Robert Wood Johnson Foundation

Published: April 11, 2008
Program Results
Grant ID: 29806

Chicago Project Delivers Support to Young Mothers-to-Be

Doula program for low-income pregnant teenagers

SUMMARY

From August 1996 to July 2000, Chicago Health Connection, a health education and advocacy organization, developed and implemented a four-year pilot project that used nonmedical birth assistants known as doulas to help low-income single teen mothers in high-risk Chicago neighborhoods.

The doulas, who were recruited from the community and trained by project staff, provided information and emotional and physical support to the mothers from the last months of pregnancy through the first weeks postpartum and generally were present during labor and delivery.

Key Findings

A researcher tracked outcome data for 259 women served by the project's three pilot sites in Chicago.

- Only 8.1 percent of the mothers with a doula present at birth had a cesarean section compared to 12.9 percent for Chicago teen mothers as a whole.
- Compared to national data, fewer doula mothers used epidural anesthesia.
- Compared to national data, more initiated breastfeeding.

Funding

The Robert Wood Johnson Foundation (RWJF) supported the project with a $327,196 grant awarded through its *Local Funding Partnerships*. *Local Funding Partnerships* is a national matching-grant program that seeks to stimulate innovative, community-based projects to improve the health and health care of underserved and vulnerable populations (for more information see Program Results).

Following the RWJF grant, Chicago Health Connection secured funding from other sources to replicate the project.

Afterward

Abramson reported in April 2008 that Chicago Health Connection now had contracts with 23 organizations in 10 states including Georgia, Indiana and Texas to provide training and technical assistance to doula programs for low-income women.

INTRODUCTION

Crystal Nelson was a 16-year-old on Chicago's West Side when she gave birth to a son, Takiah, in March 2000. For any teen still in her first year of high school, delivery would be a frightening experience. A drawn-out labor and the need for a cesarean section made Crystal's even more so. But thanks to a woman named Loretha Weisinger, the young first-time mother was not alone. When the contractions came, Weisinger was there to massage and relax her. After surgery, she was at the bedside to give encouragement.

Indeed, throughout Crystal's pregnancy, Weisinger was on hand—taking her to doctor's appointments, helping her get nutritional aid through the federal WIC program, and explaining breastfeeding and the other mysteries that come with a first pregnancy. Loretha Weisinger was Crystal's doula, and as the young mother explains, "It's really scary until your doula gets there."

The word doula (pronounced DOO-lah) comes from Greek and means an experienced woman who helps another woman. In ancient Greece, this would have been a servant or slave assigned to care for the household mistress, including during childbirth. Today the term refers specifically to a woman knowledgeable in the birth process who provides information and emotional and physical support to a mother during pregnancy, at childbirth and in the immediate postpartum period.

A doula is not a midwife or nurse, and does not perform clinical tasks. She is a nonmedical assistant to the mother and, if there is one, to the mother's husband or partner. Crystal Nelson, whose own mom has not been a constant presence, puts it this way: "A doula's like your second mother."

In 1995 a nonprofit Chicago organization named the Chicago Health Connection developed a pilot project that used doulas to assist low-income single teenage mothers like Crystal. A major portion of the start-up funding for the initiative came from RWJF through a matching-grant program called the *Local Funding Partnerships.* In collaboration with community foundations and other local givers, *Local Funding Partnerships* seeks to stimulate innovative, community-based projects aimed at improving the health and health care of underserved and vulnerable populations.

The story of the Chicago doula project illustrates how this collaboration between a national foundation and local organizations can make a significant difference in the lives

of real people. Replications of the Chicago program are now operating at 11 Illinois sites plus three locations outside the state—Albuquerque, Atlanta and Minneapolis.

THE PROBLEM

The doula is a relatively new addition to hospital delivery rooms. Doulas of North America, a nonprofit organization that trains and certifies doulas, was incorporated in 1992 and had 4,550 members as of 2002. Private insurance and government health programs generally do not cover the cost of doula services, which can run from several hundred dollars up to $1,000. As a result, families that use doulas are generally of at least moderate economic means.

A doula does not try to impose her own approach to childbirth on the mother. "The doula's goal is to help the woman have a safe and satisfying childbirth as the woman defines it," says the Doulas of North America website. As a result, according to that organization and other proponents, doulas can make childbirth a more positive experience and strengthen the emotional attachment between mother and child.

A number of studies have found doula support associated with improved obstetric outcomes, including shorter labor periods, reduced rates of cesarean-section deliveries, and less use of pain medication and epidurals. A randomized controlled study of 416 first-time mothers in Houston in the 1980s found that the doula-supported mothers averaged 7.4 hours in labor compared to 9.4 hours for women in the non-doula control group; 55 percent of the doula-supported mothers had natural vaginal deliveries (without anesthesia, oxytocin, medication or forceps) compared to 12 percent for the control group.

(For research results and other information on doulas, a commonly cited resource is the 1993 book *Mothering the Mother: How a Doula Can Help You Have a Shorter, Easier, and Healthier Birth* by Marshall H. Klaus, MD, John H. Kennell, MD, and Phyllis H. Klaus.)

The Local Initiative Funding Partners Application

Chicago Health Connection is a community-based health education and advocacy organization supported by a number of national and Chicago foundations. It began in 1986 by promoting breastfeeding as a strategy for decreasing infant mortality and morbidity rates in low-income, high-risk Chicago neighborhoods.

Then called the Chicago Breastfeeding Task Force, the organization trained women to be breastfeeding peer counselors able to provide information and emotional support to nursing mothers in underserved areas of the city. Research indicates that breastfeeding benefits the infant's physical health and also affects long-term cognitive outcomes.

The initiative worked, and the organization expanded its focus to include the prenatal, delivery and postnatal stages of childbirth. Reflecting this broader view, the group changed its name to Chicago Health Connection. In their extended role, the counselors began paying special attention to the support that mothers received at childbirth itself.

What they found, says Rachel Abramson, the executive director, was that the delivery experience—a frightening time for any woman—was especially terrifying for a teenager giving birth among strangers in the hospital. In Chicago in the mid-1990s, almost a fifth of all babies were born to teenagers.

Abramson and her staff were well aware of studies showing that babies with adolescent mothers are at significantly greater risk for infant mortality and morbidity and for child abuse and neglect. Abramson also knew of the research showing the benefits of a doula. As a consequence, the organization designed a project to use doulas to improve the outcomes of teenage childbearing in low-income areas of the city. In addition to helping a specific Chicago population, the organization designed the project to be a demonstration of the value of doulas in an underserved urban setting; the project included collection and evaluation of demographic and health data on the participating mothers and their children.

The Harris Foundation—since renamed the Irving Harris Foundation—agreed to support the initiative. For four decades this family foundation in Chicago has been supporting early childhood development efforts, providing direct service grants to Chicago projects as well as funding a number of graduate-level training programs across the nation.

Harris and RWJF combined forces earlier to help the Ounce of Prevention Fund set up a maternal and child health center in the Robert Taylor Homes (see Program Results on ID#s 012973 and 013473) and to start the Birth to Three project, a cross-agency service integration initiative serving expectant families and those with young children in Illinois (see Program Results on ID# 038175). The Ounce of Prevention Fund is a public-private partnership co-founded in 1982 by Irving Harris to initiate innovative child development programs.

Irving Harris himself, the foundation chairman, was particularly enthusiastic about the potential of doulas to improve the birth experience and, as a consequence, the intellectual capabilities of the child. "Healthy early interaction with the mother is important in providing stimulation needed for optimal brain development, which in turn is critical for later learning ability and eventual success in school," he wrote RWJF's *Local Funding Partnerships* national program office staff. He said he was convinced the project would have a national impact on the care of mothers and infants.

In December 1995, with the Harris Foundation as lead local funder, Chicago Health Connection applied to *Local Funding Partnerships* for a grant of approximately $327,000

to support training and employment of doulas at three pilot sites in Chicago. The RWJF program had not previously funded a doula model, and the *Local Funding Partnerships* national program office staff viewed the proposal as a strong, innovative one—an impression solidified by an April 2, 1996 site visit to Chicago.

The following were among the application's strengths:

- The enthusiastic support of Irving Harris and his track record of moving other child development projects forward.
- Documentation of the role and impact of doulas in obstetrical literature.
- The project's innovative nature and the capabilities of the Chicago Health Connection staff.
- Backing for the project from city and state health officials, Cook County Hospital personnel and a state legislator. (Chicago is in Cook County.)

(In 1995, RWJF's program, *New Jersey Health Initiatives*, had funded a doula project in Paterson, N.J., that focused on drug-addicted pregnant women—see Program Results on ID# 026174.)

RWJF awarded the requested four-year grant to start August 1996. Besides the required one-for-one match, the Harris Foundation provided an extra $158,000 over the four years. Also, the Prince Charitable Trusts, a family philanthropy with offices in Chicago and Washington, contributed $21,000 to hire additional doulas at two of the three pilot sites. A private individual gave $10,000, also earmarked for additional doulas.

In addition, the Harris Foundation and the Illinois Department of Human Services provided money through the Ounce of Prevention Fund to evaluate the pilot project and sustain the pilot sites.

Beyond its own funding, RWJF's involvement helped Chicago Health Connection attract additional funding for the project, says Abramson. The technical assistance of the national program office staff was also valuable, she says. "We really got much more than just funding from the *Local Funding Partnerships* program."

THE PROJECT

Some doulas assist the mother at childbirth only. The Chicago Health Connection model provided for an extended doula intervention—from the beginning of the third trimester of pregnancy to the end of the third month postpartum.

The organization collaborated with three community-based agencies that agreed to serve as pilot sites and integrate doula services into their existing teen-parenting programs. The three sites were:

- Alivio Medical Center, an outpatient clinic that serves mainly uninsured Mexican Americans and Mexican immigrants on Chicago's southwest side in the neighborhoods of Pilsen, Heart of Chicago, Little Village and Back of the Yards.
- Christopher House, a nonprofit multisite organization that offers a range of social services to low-income families in racially diverse parts of Chicago's north and west sides.
- Marillac Social Center, a Daughters of Charity facility that offers an array of services in largely low-income, African-American communities on Chicago's west side, including the areas of West Garfield, Douglas Park, Austin and Humbolt Park. Loretha Weisinger, Crystal Nelson's doula, is part of Marillac's teen parenting and prenatal program.

All three agencies already participated in Parents Too Soon, a statewide home-visitation program for teen parents administered by the Ounce of Prevention Fund. As a result, many of the project's doula-supported mothers also had a Parents Too Soon home visitor or other assistance.

The project's first six months focused on recruiting and training the doulas. Chicago Health Connection developed a 20-week training curriculum, which Doulas of North America certified. The schedule devoted one day a week to formal classroom instruction and the rest of the time to such activities as observing births and accompanying home visitors on their visits. Project staff recruited the trainees from various sources, including church groups and women whom the three agencies had previously helped through other programs. Weisinger had been a volunteer worker at Marillac for 10 years when she took the doula course. All trainees received a stipend.

From the initial training session, each pilot site hired one full-time doula and designated a number of backup doulas to handle births when the regular doula was sick, on vacation or otherwise unavailable. The Chicago Health Connection staff helped identify and screen candidates, but each of the three sites was responsible for its own hiring.

There were two training sessions during the grant period, the first in fall 1996 and the second in winter–spring 1998. In each session, nine women completed the classroom portion. A total of 14 women from the two sessions completed both classroom and nonclassroom requirements. In addition to the full-time and backup doulas, the trainees included agency personnel responsible for supervising doula services. The project also trained some doulas for other organizations.

Any pregnant woman served by the three pilot sites was eligible to receive doula services free of charge. However, Chicago Health Connection designed the model to help teen mothers specifically, and the project's evaluation phase considered only the impact on teens. Project personnel contacted hospitals to explain the project's purpose and facilitate the doulas' access to labor and delivery rooms. Doula-assisted births began in March 1997.

The model provided for the doula to accompany the expectant mother to at least one prenatal appointment, maintain weekly contact in the ninth month of pregnancy, and be at the hospital for labor, delivery and the baby's first hours. In the postnatal period, the doula was to continue contact while gradually transitioning the new mother to a home visitor provided through Parents Too Soon or another program. The project provided a health care professional to review the doulas' cases and give clinical advice and support.

In practice, the sites had considerable flexibility to adapt the intervention to their needs and preferences. Alivio, for example, ended doula services at six weeks postpartum instead of 12. Also, unlike some home-visitation programs, the model did not dictate the specific content of the home visits. Thus, the Christopher House doula gave the expectant mother information about fetal development, prenatal care, nutrition and labor and delivery but not according to any set curriculum. On the other hand, the Marillac doulas developed a curriculum and led weekly group prenatal sessions for their mothers.

Also, the project underwent changes in response to unexpected problems. A high turnover rate among the initial doulas was a major challenge. The first full-time doulas hired by Christopher House and Marillac quit before completing the training. Only three members of the first training class were still providing doula services six months after the training ended. Staffing difficulties were particularly severe at Christopher House and at times prevented that site from accepting new participants into the doula program.

Some of the women recruited to be doulas found they simply were not cut out for the job. The project staff also concluded that it had overestimated the number of mothers that one doula could manage. Initially, the full-time doulas were expected to carry a caseload of two to four births a month—a demand that led to burnout, the organization reported to RWJF.

In response, Chicago Health Connection raised money to support the addition of a second full-time doula at both the Alivio and Marillac sites. Also, project staff improved techniques for recruiting doulas, clarified expectations of the trainees, and addressed scheduling and compensation issues. (A full-time doula at a site that follows the model can expect to make $21,000 to $25,000 a year plus benefits, says Abramson.) The corrective efforts paid off. Of the nine women who completed the second series of classes, seven were still involved with the project at the end of the four-year grant.

Another problem was that the sites had difficulty developing a cadre of doula-trained women who could be called on as substitutes. According to Chicago Health Connection, at least part of the reason was that welfare reform put pressure on women in the community to take full-time jobs, leaving them unavailable for part-time work.

Each of the three sites handled the problem differently. One, for example, used a backup doula whose regular job gave her enough flexibility to substitute when needed. Another used other agency staff whose schedules could be adapted to permit attendance at births.

Once Alivio hired its second full-time doula, the two women filled in for each other during the week and left the weekend deliveries to a group of backup doulas. The downside of that system was that a mother who delivered on a weekend was unlikely to get a doula she knew.

This coverage issue was finally resolved when the state took over funding responsibility. To meet state payroll requirements, the full-time doulas covered nights and weekends and received compensatory time off.

Despite the operational changes and site-to-site differences, the model incorporated a number of key projectwide components:

- The project was community-based. The women trained and hired to be doulas were for the most part lay persons living in the service community. There was no hard-and-fast rule that the doula had to be of the same race or ethnicity as the mothers she helped, says Abramson. But the goal was to use women who understood the mothers and what their lives were like. Of the 14 doulas who completed all training requirements, 11 had themselves been teen mothers. Thirteen had graduated from high school or passed the General Educational Development (GED) exam, but only two had a bachelor's degree. Three others had some college education. Abramson, an RN, believes the power of the doula model rests in large part with its community grounding. (Not all visitation programs embrace this concept. RWJF has long supported development of a program by University of Colorado psychologist David L. Olds that employs registered nurses (RNs) to make home visits to young at-risk mothers. (See the Program Results on the Nurse-Home Visiting Program.)
- The project emphasized strong relationships. The doulas tried to develop trusting ties with the mothers. During pregnancy, the doula worked to connect the mother with her baby, encouraging the mother to think about, talk to and read to the baby in utero. The doula accompanied the mother to at least one doctor's visit, and helped the mother develop a "birth plan" for how her labor would be handled, including whether she would rely on medication or some kind of comfort measure, such as massage or breathing exercises. The doula also sought to draw the husband or partner and family members into a support network.

- The project bridged the gap between social service and medical care. The doulas provided continuity as the teen mothers moved from their communities into the health care environment. Although the doulas were lay people, their training and experience made them comfortable in the medical setting and able to serve as the mother's coach and advocate. Sara Manewith, current director of the Christopher House doula program, says young mothers often feel intimidated by health care professionals and react with inappropriate behavior – such as skipping their next doctor's appointment. The doula can avert that problem by going with the teen to the appointment and encouraging her to ask the doctor questions about matters of concern, says Manewith.
- Project staff sought to reinforce the mother's self-esteem and sense of empowerment. Pregnancy opens a woman to new ideas, personal growth and a feeling of power, says Abramson. By making pregnancy and delivery a positive experience, the doulas nurtured this feeling of competence. They provided praise, reassurance and other forms of emotional support as well as physical comfort measures. Getting through labor and delivery without medication is not a requirement, but it is a value of the model, says Abramson. Teen mothers "understand that if they can accomplish that (giving birth without medication), they can do incredible things." Breastfeeding was also a value encouraged by the doulas.

One Doula's Perspective

Iris Gonzalez is a doula-trained supervisor of home visitors at Christopher House and serves as the program's backup doula. She filled that role in the fall of 2003 while the regular, full-time doula recuperated from auto accident injuries. In an interview at that time, Gonzalez explained that the expectant teen mother is likely to be scared and anxious as her due date approaches. She may be estranged from her own mother because of the pregnancy; the baby's father may not be around; sometimes there is a friend or relative to take her to the hospital, but sometimes there is no one. "She doesn't know what to do."

The doula, Gonzalez said, comes into this situation taking care not to judge the teenager and acknowledging that this is a frightening time. She tries to find out what the young woman thinks about her pregnancy—whether she's happy about it and how much she knows about the facts of childbirth. "I ask, 'What do you think your baby is doing inside you?'" Most of them, said Gonzalez, have no idea.

The doula provides information at a level that the mother can grasp, Gonzalez said. The doula shows videos on cesarean sections and epidurals so the mother understands her options for childbirth. "We have the knowledge, but they're always the experts," Gonzalez said. "We have to empower these young women to speak out." Most mothers in the Christopher House program do not ask for an epidural. They rely, instead, on breathing exercises, massage, rhythmic rocking and swaying and other alternatives, Gonzalez said.

During pregnancy, the doula teaches the teen mother to play games with the baby in utero and to hug her belly as a way of hugging her unborn child. "We teach them to love this baby before it's born," Gonzalez said. "The more real we make this baby inside them, the more connection they will have to the baby."

When labor starts, the mother is instructed to go to the hospital and, once she is admitted, to call the doula. Through all of this, the doula gets to know the teen well, Gonzalez said. Sometimes when the child turns one or two, the mother will telephone to tell her ex-doula about the birthday. "What is rewarding is that you may be able to make a difference in someone's life," Gonzalez said.

RESULTS

The following were among the results of the four-year project:

- Chicago Health Connection concluded that the pilot project demonstrated the feasibility of including the doula model in grassroots community services for young families in low-income communities. The project showed that many of the positive outcomes of doula support identified in the research literature can be achieved among low-income teen mothers, the organization said in a report to RWJF.
- The three pilot sites provided doula services to a total of 287 women. Three of the women had a second doula-assisted birth, bringing the total number of doula births to 290. Because five of the births resulted in twins, the number of babies born to the doula-supported mothers was 295.
- The pilot project achieved sustainability. At the end of the third project year, the Illinois Department of Human Services agreed to provide continued funding for the three pilot sites as a line item in the state budget (see Afterward).
- The state support of the three pilot sites allowed Chicago Health Connection to turn its attention to expansion of the doula model. In the fourth project year, the organization initiated four new doula projects in Illinois. One was at the University of Chicago's Friend Family Health Center, where the Harris Foundation initiated a randomized, controlled, longitudinal study of doula outcomes. (That study is ongoing and the results are not yet available.)
- Chicago Health Connection formed the Harris Doula Institute as a vehicle to support replication of the doula model. The replication effort received funding from a number of foundations and led to establishment of doula programs in additional sites (see Afterward for details).

Findings

In 2003, Susan Altfeld, PhD—researcher employed by the Ounce of Prevention Fund with funding from the Harris Foundation—issued a 92-page report on the pilot project's operation and impact (*The Chicago Doula Project Evaluation Final Report*).

Her evaluation excluded 21 of the 287 doula-supported mothers because they were 20 or older at delivery. Another seven mothers asked to be excluded from the analysis—an option that was open to all participants. This left a research sample of 259 mothers involving 262 pregnancies and 265 babies. (The 265-baby total reflects two stillbirths—a number that the report said did not differ significantly from the fetal death rate for the city at large. There were no infant deaths, but given the small sample size, this also was not a statistically significant outcome.)

The mothers ranged in age from 13 to 19 and averaged 16.8 years old. About 63 percent were Hispanic and 34 percent African American. Data sources for the evaluation included hospital records and birth certificates as well as focus groups and interviews with the mothers, the doulas and other project personnel.

The evaluation design did not permit separation of the doula impacts from the impacts of other social services that the mothers received, including home visitation through Parents Too Soon. (The ongoing University of Chicago study cited above will isolate the effects of the doula intervention.)

The 2003 report by Altfeld included these findings:

- Almost a fifth (18.8%) of the participating mothers did not have a doula in attendance at labor and delivery. The reasons included:
  - A precipitous birth that left insufficient time for the doula to get to the hospital.
  - Program-related causes such as the inability to locate a backup doula when the assigned doula was unavailable.
  - Participant-related causes, such as the mother failed to notify the doula that labor had begun.
  - Refusal by the physician or hospital in four instances to give the doula access to the mother.

  Abramson said the number of unattended deliveries was unexpectedly high.
- The cesarean-section rate for mothers with a doula present at birth was lower by a statistically significant degree than for Chicago teen mothers as a whole—8.1 percent compared to 12.9 percent. C-sections are associated with such risks as infections and lengthened hospital stays. However, the C-section rate for the entire doula-supported sample—including births unattended by a doula—was 9.6 percent, which statistically

is not different from the citywide rate for teen mothers. Therefore, project enrollment by itself had no effect on the C-section rate, the report said. The critical factor was doula support at delivery. (The C-section rate for all U.S. teens was 14.5%, according to Chicago Health Connection.) The report cautioned that the study did not control for a number of factors that could affect these findings, including different practice patterns by different health care professionals and hospitals.

- When the C-section results were analyzed by race, the evaluator found that the C-section rate was statistically lower for non-African Americans but not for African Americans. A number of factors unrelated to doula services could account for this result, the report cautioned. For example, the African-American mothers were more likely to have a preexisting risk factor, thus increasing their chance for a C-section. Among African-American mothers who were risk-free, the study found a statistically significant relationship between doula attendance at delivery and a reduced C-section incidence.
- The doula mothers—both those enrolled and those with a doula in attendance at delivery—had lower rates of forceps/vacuum-assisted births than teen mothers citywide. Again, however, when stratified by race, the difference held for non-African Americans and not for African Americans.
- Doula mothers used epidural anesthesia in only 11.4 percent of the vaginal births. Comparison data are limited, but the report cited estimates that epidural anesthesia is used in 50 percent of vaginal births at urban hospitals.
- Eighty percent of the doula mothers initiated breastfeeding compared to 47.3 percent for teens nationwide. After six months, 21.8 percent of the doula mothers were still breastfeeding compared to 12.2 percent of all U.S. teens. "Breastfeeding outcomes have been a major achievement of the Chicago Doula Project. Doulas were especially well trained in this area and were able to effectively assist participants," the report said.
- Compared to teen mothers citywide, the doula-supported mothers were less likely to have inadequate prenatal care and also less likely to have a preterm or low-birthweight baby. Also their babies had higher APGAR physical condition scores one and five minutes after birth. (APGAR is a test given immediately after birth to evaluate the newborn's heart rate, respiration, muscle tone, reflex response and skin color.) However, the report cautioned that it was unclear if these outcomes resulted from the doula intervention or if the women who chose doula support were more likely to take better care of themselves. (Based on self-report, the doula mothers were less likely to smoke cigarettes during pregnancy than Chicago teen mothers in general.)
- A depression-screening inventory indicated a high level of depression among the doula-supported mothers. On the Center for Epidemiological Studies Depression Scale, about half of the tested mothers scored at or above the cutoff point for significant symptoms. The scores are in line with other surveys of young and low-

income mothers. Two of the three sites initiated mental health services for participants in response to the finding.

- The cost of the doula program is $2,500 per participating mother in the first program year if the site handles at least 18 births per doula, has two doulas, and there is no staff turnover. The figure includes $80,000 in operating costs per site and $10,000 in training costs per site. If there is no staff turnover, the per-participant cost drops to $2,222 in succeeding years. The $80,000-per-site figure includes salaries and benefits for two full-time doulas, a portion of the program director's salary, clinical consultation by an RN or midwife, materials and travel.

- The program saved an estimated $89,268 in reduced cesarean section costs over the three-year evaluation period. This estimate assumes doulas averted 12 C-sections, each one resulting in a saving of $7,439—the difference between the average hospital charges for a C-section and for vaginal delivery. The project also estimated savings of $92,000 in decreased hospital charges for epidurals. The analysis found $259,603 in savings from shortened hospital stays. However, the shorter-stay saving applied only to Alivio participants, a large number of whom had no insurance coverage, giving the hospital an incentive for early discharge. Chicago Health Connection cautioned that more study would be necessary before cost-benefit conclusions could be drawn from these data.

The report also drew a number of nonstatistical conclusions, including:

- The model's flexible application allowed the pilot sites to add additional services and adapt the program in the way that worked best for them. However, the flexibility also permitted the sites "to omit program elements that seemed difficult or challenging" and complicated the effort to measure the impact of the intervention.

- All of the doulas trained under the project "found the job to be physically and emotionally difficult." Doulas must buffer the mothers from negative attitudes of health care professionals and are themselves sometimes seen as adversaries by hospital staff and family members. The job's unpredictable time demands compound the stress. To be successful, a doula needs a "supportive personal network, as well as agency support." Nevertheless, many of the project doulas found the role to be personally and professionally meaningful and viewed becoming a doula as a significant accomplishment.

- Doula selection is "key to the success of the program." The identification and hiring of women who will be successful doulas is a time-consuming process. Retaining doulas is also a challenge. "Salaries, working conditions and personal satisfaction are important elements in retention."

- Doulas felt welcomed and accepted by midwives, but support from other health care professionals was variable. While some physicians were helpful, sometimes "the attending resident physician was rude to the doula, refused to answer her questions about the care of the patient or seemed to resent her involvement." In only one case

did the doctor prohibit the doula from attending the birth. However, some nurses raised barriers to the doula's involvement, most commonly by counting the doula as a visitor and invoking the hospital rule against more than two visitors at one time. For example, if her own mother and the baby's father were both present, the mother would have to choose one of them or the doula to leave the room. Hospital security personnel could also be a problem by questioning and delaying the doula and sometimes denying her access because she was not a relative of the mother.

- Directors at all three pilot sites felt doula services had improved the Parents Too Soon program and had had beneficial effects on mothers' birth experiences and mother-baby interaction. "The moms are more sweet with their baby. They seem happier," the report quoted one director as saying. However, the site directors also said the program was time-consuming to implement.
- Feedback from the mothers was positive. They saw doulas as reliable sources of support—more reliable than their own mothers or partners because the doulas were experienced and not "overwhelmed at seeing the participant in pain during labor."

Communications

The project director and other staff made numerous presentations about the pilot project at conferences and meetings held by professional organizations. These included the Early Head Start Institute, Doulas of North America Conference, and American Public Health Association Annual Meeting.

In addition, Chicago Health Connection sponsored a conference and a number of workshops on doula support and related subjects. Articles in the journal *Zero to Three* gave the project national attention, and an article in the *Chicago Tribune* helped build support locally. The project produced a glossy brochure and three videos about the doula intervention. (See the Bibliography for details about many of these communications activities.)

AFTERWARD

Replication in Illinois

Irving Harris encouraged Chicago Health Connection to replicate the model nationally and committed financial support to the expansion for six years following the end of the RWJF grant—until 2007, Abramson says. The replication effort also received funding from the W. Clement and Jessie V. Stone Foundation, A.L. Mailman Family Foundation, Pritzker Cousins Foundation and the Hasbro Charitable Trust. The Chicago Health Connection commenced ongoing exploration of possible public funding streams for doula services, including Medicaid reimbursement.

As of late 2003, Chicago Health Connection had helped establish doula programs at eight Illinois sites in addition to the three original pilot sites, which continued in operation. Four of the new Illinois sites were in Chicago, two in Rockford, and one each in Peoria and Kankakee. During 2004, the Ounce of Prevention Fund expanded doula services into their family support work in other sites, and by the end of 2004 there were 19 doula sites in Illinois.

Replication in Other States

By December 2005, Chicago Health Connection had also partnered with local agencies to implement replications in Albuquerque, Atlanta, Minneapolis, Denver, Phoenix and Indianapolis.

As of November 2007 staff at the Chicago Health Connection was working with 34 Doula Projects in 10 states. Senator Richard J. Durbin (D-Ill.) had sponsored a $1.5 million request for federal support for a national replication of the program that was approved in the Senate budget in October 2007.

Although Rachel Abramson has great faith in the Chicago doula model, she says the wide replication of the project has surprised even her. Abramson, executive director of Chicago Health Connection, attributes the rapid spread of the model in part to the positive outcomes of the RWJF-funded pilot project.

The replications do not necessarily follow the model precisely. For example, while the pilot targeted teenagers, the Albuquerque program includes women beyond their teens. The length of the intervention differs from site to site as well. So does the number of mothers served, although generally a site with two doulas handles 50 to 60 births a year—a larger number than served by the RWJF-funded pilot.

Chicago Health Connection has implemented its model in collaboration with a number of different programs, including Early Head Start, Healthy Start and Healthy Families Illinois. Abramson and her staff developed a packet of replication materials, including an application for organizations interested in establishing the model in their communities. The staff helps groups evaluate their local needs, plan a doula program to meet the needs, and recruit and train the doulas. The local collaborating agency pays consulting and training fees to Chicago Health Connection.

Abramson reported in April 2008 that Chicago Health Connection now had contracts with 23 organizations in 10 states including Georgia, Indiana and Texas to provide training and technical assistance to doula programs for low-income women. One program was located in a residential addiction treatment facility. The doulas there were graduates of the residential program.

The organization was continuing to facilitate a network of community-based doula programs and advocate for public funding to help support the programs. Abramson said the first federal grant to support community-based doula programs was a $1.536 million SPRANS (Special Project of Regional and National Significance) competitive grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA).

Abramson also said that the organization was about to pilot a Web-based data collection system to gather data from the network of doula programs on such information regarding doula-assisted births as:

- Medical intervention rates in labor and birth.
- Breast-feeding rates.
- Mother-infant interaction.
- Prevalence of low-birth weights.
- Use of birth control post-partum.

A Replication Example: The Atlanta Replication

The Atlanta program—Georgia's first community-based doula service for pregnant teens—provides an example of how a replication may work. The replicating agency is the Georgia Campaign for Adolescent Pregnancy Prevention, a private nonprofit supported by foundations and individual donors. G-CAPP, as the organization is known, operates the doula program under a contract with the Fulton County Health and Wellness Department (Atlanta is in Fulton County).

To initiate the program, G-CAPP recruited 12 women for a 10-week doula training course taught by Chicago Health Connection staff. G-CAPP gave the women—half of them African-American and half Latina—a stipend during the training period. At the end of the training, the agency selected one African American and one Latina to be full-time, county-paid doulas. A third trainee got a job with another organization. Michele Ozumba, G-CAPP executive director, said the organization trained more women than needed in order to have a sizable hiring pool.

The two Atlanta doulas work out of county health clinics and are in contact with the mothers from the sixth month of pregnancy through the fourth month postpartum. As a small program in a large county bureaucracy, the doula initiative has not had the priority and visibility that Ozumba believes it deserves.

Nevertheless, after some initial kinks, the program is working well, she says. In the first year, it enrolled 37 young women and achieved a 100-percent breastfeeding rate. The

doula-served mothers who participated in a focus group were positive about the support they received, says Ozumba. She hopes eventually to hire more doulas and base them in a hospital system instead of county government.

Nacira Amedetohou was a 17-year-old high school senior living in a predominantly African-American neighborhood on Atlanta's southeastern side when she became pregnant. Nacira's doula, Ponchita Ridley, helped her enroll in a Lamaze childbirth class, taught her relaxation techniques, brought her a book illustrating a baby's appearance at each stage of pregnancy, and impressed on her the importance of connecting with the little life taking shape inside her, including reading to the baby even in utero.

When Nacira gave birth to her daughter, Zariya, in March 2003, Ridley was at the hospital. Afterwards she continued to visit the new family, and when Nacira graduated from high school, Ridley was on hand then, too. "We're like friends now," says Nacira, who entered Atlanta Metropolitan College the following fall with plans to become a high school English teacher.

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Program area: Vulnerable Populations

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