries. She argues “support companions are often denied access to laboring women … [and] there is little choice offered to the patients about what their birth should entail” (Smith-Oka 2015: 173). Instead, we find an attempt to incorporate the doula role through the integration of traditional midwives as labor support (Smid et al. 2010).

When maternity care takes place in state-sponsored health systems open to midwifery, doulas have started to enter hospitals as it becomes clear that midwives in these systems cannot provide continuous care. The United Kingdom, Sweden, and Australia are examples of this (Lundgren...
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2010; Fearn 2015; Fromberg 2019). In Sweden, where midwives attend women in hospitals, doulas are a rarity within the public healthcare system (Lundgren 2010). In the UK as the funding cuts mean midwives are stretched thin, doulas have entered hospitals in the last decade (Fearn 2015). A similar narrative about the importance of labor support emerged recently in Australia (Fromberg 2019). However, more recently we are seeing possibilities for increased doula care as part of healthcare systems. For example, in Australia, where doulas were described as relatively new in 2008 (Cencighalbulario 2008), demand for their services has been increasing, prompting a recent government-accredited six-month program created to certify Doula Support Services (Steel et al. 2013).

It is clear that there is a need for more research to explore the impact of cultural context on how doulas operate. How does the type of healthcare system affect the role doulas play? How do types of markets and capitalism impact the way doulas fashion themselves as professionals? In 2018, prominent obstetrician Michel Odent wrote about a global doula phenomenon in Midwifery Today. His article identifies the basic needs of a laboring woman and consequently the presence of a doula at a birth to help provide this basic need, writing, “a labouring woman needs to feel protected against all possible stimulations of her neocortex. The keyword is protection” (Odent 2018). Odent asserts that we find a global doula movement because “Many pregnant women have expressed their feeling that the current health systems—whether public or private, and whatever the country—cannot ideally satisfy their needs.”

Current challenges

What does the presence of doulas tell us about our current system? As Morton and Clift (2014) note,

The presence of doulas is both a critique of the current system for not being centered around women’s emotional experience of birth and a solution to this critique: the labor support role is a complement to existing clinical roles within the current system of medicalized birth.

However, scholars such as Norman and Katz Rothman question whether doulas are engaging in a critical role or “just making women feel better about their births” (2006: 281). Our research suggests that respectful birth matters and we respond to both of these possibilities by using the voices of doulas and mothers to argue that the presence of a doula in an institutionalized birth setting goes beyond critique or complicity to form an act of resistance. As Janis, a senior doula in our research, affirmed, “it’s a mistake to think that the very act of having someone in the room caring for emotions is not a radical act.” Our research seeks to move beyond a restrictive reductionist understanding of the role of birth doulas to better understand the relationship between birth outcomes as well as how women are made to feel during birth.

In 2011, we began collecting ethnographic data on doulas in a small Midwestern city. Using focus groups, interviews, and participant observation, we continued our work through 2019 and during this time have been able to assess changes and challenges faced in this doula community. Some of these challenges, which reflect larger national trends and previous publications, include tension with care providers, a push towards professionalization, and the role of doulas in birth culture.
Tension with care providers

With the majority of births in the United States taking place in institutionalized clinical settings, a common theme across doula research acknowledges the tension between care providers and the need for building teams or alliances across birth workers (Everson and Cheyney 2015, 2017; Gilliland 2002; Hunter and Hurst 2016; Morton 2014; Norman and Katz Rothman 2007; Roth et al. 2016). As doulas enter hospitals, they encounter the medical professionals who work there—principally labor and delivery nurses. In Birth Ambassadors: Doulas and the Re-Emergence of Woman-Supported Birth in America (2014) Morton and Clift describe doulas as “simultaneously powerful and powerless in the hospitalized birth setting” (Morton and Clift 2014: 123). They emphasize the importance of achieving a “satisfying birth memory” (230) for mothers and yet the inability of doulas to be seen as “part of the team” persists as doulas lack buy-in from obstetric professional organizations (263).

In our research, we found tension between labor and delivery nurses and doulas as they struggled to find common ground, each with their own set of expectations and limitations. Much of the tension felt by birth workers stems from territorialism and turf wars. A nurse in our study reported, “It sometimes feels like we’re the enemy,” referring to the way she saw doulas operating in tandem with the couples who had hired them. We argue that tension between nurses and doulas is a result of undefined relationships. Nurses have an institutionalized role with specific tasks to perform; and doulas, as Everson and Cheney point out, occupy a liminal space (2015). Their role at any given hospital birth has to be negotiated and determined by the people present.

Intimate labor is a useful lens to understand the tension in doula work. Using the work of Eileen Boris and Rhacel Parreñas, intimate labor is defined as “work that involves embodied and affective interactions in the service of social reproduction” (2010: 7). It involves bridging intimate care both within and outside of an individual’s home. Doulas cross these boundaries and often blur the divisions between and across public and private spheres in their practice of intimate labor. Doulas often speak of their job as “holding the space” and Hunter points out that this phrase indicates the ways doulas work to create intimacy in institutionalized settings (Hunter 2012). The work that doulas and nurses do gives each a particular knowledge about the birthing body and sometimes when these overlapping, but different kinds of knowledge come into contact, tension emerges.

Nurses draw on the power of their institutional position and their clinical knowledge, while doulas use their unique form of intimate knowledge to assert their right to participate in the work of birth. Doulas see a woman across a longer space of time and work with her in different settings, while a nurse’s institutional and clinical role means they work with a woman in a single location and in a shorter, bracketed time. In their intimate observation and bodily closeness, doulas and nurses also use different tools to access information about the laboring woman’s body. Nurses have a clinical gaze mediated by the use of technology such as electronic fetal heart monitors, IVs, and ultrasound machines. Nurses are insiders in the hospital, evidenced by their authority and use of technology; as insiders, they must work within institutional constraints that may restrict their capacity to meet the nonmedical psychosocial needs of women. Doulas are outsiders in hospital settings whose sole purpose is to provide psychosocial support. As outsiders, inside the hospital, doulas’ liminal status allows the doula to meet emotional and psychosocial needs and at the same time can also be a reason why medical professionals dismiss or undermine their role at a birth (Everson and Cheney 2015). Recognizing the inside-outside position that they occupy, doulas turn to professionalization in an effort to gain respect from medical professionals.
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Push towards professionalization

In the last decade, doula organizations and training programs have proliferated thus contributing to the professionalization of doula work. As Morton and Clift found in their research on doulas, “The multiplicity of doula training organizations today reflects ideological and interpersonal tensions operating at the grassroots level as well as organizational competition for market share for aspiring doulas and pregnant clients” (2014: 96–97). Our research also documents how doulas find themselves navigating the call for certification, contracts, and a more entrepreneurial form of intimate labor. In 2014, we published our first project on doulas, “Mothers, Doulas, Flexible Labour and Embodied Care in the United States” in *Mothering in the Age of Neoliberalism*, where we highlight the complex ways in which doulas articulate their work using a neoliberal frame for market agency while also struggling to configure relationships in ways that resist neoliberal constraints. We concluded that:

Doulas exist at the very intersection of the neoliberal “mother” versus “worker” construct where women are expected to identify in terms of economic agency while also maintaining essentialist conceptualizations of mothering. In their efforts to negotiate these two constructed contrasting logics, doulas turn to professional organizations and marketing techniques in an effort to find spaces that help regulate and mediate the conflict of interest inherent in neoliberal alliances.

(2014: 89)

Doulas turn to professional organizations and marketing techniques to find spaces that help regulate and mediate the conflict of interest inherent in their work (Castañeda and Searcy 2014).

As the majority of births take place in institutional settings, many doulas find certification a form of credibility that enhances their sense of professionalism in the eyes of clinical care providers. Indeed, Norman and Katz Rothman found certification connected to working within the hospital system, claiming, “Certification reinforces the authority of medicine” (2007: 279). Interestingly, we found that doulas did not see certification as an essential component required to appeal to the parents they hoped would hire them, nor did the mothers we interviewed find certification to be of importance when choosing a doula (Castañeda and Searcy 2014). We did find other negative outcomes to certification including, “divisions from within” (Norman and Katz Rothman 2007: 256) as different certification organizations represented different ideological positions.

As the number of certifying organizations expanded, we documented increased tension within our field site. While doulas once worked harmoniously under the umbrella of one nonprofit in the city, the push towards professionalization created a divide between doula work as a business or an identity. Inherent in this conflict were questions about gender identity and work, in particular, intimate labor. We heard doulas express how they often struggle with balancing being “selfless” and “of value.” Doulas described having to navigate this difficult tension—asking to be paid for doula work denaturalized feminine labor. One doula described it this way:

The main model for being a doula is being a mother, and that’s the tricky part. It’s foregrounding a whole set of attributes and qualities that our society doesn’t value: giving, loving, being patient and nurturing. The entrepreneurial stuff is all the things we think of as male: drawing boundaries, putting a price on our work, contracts, running our work like a business, etc. The ideal doula situation is the one that combines both of...
these models because you need that nurturing for the work, but you also need to be able to take care of yourself and that requires setting boundaries and setting a price.

Doulas navigate the boundaries within their own community as they undertake the intimate labor of balancing professionalization with the emotional and spiritual nature of the labor they provide. We found a spectrum of responses to this tension, some doulas struggled to even charge, while others positioned their work as a “luxury service” with accompanying high fees.

In our community, doulas costs range from zero, for a new doula who trades service for experience, to over $1,000 for doulas who charge extra fees or hourly for long births. The consequence of this professionalization has meant an already elite service has become a “luxury service” with further lack of access for marginalized socioeconomic groups. Doulas described their attempts to address inequalities with sliding scales, bartering or trading for their services, or setting aside funds to cover clients unable to afford their services. As new doulas arrived, with certification and highly business-oriented training, rates increased across the board for all doulas. Entrepreneurial doulas defend their position by citing their work to create “a living wage.” However, an increased push towards certification, with higher fees for training and mandatory continued education, meant that even becoming a doula was now cost prohibitive for many. Despite working in a community with only one hospital, today we find a splintered doula community lacking a central network. While doulas express their concern over a loss of community, part of the splintering stems from ideological differences about the monetary value of intimate labor. Doulas recognize that this push towards professionalization creates tension around their services—should birth support be a right all are afforded or a privilege for a select few?

**Role in birth culture**

The intimate labor involved in doula care is not only a source of tension between care providers due to the blurring of boundaries in traditional systems of care and compensation, it also provides a space from which doulas can operate to enact change. While some scholars recognize that doulas want to be change makers, there are also critiques over how powerless they are within a system that treats them as “fourth-class birth workers” (Norman and Katz Rothman 2007: 267). Norman and Katz Rothman write, “Doulas want to see themselves as having the power to effect change in the maternity care system, but they experience their repeated failure at protecting even one woman at a time” (2007: 273). We suggest that this critique does not account for the role in birth culture doulas play. We argue that doulas do provide evidence of improved outcomes for mothers on a large public health scale and that they center embodied experience through personalizing birth in ways that shift birth for individual women and foreground respectful birth in the larger culture.

Doulas impact on large-scale health outcomes for women was demonstrated in 2018, at a crucial moment when the elevated rates of maternal mortality were being discussed and the role of doulas was considered in possible solutions. Everson and Cheyney published “Outcomes of Care for 1,892 Doula-Supported Adolescent Births in the United States: The DONA International Data Project, 2000 to 2013.” Their findings support previous studies on the improved outcomes from doula care, in particular for marginalized and medically underserved communities. Everson and Cheyney call for collaboration between childbirth educators and doulas, and they propose “the implementation of doulas as a cost-effective strategy for improving maternal and infant health outcomes and decreasing inequities among childbearing adolescents” (2018: 145). Like this large-scale research shows, doulas in our study saw personalized doula care as a form of resistance and change to our current medical system.
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In moving between home and hospital, and from physical support to emotional support, doulas recognize the fluid nature of a birthing body, which can be liberating for both the doula and mother. Doulas foreground embodied birth, personalizing their experience and acknowledging that a woman's experience and feeling of her birth have profound and lasting impacts (Forseen 2012; Simkin 1991, 1992). Hunter and Hurst documented the way doulas recognize that part of their work is protecting the embodied process of birth, regardless of the outcome: The role of a doula to support birth as an embodied process with an inward-focused understanding of birth:

Doulas recognized that the embodied experience of birth would be mapped onto memory and subsequently integrated into the woman’s identity as a mother. As a result, doulas recognized that the embodied experience of childbirth should be protected for women not only in the immediate needs of birth, but also for the woman’s integration of that experience into her future life.

(2016: 98)

We argue that personalizing means materializing, uncovering, acknowledging, and respecting a birthing body (Castañeda and Johnson Searcy 2015). Several mothers in our focus groups provided examples of how doulas personalize birth experiences while engaging in resistance. Mothers described being grateful that doulas spoke up to represent their interests when they felt too vulnerable during birth. Sarah described her experience during labor, “At the hospital a group of trainee nurses came in and asked, ‘Can we watch?’ And I remember her [my doula] saying vehemently, ‘No, you cannot. This is not a theatre.’” And after her daughter was born with breathing issues and taken to the nursery, Olivia recalled the role of her doula:

It was important to have the doula with me to keep me distracted and eventually get pissed off after they kept her [my daughter] from me, far longer than the optimal time to latch. Her knowing that it was time to get pissed off was really helpful.

The act of providing personalized intimate labor is rooted in doula practices which are also a form of embodied resistance. In our chapter, “My Role is to Walk the Tightrope: Doulas and Intimacy,” we investigate the importance of personalizing a birthing body in doula work describing it as “a process that highlights the relational nature inherent in doula work, and it emphasizes the intimate and liminal contexts within which doulas operate. These are characteristics of doulaing that open the door to embodied forms of resistance” (Castañeda and Searcy 2015: 136). Doulas engage in embodied resistance when they materialize the birthing body as emotive and layered; a practice that conflicts with a more homogenized institutional birthing body as identified from a clinical gaze. Jane, a veteran doula, identified the difference between standardized and individualized care:

A culture that thinks it’s good to have labor support is a culture that is making better births for women. Because this would mean we would no longer be one-size-fits-all for births. It would be admitting that individual women want different things, whatever that is … it’s a mistake to think that the very act of having someone in the room caring for emotions is not a radical act, because the hospital doesn’t give a shit about her emotions. They’re concerned with did the baby come out and breath? Is she alive at the end? And is the baby alive? That’s what they care about. And they should care about that, I don’t mean to denigrate that at all, that’s extremely important, however it leads them to dismiss what [a laboring woman] is feeling.
Jane demonstrates the way doulas foreground the embodied experience of individual women, in addition to health outcomes for mothers and babies. Everson and Cheney reinforce Jane’s point when they argue, “As laboring women receive messages of compassion and individualized support through their doulas, they may begin a process of unlearning and relearning, emerging confident in the power of their own bodies” (2015: 220).

Doulas also perform the role of educator or information provider, especially involving protection from negative forms of boundary crossing, such as misuse of authoritative knowledge or (mis)informed consent (Jordan 1997; Rapp 1997). As one doula shared, “It’s tricky because what I do as a doula is a dance between honoring what my client wants and what she comes to me with, but in the end, I’m an educator and education is always radicalizing.” Doulas reported the need for care providers to give “trauma informed care and vaginal exams with informed consent” and often helped parents advocate for this kind of care. In one instance a doula took a more active role by repositioning a mother to avoid a threatened c-section recalling,

> It was infuriating when they said the baby had shoulder dystocia, but the baby just had sticky shoulders, and they never repositioned the mom. They were all ready to take her for a c-section, so I finally just repositioned her to hands and knees, and the baby came out.

Another doula watched an obstetrician prepare to perform an episiotomy on a laboring woman without informing her. In prenatal visits with the couple, episiotomies were discussed and the mother made her preference against one very clear. The doula discreetly pointed out to the husband what led to him questioning the obstetrician. The obstetrician, clearly annoyed, told the mother she was “going to tear anyway” and needed his help. The mother told the doctor she did not want his help and was able to avoid an episiotomy.

Doulas can play a critical role in foregrounding the importance of respectful birth. In our research, we heard doulas tell stories of watching disrespectful births unfold. Morton et al. (2018) focus on the consequences of witnessing disrespectful care for doulas and nurses, and Morton and Simkin (2019) define disrespectful maternity care and highlight the importance of adopting safe, respectful care practices which follow World Health Organization recommendations. In particular, they utilize the “take charge routine” as an example of a doula technique used to prevent or reduce postpartum PTSD (Morton and Simkin 2019: 392). The role of a doula in contributing to respectful maternity care is clear, and the authors emphasize the potential long-term impact writing,

> A mother who received respectful maternity care begins parenthood with greater confidence and more rapid healing than one who was treated disrespectfully or injured … It is important for us all to be aware that women will likely remember their labors and births all their lives.

(2019: 394)

As obstetric mistreatment and violence become increasingly visible, our research suggests that the presence of a doula can provide women a form of protection as it creates a liminal space from which new possibilities may emerge.

**Future directions**

Today the statistics on increasing maternal and infant mortality rates in the US, especially impacting marginalized populations, have cast a new light on the role of doulas. As institutions and state...
Doulas look for answers to their rising mortality rates, doulas are cast as a potential public health tool. Most recently, the New York state legislature, in an effort to reduce maternal mortality and improve disparate racial outcomes, proposed a law that outlines state certification for doulas, which they claim would be a key step in providing federal and state Medicaid reimbursement for doula services. However, the bill was stalled after strong critiques from practicing New York doulas. Doulas expressed concern with their lack of involvement in the process, that the current plan for doula compensation is not equitable, and that they already have comprehensive certification procedures (Myerson 2019). Within our own field site, doulas discussed a new strategy being proposed by the local hospital that uses doulas to train nurses to help change outcomes, specifically the reduction in c-section rates. A doula shared, “I think we are asking our nurses to be doulas. We are trying to lessen the number of cesareans by wanting our nurses to do more, and it’s not realistic. Honestly that’s just not their role. They’re there for medical.” This example, along with the New York case, illustrates a proposed solution that does not address the systemic issues at the root of high rates of intervention, c-sections, and maternal mortality. Disparities in access to care, toxic chronic stress, and bias in healthcare have contributed to the structural violence found within our healthcare system (Williams 2012; Caiola et al. 2014). Instead we find doulas, and in the second example nurses, being called upon to change outcomes. Asking lower status and more dispensable care workers, nurses, and doulas, to intervene within this broken system is ignoring important power dynamics. If we really wanted to shift outcomes we would challenge those with power and status.

As doulas move between worlds and learn to live in liminal spaces, they occupy areas that allow them to generate new cultural narratives about birthing bodies. Paying attention to the intimate labor doulas perform opens up a scholarly space to consider how intimate labor materializes bodies and sees people through transitions. Critical analysis of doulas as they both encounter and redefine boundaries suggests new ways of approaching maternity care and reproduction reform. It also demonstrates larger social debates at stake in the discussions that surround maternal care. Doulas call our attention to the way intimate labor requires a mindfulness of self and other. Intimate labor requires doulas to straddle a space between the intimate and the public—like mothers, and like anthropologists, they move between boundaries, moving inside and outside of different spaces and across thresholds. We hope that this chapter will serve as the impetus for further research on doulas and what a powerful analytic they can be in expanding the debates on reproduction.

References


