



# A Cost-Benefit Analysis of Doula Care from a Public Health Framework

**By Ariel Eastburn, Erin Hubbard, and Ashley Mitchell**

## Table of Contents

## Prologue: Access to Doula Care in the U.S. and the Disparate Pregnancy Experiences and Outcomes that Result

In various parts of the country, people experience pregnancies differently. This is due to a myriad of factors that impact health disparities, including socioeconomic status, racism, and age, among others. There is also a patchwork of policies and practices that shape a person's ability to access a doula, a birth worker who provides non-medical support throughout pregnancy, during childbirth, and after the end of the pregnancy. Research shows that many people have improved health outcomes and better birthing experiences when they have access to desired doula care.

People who are able to access doula support starting early in their pregnancy and who rely on their doula to care for and support them throughout their labor are often better equipped to advocate for the birth they want. The infants of those who receive good support in pregnancy also tend to show signs of strong physical and developmental health shortly after birth. Doulas can also offer support for new parents in their infant feeding decisions, including coaching and assistance to initiate and sustain breastfeeding.

Unfortunately, many individuals face insurmountable financial, geographic, and language barriers to securing a doula. Throughout their pregnancies, these individuals may rely on family and friends with inconsistent availability and knowledge to provide support between visits and during the time leading up to their birth. In some cases, individuals feel pressure to succumb to interventions to begin labor early and may subsequently be rushed through the birthing process or coerced into an unwanted cesarean birth. Those with inadequate support during the postpartum period may be at an increased risk of postpartum anxiety and depression.

These anecdotes highlight some of the health costs and benefits of doula support and several of the short-term impacts on pregnant people.[1] The gap between receiving desired doula care and lacking access to it reflects the variation of doula policies across the nation. While market

[1] Note: we use the terms "pregnant people" and "birthing people" to be inclusive of all people with the capacity for pregnancy, including non-binary and transgender pregnant people. However, not all research and other sources cited throughout are inclusive of non-cisgender women with the capacity for pregnancy.

rates for doulas vary by state and region, generally out-of-pocket costs for doula support it is upwards of $1500 to $2000.

An individual's identity, geographic location, or income should not determine their experiences or outcomes during pregnancy or birth—yet research continues to show that a variety of social and structural determinants cause poignant differences. Efforts at combining community-engaged advocacy and capacity-building to inform and implement more equitable policies and practices are increasing, such as the Black Maternal Health Momnibus. Still, given the state of maternal health nationally, more must be done. This document aims to further equip those wanting to make further change with an evidence-based cost-benefit analysis of the role that doulas play in maternal health.

This analysis utilizes public health and Reproductive Justice frameworks to analyze the cost-effectiveness of doula care coverage. The document focuses on improving community and personal health through preventive approaches (e.g., doula support in pregnancy, birth, and postpartum) that help to address the root causes of poor health outcomes. This further considers social domains that shape health and wellbeing such as economic status, education, health access, and social contexts. For instance, the quality of patient experience is a metric akin to positive clinical outcomes and economic benefits. This cost-benefit analysis will address principles of health equity and actions that address social determinants of health (the conditions we live in and the wider systems that influence those conditions and shape health outcomes).

Reproductive Justice (RJ) is the human right to control our sexuality, our gender, our work, and our reproduction. Reflecting on doula coverage within the context of RJ includes the importance of *access* to these services, not solely the legal rights to have them. RJ necessitates an assessment of the social and political systems (including those designed to deliver healthcare), addressing the multiple oppressions and barriers in a birthing person's life that further affect their ability to access care, and centering the needs of the most vulnerable communities when creating doula care policies. In short, Medicaid reimbursement of doula coverage has the potential to offer a practical option for more communities to seek out additional prenatal, labor, or postpartum support, should they choose to.

# Introduction

## Scope and Rationale

The maternal health crisis continues to worsen in the United States. The country remains behind comparable high-income nations in important measures including maternal and infant mortality. The risk for poor birth outcomes disproportionately affects Black and Indigenous communities.

In recent years, to help address the growing crisis, advocates and policymakers have proposed solutions including the Pregnant Workers Fairness Act, Medicaid postpartum extensions, and the Black Maternal Health Momnibus. In June of 2022, the Biden-Harris administration released the White House Blueprint for Addressing the Maternal Health Crisis. The administration subsequently dedicated $471 million to five goals and 50 actions with the overarching objective of "combating maternal mortality and morbidity, reducing persistent disparities, and improving the overall experience of pregnancy, birth, and postpartum for women in this country."

Doula care represents a promising way to address this crisis, especially as it is supported by a growing evidence base – including analyses on potential cost-savings – and innovative policies for wider implementation. Over half of states in the U.S. have implemented or are in the process of implementing Medicaid coverage for doula services, with Minnesota and Oregon being the earliest adopters of such efforts, both in 2014. Doula support shows promise to improve outcomes, promote equity, and contribute to cost savings.

This resource is a broad cost-benefit analysis of Medicaid reimbursement for doula services in the United States. It may also contribute to conversations around private insurance coverage of doula services. Importantly, we aim to highlight the critical importance of doula care while contextualizing the fact that they alone cannot solve the abysmal state of national maternal health. Instead, they represent one piece to the puzzle which must include multidisciplinary stakeholders working in unison to better support pregnant and birthing persons.

## Definitions

We crafted our analysis with the following definitions in mind:

- **Accessibility:** a quality of access to health care that includes: 1) an opportunity to access services (they are available and in adequate supply), 2) level of utilization by a population that includes financial, social, organizational, or cultural barriers, 3) care that is relevant and effective leading to satisfactory health outcomes.

- **Doula:** a trained professional who provides physical, emotional, and informational support to their client before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible—often specified as a birth doula. While full-spectrum doula care exists that covers the entirety of the reproductive and life experience (including but not limited to pregnancy, birth, postpartum, abortion, and bereavement), the use of "doula" in this document will be referring specifically to birth and postpartum doulas.
- **Maternal morbidity:** any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative short or long-term impact on the woman's well-being and/or functioning.
- **Maternal mortality:** death of a birthing parent from complications of pregnancy or childbirth that occur during the pregnancy or up to one year postpartum.
- **Perinatal:** the time before and after the birth of a child, and it includes health of birthing parent and child.
- **Postpartum**: up to one year following the end of pregnancy.
- **Reproductive Justice:** Reproductive Justice (RJ) means the human right to control our sexuality, our gender, our work, and our reproduction. That right can only be achieved when all [birthing people] have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives.

## The Cost of Maternal and Infant Mortality and Morbidity

Maternal and infant mortality and morbidity have significant costs to health systems, health insurers, and states. In the United States, the main causes of pregnancy-related deaths include: hemorrhage, infections, cardiovascular conditions (e.g. blockages in arteries and veins), blood pressure disorders like preeclampsia and eclampsia, heart disease, problems with anesthesia, and non-cardiovascular conditions (e.g. diabetes and breathing problems). It has been determined that over 80% of these pregnancy-related deaths are preventable.

Maternal and infant mortality and morbidity disproportionately affect marginalized communities. Despite improvements in perinatal care, pregnancy-related mortality rates among Black and Indigenous pregnant people are 2-3x higher compared to white pregnant people. Black and Indigenous pregnant people also have higher shares of preterm births, low birthweight births, and reduced or no prenatal care compared to white pregnant people. Rates of infant mortality are also significantly higher across Black and Indigenous communities compared to white communities. It is crucial to note that racial disparities in mortality and morbidity persist despite controlling for socioeconomic factors (e.g. income, education), indicating that systemic racism is largely to blame for pervasive inequities in care.

The table below from a 2021 report by the Commonwealth Fund estimates societal costs of maternal morbidity through five years following childbirth.

| Cost due to morbidity (0-5 years after childbirth) | Total cost (medical and non-medical*) |
|---|---|
| **Maternal outcomes** | |
| Productivity losses | $6.6 billion |
| Cesarean delivery | $895 million |
| Increased peripartum stay | $350 million |
| Social service use | $239 million |
| Suicide | $153 million |
| Maternal mortality | $30.8 million |
| Stroke | $1 million |
| **Child outcomes** | |
| Preterm birth | $13.7 billion |
| Developmental disorders | $6.5 billion |
| Respiratory distress syndrome | $2.1 billion |
| Fetal malformations** | $995 million |
| Injury | $250 million |
| Emergency department visits | $189 million |
| Hypoglycemia | -$121.9 million*** |
| Asthma | $106 million |
| Poor fetal growth | $104 million |
| Suboptimal breastfeeding | $76 million |
| Cardiovascular conditions | $38 million |
| Obesity | $30 million |
| Stillbirth | $27 million |
| Sudden infant death syndrome | $12.5 million |
| Missed well-child visits | $12 million |
| Diabetes | $9.4 million |
| Infection | $3.6 million |
| **Total**** | $32.3 billion |

**Non-medical costs = expenses unrelated to medical care, including productivity loss and use of social services*
***While the original report did not include a definition, typically fetal malformations are defined as a type of fetal anomaly, which refers to unusual or unexpected conditions in a baby's development during pregnancy and may include structural (e.g., malformations of or missing body parts) or functional changes (e.g., changes to the way a body part or system works). More can be found here.*
****Decrease in hypoglycemia incidence due to maternal gestational diabetes contributes to a $121.9 million reduction in costs during the first year postpartum.*
*****2019, age 0-5, $8,624/parent-child pair*

The totals above likely underestimate the true costs, as they fail to capture breastfeeding challenges requiring medical treatment (compounding already high costs of infant feeding), undiagnosed mental health concerns, and other expenses. The table also underestimates the current crisis post-COVID-19, as the 2021 CDC report on maternal mortality rates in the U.S. presents a 40% increase from previous years, with non-white birthing people experiencing the greatest increase. The authors of the report point to COVID-19 as a key factor for record-high rates. While we don't have an updated report on medical and non-medical costs due to morbidity, we anticipate that this increase in rates might be reflected in similarly higher costs.

Despite spending more on health care, the U.S. leads in negative maternal outcomes compared to other countries of similar economic standing. Pregnancy and birth-related illness and death can take an incalculable toll on families, leading to needless suffering for birthing parents, children, families, and communities. Moreover, the financial costs can also be exorbitant. A recent report estimated that maternal morbidity cost $6.6 billion in lost productivity nationwide over a 5-year period. Reducing maternal and infant morbidity would improve quality of life and economic health for all birthing people and their families.

Strategies to reduce mortality and morbidity must include principles of health equity and justice, such as focusing on emotional safety as patient safety, providing culturally appropriate care, and eradicating explicit and implicit bias from the health care system. Efforts should prioritize closing racial disparities in maternal health for Black, Indigenous, and other marginalizedpopulations who face disproportionate risk for these negative outcomes.

## Cost Savings

Doula support is a well-researched and evidence-based pathway to improve pregnancy outcomes and experiences, and reduce medical interventions related to birth. This section details the potential cost savings doula support can provide, specifically by preventing cesarean births and preterm births.

While we can estimate savings for these two outcomes, there are several other benefits of doula care we are not yet able to quantify in terms of cost savings. One of these outcomes includes lower rates of perinatal mood and anxiety disorders (PMADs). One study documented 60% lower odds of experiencing a PMAD for birthing people with doula support. Another outcome is higher rates of initiation of breastfeeding. An analysis found that if 90% of families were able to exclusively breastfeed for 6 months, the associated cost savings for mortality and morbidity in U.S. would be $13 billion per year and could prevent 911 deaths. Another study found that among a sample of Medicaid beneficiaries, those with doula-supported births had

almost universal breastfeeding initiation rates at 97.9% as compared with 80.8% of the general Medicaid population. More research is needed to further quantify potential cost savings with doula on PMADs and breastfeeding, as well as other outcomes. For example, with the outcome of breastfeeding, while we know that doula care can improve breastfeeding initiation rates, we do not yet have enough research on how doulas impact exclusive breastfeeding further into the postpartum period to calculate meaningful cost-savings estimates. Additionally, some parents are not able to or do not want to breastfeed, and so a 90% exclusive breastfeeding rate may be unrealistic for cost savings analysis.

To calculate cost savings estimates in this section, we used data (including number of total births and number of births affected by specific outcomes) from the National Vital Statistics report on U.S. Medicaid and privately insured births in 2021, coupled with cost-savings estimates for doula care from peer-reviewed sources on specific outcomes, including cesarean births and infant hospitalizations from preterm birth. See **Appendix 1** for a more detailed guide to how we calculated cost savings, including where to find this data for your state.

## Cesarean Births

Cesarean births are an important medical intervention that can prevent maternal and infant mortality and morbidity in certain situations. Pregnant people may opt for cesarean birth for many reasons, and should be supported in their decision. At the same time, pregnant people should not be pressured by providers to undergo medically unnecessary cesarean births. One nationally representative study found pregnant people who reported experiencing pressure from a clinician for cesarean delivery had higher odds of cesarean without medical reason and higher odds of unplanned cesarean. Cesarean births have been linked with increased risk of blood clots and infections, and medically unnecessary cesarean deliveries can contribute to more of these preventable complications for low-risk birthing people. Possible ways doula support can reduce cesarean deliveries for low-risk pregnancies include helping avoid unnecessary inductions and avoiding or delaying epidurals. We estimated the potential cost-savings doula care can generate by preventing non-indicated cesarean births among Medicaid and privately insured births:

| United States, 2021 | Medicaid | Private Insurance |
|---|---|---|
| % of total births | 41.0% | 51.7% |
| Number of births | 1,502,360 | 1,894,439 |
| Number of cesarean births | 482,257 | 608,115 |
| Cesarean birth rate | 32.1% | 32.1% |

| | | |
|---|---|---|
| Estimated cesarean births preventable with doula support (39%) | 188,080 | 237,165 |
| Average additional costs per cesarean birth | $4,459 | $9,537 |
| **Estimated savings per birth** | **$558.22** | **$1,193.94** |
| **Estimated savings per year** | **$838,648,720** | **$2,261,842,605** |

## Preterm Birth – Infant Hospitalization Costs

Preterm birth occurs when a baby is born before 37 weeks of pregnancy, and it is a leading cause for infant deaths in the U.S. About 1 in every 10 infants born in the US were affected by preterm birth in 2022 and although the preterm birth rate declined from the previous year, racial and ethnic disparities persist. A study using data from Truven Health Analytics MarketScan® Commercial Claims and Encounters and Multi-State Medicaid Databases found the average cost of a birth hospitalization was $60,530 more for commercially insured premature infants compared to full-term infants and $41,964 more for Medicaid insured premature infants compared to full-term infants (see appendix for calculations). The 2016 study by Kozhimannil et al used data from 12 states and a local doula program found that doula-supported births had a 4.7% rate of preterm birth compared to a 6.2% rate of Medicaid births regionally without doula support (simplified, a 24.2% decrease). We used this study and the cost data above to make projections about savings doula support could generate related to premature infant hospitalization costs for Medicaid births:

| United States, 2021 | Medicaid |
|---|---|
| Number of births | 1,502,360 |
| Rate of preterm birth | 10.49% |
| Number of preterm births | 157,598 |
| Number of preventable preterm births with doula support (based on 24.2% decrease) | 38,139 |
| Average cost per preterm birth hospitalization | $43,858 |
| **Estimated savings per birth (avoided preterm birth)** | $41,964 |
| **Estimated savings per year (avoided preterm births)** | **$1,600,464,996** |

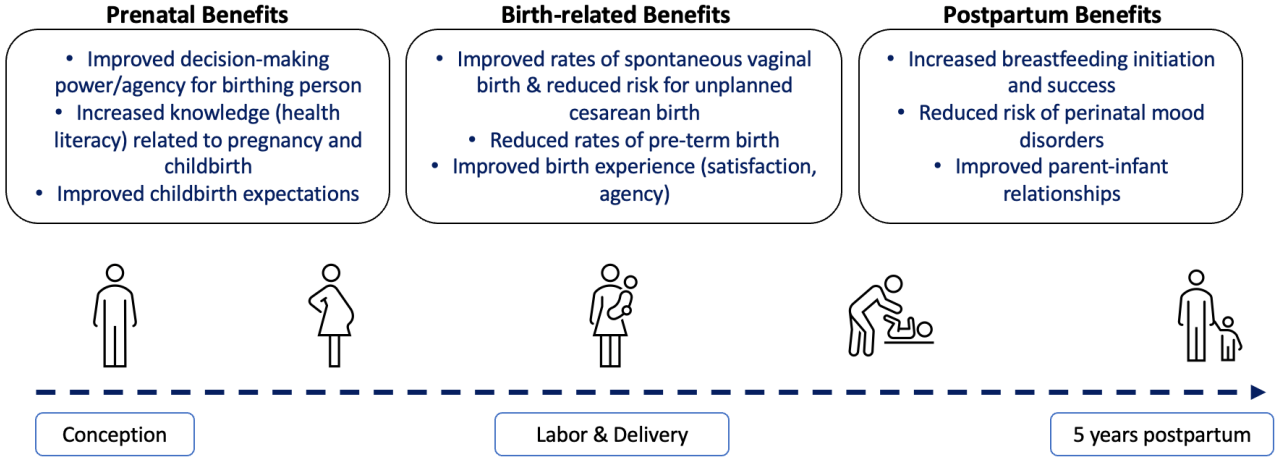
## The Health Benefits of Doulas

Beyond cost savings, the broader health benefits of doulas are well documented across the pregnancy and care continuum for birthing people (**Figure 1**) and include:

- a 15% improvement in the likelihood of having a spontaneous vaginal birth;
- a 40% reduction in the likelihood of cesarean births;
- a more than 20% reduction in the odds of preterm birth;
- a 10% reduction in the use of pain medications during labor;
- an average 41 minute reduction in total labor time;
- a four-fold reduction in babies with a low birth weight;
- a two-fold reduction in birth complication involving birthing parents or their baby;
- a 35% reduction in the likelihood of having a negative birthing experience;
- a nearly 65% reduction in the odds of experiencing postpartum anxiety or depression; and
- a 20% improvement in the likelihood of breastfeeding initiation among Medicaid recipients.

Additionally, doulas are known to spend up to 11 times the amount of time with their clients as compared to clinical providers and staff.

**Figure 1. Benefits of doulas across the pregnancy and birth continuum**




*Pregnancy and Birth Continuum*

Doula care has also proven to be particularly valuable among historically marginalized groups:

- One study in New York found that Black patients with doula support had a nearly **50% reduction in rates of preterm birth and low birthweight** compared to typical rates in the area.
- A study in North Carolina among mostly Black mothers found those with doula support were four times less likely to have a low birthweight infant.

- One qualitative study from a community doula program for Black, Pacific Islander, and Latinx families in San Francisco explored how labor and delivery staff saw doulas increase individual and institutional accountability in the hospital setting and fill gaps in pregnancy care for patients.

Black pregnant people and other pregnant people of color can especially benefit from doula support given the barriers to respectful, quality care they confront due to racism. Community-based doulas, who are usually members of the communities they serve, often go above and beyond standard doula services to serve the specific needs of their clients. Although their work is critical to birthing people of color having healthy pregnancies and safe births, many community doulas do not earn a thriving wage. Therefore, some doula programs have explored payment models that more adequately compensate them for the support they provide. Qualitative studies illustrate examples about how they can advocate for their patients in the medical setting and provide resources for social and structural support. Studies have also shown that when working with Black mothers, community doulas are often forced to mitigate instances of racism in the perinatal setting. However, it should be noted that this is a heavy burden and BIPOC (Black, Indigenous, and People of Color) community doulas cannot and should not be responsible for solving institutional racism present in medical institutions for their clients.

Though a growing body of literature documents several statistically significant improvements in multiple birth and postpartum outcomes from doula care, not all the benefits of this support can be quantified. Birth experiences with doulas cannot always be easily captured in a quantitative survey or medical record review. Qualitative studies can show the importance of doulas for birthing people's experiences from a non-statistical perspective. One review summarized the many benefits of doula care supported by the qualitative literature, finding that doulas provide information support that helps to bridge gaps in communication between medical providers and pregnant people, advocate for their clients, and provide emotional support for pregnant people. Additionally, though doulas increase birth satisfaction, there is not an obvious way to quantify the absence of a traumatic birth. Thus, while we know doulas help their clients avoid traumatic births, we are not able to quantify the corresponding costs avoided. Yet just because we cannot quantify cost-savings for a particular outcome does not mean this aspect of doula care is not beneficial to clients and cannot potentially help generate cost-savings for perinatal care.

## Recommendations/Conclusions

Given the many evidence-based benefits and cost-savings associated with doula care, increasing, and ensuring access to doulas for all birthing people is a matter of Reproductive Justice. Achieving improved access will require a multifaceted approach with action from a variety of stakeholders. Some opportunities for doula allies include:

- **States with Medicaid reimbursement for doulas** should evaluate current policies and practices to ensure that they are equitable, sustainable, and responsive to possible cost savings. For example, several states have increased their reimbursement rates—more should follow, and rates should remain dynamic to local costs of living.
- **Policy Administrators and Implementing Groups** should work to streamline administrative processes for doulas (including enrollment and billing processes), as well as support outreach and education around doula services for Medicaid enrollees.
- **States without Medicaid reimbursement** should prioritize rapid policy implementation supporting fair doula payment, particularly because 25% to 60% of births are financed by Medicaid nationwide. Any policies must be implemented with leadership from and the guidance of practicing doulas, especially those who have identities from marginalized and historically disempowered groups, including BIPOC and LGBTQ+ people.
- **Private insurers and employers** should follow the lead of early-adopting organizations who have added doula benefits. In addition to cost-savings, this action aligns with the stated health and wellness values of many employers and underscores a commitment to equity. Not only is this the right thing to do; it can also help to attract and retain employees.
- **Medical providers** should understand the role and value of doulas as members of birth teams and assist in combatting misinformation about doula care.
- **Funders and philanthropists** should prioritize community-based, BIPOC doula organizations in their strategic planning—including ways to fund doula training toward establishing a diverse, sustainable workforce—and seek opportunities to support maternal health equity and cultural rigor (i.e. an expansion of cultural humility to include institutional recognition and mitigation of harm).
- **Doula organizations** should continue to advocate and leverage existing budgeting resources to ensure cost-effective approaches that fully incorporate all available revenue and support streams.
- **Researchers** should collaborate with doulas on shared research agendas toward providing rigorous, comprehensive evidence informing practice and policy following the lead of community-focused centers already engaged in this work.
- **Individuals** should strive to understand current evidence to equip themselves to lobby with state representatives and other stakeholders on the urgency of doula support. Individuals can also support doula work by telling others about doulas, providing word of mouth information and education.

## Want More Information?

- Doula Medicaid Project by National Health Law Program
- Doulas in Medicaid: Case Study Findings by Medicaid and CHIP Payment and Access Commission (November 2023)
- Doula Medicaid Storybook by HealthConnect One (April 2023)
- Getting Doulas Paid: Advancing Community-Based Doula Models in Medicaid Reimbursement Conversations by HealthConnect One, SisterWeb, BirthMatters, Accompany Doula Care, and Ancient Song (February 2023)
- Doula Care and Maternal Health: An Evidence Review by Office of Health Policy, U.S. Department of Health and Human Services (December 2022)
- Improving Our Maternity Care Now Through Doula Support by National Health Law Program in partnership with National Partnership for Women & Families, HealthConnect One, and Tewa Women United (September 2022)
- Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities by Ancient Song Doula Services, Village Birth International, and Every Mother Counts (March 2019)

## Methods & Data for Cost Savings Calculations (Appendix)

### Cost-Saving Calculations

In this report, you can find an outline of cost-savings calculations for reductions in cesarean births and preterm births. To replicate this for your own state, you can find the total number of births in your state in Table 6 of this 2021 National Vital Statistics report. You can find the proportion of births financed by Medicaid at this resource from the Kaiser Family Foundation.

To calculate the cost savings for cesarean births prevented by doula care, we used $4,459 as the average savings per cesarean delivery for Medicaid beneficiaries and $9,537 as the average savings per cesarean delivery for privately insured individuals from a Truven Health Analytics MarketScan report on the cost of having a baby in the U.S. We also used 39% as the number of preventable cesareans with doula support from this Cochrane review on continuous support during childbirth.

- Number of cesareans: Multiply the total number of births for your state by the cesarean rate for your state, which you can find from the CDC here.
- Estimated savings per birth: Multiply the average additional cost per cesarean (for Medicaid or private insurance) by the number of cesareans, which you calculated above. Divide this by the total number of births in your state to get the estimated savings per birth.

- Estimated savings per year: Multiply the estimated savings per birth by the total number of births per year in your state.

To calculate the cost savings for Medicaid preterm births prevented by doula care, we used the preterm birth rate from the 2021 National Vital Statistics report. To replicate this for your own state, you can find CDC data on your state's preterm birth rate here. We used the % change in rates of preterm birth among Medicaid beneficiaries with doula support from the 2016 study by Kozhimannil et al.

- Number of preterm births: Multiply the total number of births for your state by the preterm birth rate for your state.
- Number preventable preterm births with doula support: Multiply the number of preterm births by 24.2% (0.242) to get the number of preventable preterm births with doula support
- Total savings from preterm infant hospitalizations: Multiply the number of preventable preterm births by the savings for avoiding preterm hospitalization ($41,964 – see this calculation in data sources below)

## Data Sources

- CDC: Percentage of Preterm Births by State
- CDC: Cesarean Delivery Rate by State
- National Vital Statistics System (NVSS) Birth Data
    - Proportion of Medicaid and privately insured births
    - National rates of preterm birth, cesarean section
    - Final Birth Data for 2021
    - Provisional Birth Data for 2022
- Report: The Cost of Having a Baby in the United States from Truven Health Analytics MarketScan
    - Average additional cost per cesarean for Medicaid beneficiaries: $4,459
    - Average additional cost per cesarean for those privately insured: $9,537
- Study: Characteristics and health care utilization of otherwise healthy commercially and Medicaid-insured preterm and full-term infants in the US
    - Average cost birth hospitalization cost for preterm infant (private insurance): $62,931
    - Average cost birth hospitalization cost for preterm infant (Medicaid): $43,858
    - Average cost birth hospitalization for full term infant (private insurance): $2,401
    - Average cost birth hospitalization for full term infant (Medicaid): $1,894
    - Average additional hospitalization costs per Medicaid insured preterm infant: $43,858 - $1,894 = $41,964
    - Average additional hospitalization cost per privately insured preterm infant: $62,931-$2,401 = $60,530

## About the Authors

This report was written in collaboration between members of the Bixby Center for Global Reproductive Health at the University of California San Francisco (UCSF) and the National Health Law Program (NHeLP). The authors of the report are fellows with the UCSF Bixby Advocacy and Communications Fellowship.

- **Ariel Eastburn McCormick, MA (she/her)** is a Research Coordinator with the UCSF Program on Reproductive Health and the Environment (PRHE) and a full-spectrum doula-in-training with the Birthing Advocacy Doula Trainings (BADT) program.
- **Erin Hubbard, MPH (she/her)** is a Senior Research Coordinator in the Sexual Health and Reproductive Equity (SHARE) program in UC Berkeley School of Social Welfare.
- **Ashley Mitchell, PhDc, MPH, CPE (she/her)** is a Research Data Analyst with UCSF Global Action in Nursing (GAIN) and a Co-director of the Global Health Practice Seminar for the Global Health Sciences Masters' students.

ALL PREGNANT AND POSTPARTUM PEOPLE DESERVE ACCESS TO FULL SPECTRUM DOULA CARE.

NATIONAL HEALTH LAW PROGRAM