



Opening Doors to Doula Care: History, Access, and Integration in California

Moderator: Adrienne McIntyre

Panelists: Rafeal Newport, Kimberly Robinson, and Natasha June

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Continuing Education Information

MCCPOP

Mid-Coastal California
Perinatal Outreach Program

- Attendees will be eligible for contact hours through the the Mid-Coastal California Perinatal Outreach Program (MCCPOP). MCCPOP is approved as a provider of continuing education by the California Board of Registered Nurses, Provider #3104. This course has been approved for **1.0** contact hour.
- Attendees must remain on the webinar **for at least 50 minutes** and are required to complete the evaluation post session, in order to receive contact hours.



Moderator and Panelists



MODERATOR
Adrienne McIntyre



PANELIST
Rafeal Newport



PANELIST
Kimberly Robinson



PANELIST
Natasha June

Objectives

1. Trace the historical roots and evolution of doula care and explain why this history is important for understanding respectful maternity care, birth equity, and today's cesarean disparities.
2. Describe the role of doulas across the perinatal continuum, including prenatal, labor and birth, postpartum, and other reproductive health services. Compare how doula care is provided in home, birth center, and hospital settings.
3. Review the current landscape of doula integration in California, including partnerships with healthcare teams, Medicaid reimbursement policies, and payment models that affect access to doula services.

Two roles. One cannot stand in for the other.

Before we talk about cesarean rates, we have to be precise about who does what.

MIDWIFE

clinical care provider

- Assesses and monitors birthing person and baby
- Provides prenatal, birth and postpartum clinical care
- Catches the baby; recognizes and manages complications
- Carries clinical scope, training and legal accountability

DOULA

non-clinical support

- Continuous physical and emotional support in labor
- Information and preparation for decision-making
- Advocacy and continuity across the whole birth
- No clinical scope: does not assess, monitor or deliver

MONTRICE

The role that already bridges them: a midwife or nurse who provides clinical assessment at home and continuous support through a hospital birth. The bridge exists. There is just no pathway into it.

Both are needed. Only one of them replaces what these communities lost.

Who named this role - and what they built it for.

The word and the profession both came from outside the communities that had lost their midwives.

THE WORD

the Greeks had two words

- μαῖα (maia) was the woman who attended birth - the midwife. Socrates' mother was one.
- δοῦλα (doúla) meant something else: female slave, bondwoman. That is the word the modern role was given.
- Black and Indigenous birth workers are moving away from it. Names used instead: birthworker, birth keeper, birthing assistant.

THE MAKERS

who built the modern role

- Dana Raphael, medical anthropologist, names the role in 1966 and 1973.
- Marshall Klaus and John Kennell, pediatricians, find the effect during a 1973 Guatemala bonding study; publish in NEJM in 1980.
- DONA founded 1992 by Klaus, Kennell, Phyllis Klaus (psychotherapist), Penny Simkin (physical therapist) and Annie Kennedy.

Researchers built a role to put support back into hospital birth. Nobody built a role to give midwifery back.

What we had here - and what was taken.



Midwife near Siloam, Greene County, Georgia. Photograph by Jack Delano, 1941. Library of Congress, FSA/OWI Collection - no known restrictions.

1900s-40s

Black "granny" midwives attend up to 75% of births across the South - and carry full scope: prenatal care, birth, postpartum, and the health of the whole community.

1910

The Flexner Report recommends hospital birth and the elimination of midwifery.

1921

Sheppard-Towner ushers in state licensing. Alabama's new rules end the practice of 150 granny midwives almost overnight.

1925

The Frontier Nursing Service formalizes nurse-midwifery in Kentucky - and excludes Black women from training.

1980

Midwives attend 1.1% of all U.S. births.

This was not a fading tradition. It was a profession that was legislated out of existence.

Why this history belongs in the cesarean conversation.

37.0% vs 30.8%

Cesarean rate for Black versus white birthing people in California, 2022-2024 average.

39%

Lower likelihood of cesarean birth with continuous support from someone in a doula role.

35%

Lower likelihood of reporting a negative birth experience with that same support.

- Doula support is the most effective thing we have for how a birth feels - dignity, safety, protection from birth trauma. That is real, and it is not small.
- It is also not clinical care. A non-clinical role cannot assess, cannot monitor, cannot manage a complication - and asking it to anyway is burning doulas out.
- The doula role should stay exactly as it is. What is missing is the rung above it.

Keep the doula role. Build the rung above it - a paid clinical-support tier a doula can train into, which the monitrice already does - and give these communities back the midwifery that was taken from them.

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Upcoming Health Equity Advisory Council Webinar (11/19/26)

Birth Empowerment Through Partnership: Integrating Doula Care into California's Healthcare System

🤝 Partnering With Doulas

Key recommendations from ACOG's 2026 guidance and evidence on the benefits of continuous doula support.

🏢 Integrating Doulas Into Clinical Care

Common concerns around liability, scope, roles, and workflows, along with strategies for effective hospital–doula partnerships.

💡 Building Understanding & Connection

Strategies to increase clinician understanding of the doula role, including staff education, hospital policies, advisory boards, and referral pathways.

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The Mid-Coastal California Perinatal Outreach Program Presents

Advanced Fetal Monitoring Webinar Series

MCCPOP

Mid-Coastal California
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Monday, November 9, 2026 OR Monday, December 7, 2026 | 1:00pm – 4:00pm PT Live on Zoom, *Registration Required*

This three-hour workshop focuses on the principles of advanced fetal monitoring knowledge and the skills necessary in clinical practice. Utilizing a case-study format, we will analyze complex FHR patterns/characteristics, underlying maternal-fetal physiology related to various maternal complications, appropriate interventions, documentation, communication and risk-management strategies.

Participants in this webinar will:

- Improve decision-making and critical thinking skills by utilizing standardized terminology, protocols and patient safety principles in EFM strip analysis.
- Review the relationship between maternal/fetal physiology and fetal heart rate patterns.
- Discuss the medical/legal implications of EFM through case review to reduce errors, improve outcomes and ultimately decrease liability.
- Review the importance of excellent communication and teamwork to improve outcomes.

Scan to Register for 11/9



Scan to Register for 12/7



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