Strategic Advocacy: Doula Care, Liminality, and Reproductive Justice

Angela Castañeda
*DePauw University, acastaneda@depauw.edu*

Julie Johnson Searcy
*Butler University*

Ellen Block
*Butler University*

Follow this and additional works at: https://scholarship.depauw.edu/socanth_facpubs

Part of the Sociology Commons

**Recommended Citation**


This Article is brought to you for free and open access by the Sociology & Anthropology at Scholarly and Creative Work from DePauw University. It has been accepted for inclusion in Sociology & Anthropology Faculty publications by an authorized administrator of Scholarly and Creative Work from DePauw University.
Strategic Advocacy: Doula Care, Liminality, and Reproductive Justice

Julie Johnson Searcy1 · Ellen Block1 · Angela N. Castañeda1

Accepted: 2 May 2024 © The Author(s) 2024

Keywords Reproductive justice · Maternal health · Doulas

Introduction

“When I was pregnant, the amount of fear that I had not knowing if I was going to make it. It is something that I don’t want more women to have to go through. So if there’s a way I can help, if there is education, or resources, or connecting a doula to a mom, if there’s something that I can do to alleviate all that and try to make it one less number, I will do that. I will do that.”

Ana, Black Doula in the US

Maternal and infant health are highly sensitive measures of the general health and wellbeing of a population. To assess the level of inequality in a society, look first at the maternal and infant health statistics. In 1994, the United Nations International Conference on Population and Development (ICPD) called for more comprehensive, women-centered approaches to maternal and reproductive health care globally, acknowledging that development and reproductive health are linked (1994). In the 25 years since the adoption of its Program of Action (PAC), the ICPD recognized reproductive rights as human rights and emphasized the critical need for quality reproductive health care in improving maternal health and maternal mortality. This focus on maternal health has led to increased attention and investments in improving maternal care globally (WHO 2021). Despite its stated commitment to ICPD goals (U.S. Department of State 2023), more people die from complications of pregnancy and childbirth in the USA than in any other high resource country (Zarocostas 2023; Ellmann 2020; Gunja et al. 2022).

Compared other countries in the Global North, the USA ranks at the very bottom in terms of maternal mortality by a significant gap (Hoyert 2022; Gunja et al. 2022).
In 2017, the USA and the Dominican Republic were the only two countries to report a significant increase in their maternal mortality ratio (Declercq and Zephyrin 2020; WHO 2019). A person giving birth today in the USA is twice as likely to die from pregnancy-related complications as their family members were a generation ago, even though the USA spends more on health care than any other high-income country (Every Mother Counts 2022; Gunja et al. 2022). Tragically, the CDC recently noted that 80% of these maternal deaths are preventable (Trost et al. 2022).

Layered on top of these troubling statistics are stark racial disparities. Black and Indigenous people are three to four times more likely to die from pregnancy-related causes; this devastating reality is not a surprise given the racist history of obstetrics in the USA (Owens 2017). Neither income nor education level are protective factors for these groups (Taylor et al. 2019; Hill et al. 2022; CDC 2023; Ellmann 2020). The US maternal health crisis is fueled by an over-medicalized health system and structural racism which drives racial disparities in maternal morbidity and mortality (Davis 2019a; Williams 2012; Feagin and Bennefield 2014; Mullings and Wali 2001; Roberts 1997; Ellmann 2020). Scholars have long noted the technocratic and hyper-medicalized nature of births in American hospitals and have raised the alarm about the impact it has on mothers and babies (Rothman 1982; Davis-Floyd 1992). High-income countries like the USA operate with a “too much too soon” model in which high rates of medical intervention produce worse outcomes for people giving birth, in contrast to other parts of the world where lifesaving interventions are “too little too late” (Miller et al. 2016; Davis-Floyd and Cheyney 2019). Other factors impacting maternal health read like a laundry list of challenges preventing the USA from meeting ICPD standards: privatized single-payer insurance system that prohibits quality care to all people during pregnancy, provider shortages—especially in rural areas—mean many communities cannot get the care they need, disrespectful treatment of marginalized people in hospitals, the underuse of evidence-based practices, and inadequate postpartum support and policies all contribute to the alarming outcomes. As awareness increases of the United States’ dismal maternal health record and deep racial inequities, public health officials, activists, communities, and politicians are turning to doulas to help improve maternal health in the USA.

Doulas are trained professionals who provide physical, emotional, and educational support to birthing parents through the pregnancy, birth, and postpartum period. At the national level, members of the Black Maternal Health Caucus continue to work to pass the Momnibus bill, which includes funding for more midwives and doulas. According to the National Health Law Program, more than half of all states either currently offer Medicaid coverage for doula care, are in the process of implementing that care, or are taking some action related to Medicaid coverage for doulas (2023). These national efforts to include doulas in maternal health care acknowledge doulas’ role in alleviating some of the negative effects of unequal access to reproductive healthcare, obstetric violence, technocratic models of birth, and racism (Greiner et al. 2019; Ellmann 2020; Gruber et al. 2013; Sobczak et al. 2023). The presence of a doula increases rates of spontaneous vaginal delivery, reduces cesarean rates, decreases rates of preterm birth and low birthweight babies, increases rates of breastfeeding initiation and maintenance, and improves the emotional wellbeing of the birthing person before, during, and after birth (Sobczak et al.
Doulas can play a role in bringing US maternal health into alignment with ICPD goals and objectives, especially because many doulas see their work linked to reproductive justice. At the same time, it is critical to understand the liminal position doulas occupy, and the strategic advocacy required to do their job well.

Reproductive justice is a social justice movement centered around sexuality, gender, and reproduction that is built on three foundational concepts—analyzing power systems, addressing intersecting oppressions, and centering the most marginalized people (SisterSong, 2022). We argue that the role of the doulas creates the potential for reproductive social justice. The liminal position doulas occupy allows them to understand medical systems; as witnesses they observe different hospital practices that give them a unique perspective on power hierarchies. Doulas also address intersecting oppressions through their advocacy both inside and outside of the hospital. Finally, the most essential task of a doula is to provide continuous and attentive care to the birthing person. As scholars of reproduction have noted, biomedicine decenters the person giving birth and foregrounds efficiency through routine hospital procedures and policies (Davis-Floyd 1992; Davis-Floyd 2001). Doulas however see their primary work as centering the person giving birth, offering close individual attention to their needs throughout labor and postpartum. This is a radical act in a system that often makes the person in labor the most marginalized one in the room. However, we also recognize that doulas’ liminal position creates constraints for doulas. This liminality enables what we call strategic advocacy—a creative form of advocacy that gives doulas an important role to play in the reproductive justice movement. We argue that doulas embody care ethics through strategic advocacy that is critical for reproductive justice in the face of a biomedical/technocratic approach to birth.

In this paper, we explain the larger political economy in which doulas work, highlighting the nature of their liminality, and their role in the reproductive justice movement. We then draw on over 60 qualitative interviews with doulas to articulate experiences and perspectives, demonstrating the ways they use strategic advocacy to meet the needs of birthing people. Finally, we consider how doula policies and practices could support doulas without compromising their focus on the birthing person. We argue that doulas embody care ethics that are critical for reproductive justice as their work is about humanizing the birthing person, often in the face of a heavily medicalized or biomedical/technocratic approach to birth that is depersonalizing or worse.

The Political Economic Context of Doula Care

Doulas occupy a liminal position; they work for families, but they are not part of the family. They attend births in hospitals, but most are not employed by hospitals. They walk a space in-between, navigating interactions with the families whose births they are there to support while also navigating interactions with hospital staff. Despite their growing presence in the USA, doulas still struggle to gain legitimacy in clinical spaces. They can be met with confusion, suspicion, and sometimes hostility from
hospital clinicians. Nurses and doctors may not understand why they are there or the expertise they bring to a birth. Everson and Cheyney describe the doulas’ position this way: “Situated within the in-between, doulas find themselves metaphorically and theoretically stateless, between two worlds, suspended in limbo. However, they may capitalize on the ritual power of the in-between” (Everson and Cheney 2015, 205–206). Doulas’ liminality is part of larger historical political economies that devalue reproductive work.

Doula work exemplifies the work of social reproduction that Nancy Fraser argues is essential to society as it provides the social bonds between and across communities that enables social organization (Fraser 2017). Social reproduction has long been gendered and split from economic production; there has been little monetized value accorded to care work historically (Folbre 2002). This political economic structure in the USA is deeply tied to racial politics, with women of color often constrained to perform this kind of reproductive care work in deeply problematic ways (Mullings 1997; Bonaparte 2015). Doula work is set within this gendered and racialized political economy of social reproduction that casts it as low status and of little economic value. It is not surprising then that many doulas struggle to sustain doula work as a full-time job because it is difficult to make a living wage. For many years, being a doula was accessible mostly to people in two-income families, where one person made enough to sustain their family, giving the doula a financial cushion (Searcy and Castañeda 2022). Economic barriers to this work remain in place, especially for marginalized women who want to be doulas. In addition to the difficulty of making a living wage as a doula, there are economic barriers to entering the profession as the high cost of training and certification programs can be prohibitive for many communities (Davis 2022).

Performing low-status care work, doulas also find themselves navigating the hierarchies of the US biomedical system. These hierarchies are deeply entrenched and well documented, and the dynamics between doctors, nurses, and patients are instilled starting in medical school (Vanstone and Grierson 2022; Good 1998). These hierarchies discourage collaboration and clinicians are trained to dismiss other forms of data and knowledge such as the social histories and emotional states of the patient or nonclinical forms of healing and support, all of which are types of knowledge doulas bring to the birthing room (Jordan 1997; Davis-Floyd and Sargent 1997). Thus, doulas in a biomedical space do not rank as experts with legitimate knowledge, and their low status reinforces their liminal position. In addition, doulas often support families who want a nonmedicalized birth and advocate for patient choices that fall outside the technocratic models of birth employed in hospitals. This creates a fundamental gap between the goals of the doula, who are working to support a person’s autonomy during labor, and the goals of the hospital system which favors technocratic medicalized birth (Davis-Floyd 1992). Though official organizations like The American College of Obstetricians and Gynecologists (ACOG) acknowledge the positive impact of a support person during birth, in actual practice, doctors and nurses often treat doulas as low-ranking outsiders (Adams and Curtin-Bowen 2021).

The liminal context in which doulas operate has shaped the ways doula training and certifying agencies have positioned themselves. In the early 1990’s, training
organizations like the Doulas of North America (now DONA International) urged their doulas to approach clinician-doula relationships respectfully and deferentially. This way of navigating these larger medical systems reflects the difficulty doulas had in gaining access and legitimacy in hospitals at that time. Their resistance to making advocacy an official part of doula work was a strategy employed to maintain access to those spaces. They did not want doulas framed as troublemakers in ways that would exclude them from hospitals (DONA International 2017). As increasing public acknowledgement of maternal health inequities have come to the foreground, other doula training and certifying organizations have pushed back against this reluctance to position doulas as advocates. Many doulas of color see advocacy as central to their work (Davis 2022), and in the last decade, some training organizations teach advocacy and reproductive justice as critical to the work of doulas. The ever-growing number of training and certifying doula organizations has reached into the hundreds now, but there is no unified national or transnational doula organization or certifying body (Searcy and Castañeda 2022). The absence of a central board of doulas, or national professional body, makes formal conversations and collaboration between doulas and professional health organizations like ACOG or the American Nursing Association challenging.

As more states implement policies that make doulas payable through Medicaid, the fragmented process and different policies being implemented in different states reflect these broader national efforts and signal its lack of coordination or standardization. The USA has no public healthcare system which makes it difficult to get any kind of large-scale traction as different hospital systems implement different policies. Doulas who attend births in several different hospitals in their local area may encounter different policies and practices—as well as different attitudes—toward them in each place. The difficulties of this situation reinforce the liminality of a doula’s position. Yet, as we demonstrate in this article, this liminality allows space to transform doula care into a form of reproductive justice.

**Reproductive Justice, Doulas, and Strategic Advocacy**

Considering the troubling maternal health inequalities in the USA, reproductive activists and birth workers have turned to the reproductive justice framework in an effort to address these disparities (Wade 2023; Dillard and Cavallo 2023). Reproductive justice emerged as a concept in the USA in 1994 when a group of Black women, organized as the Women of African Descent for Reproductive Justice, recognized that the reproductive rights approach was limiting, and did not account for deeply rooted structural violence and racism that requires a broad, system-focused approach. Reproductive justice allows for “a capacious framework” with a commitment to ‘intersectional analysis’ while still grounded in human rights (SisterSong 2022). Developed in the USA, reproductive justice challenged the “restrictive domestication of human rights” by instead highlighting social and economic factors contributing to structural inequality in the reproductive process (Luna 2020, 4). Reproductive activism emerged in the Global South with a broader, more inclusive agenda (Suh and McReynolds-Pérez 2023)
where activists have protested population control, advocated for more holistic strategies in addressing reproductive health, and more specifically, called attention to obstetric violence as they argue for more humanizing birth. These activists define obstetric violence as “aggressive, humiliating and disrespectful treatment of women and girls during labor” and link this treatment to “broader entrenched gender violence and social inequalities of race, class, age and ethnicity” (Chadwick 2016, 423). Activists in Latin America, in efforts to center ICPD principles and goals have pushed to make obstetric violence a legal term, lobbying for legislation that would protect birthing people against obstetric violence. While obstetric violence has been documented in the USA as well (Garcia 2020; Diaz-Tello 2016), efforts to improve maternal health in the USA have coalesced around the reproductive justice framework to address racial inequalities in maternal health outcomes. It is important to note the critical concepts that inspired reproductive justice in the USA share a common ethos with Global South advocates—both critique the emphasis on population control and argue that reproductive health must center broader measures of wellbeing that go beyond birth control (Suh and McReynolds-Pérez 2023, Unnithan and Pigg 2014).

In a US context, doulas have increasingly become part of an effort towards reproductive justice. Doulas have long worked alongside marginalized communities to accompany birthing people through important life transitions. They have worked hard to gain legitimacy over the past several decades in hospitals and birthing centers (Castañeda and Searcy 2014). One of the ways they have done so is by seeing advocacy in the birthing room as outside the scope of their role (DONA International 2017). Yet, in the context of exclusionary practices that emerged during the COVID-19 pandemic and increasing national recognition around reproductive injustices in the USA, doulas and doula organizations are shifting their narrative around the role of advocacy in doula work.

Doulas have learned to advocate strategically in order to protect their position in the birthing room. Doulas must center the birthing person while working to gain legitimacy from medical staff as members of the birth team. Yet it is precisely their liminality that allows doulas to advocate for the birthing person effectively without being beholden to the policies and practices in hospitals that lead to negative birth experiences and outcomes. Most doulas prefer an indirect or “soft” form of advocacy (Yam 2020) that is less likely to create conflict with the medical staff and more likely to protect the integrity of the birthing space. However, sometimes strategic advocacy requires a direct approach that is often more confrontational to protect the birthing person and prevent obstetric harm or violence. Strategic advocacy requires doulas to carefully assess the dynamics, possible outcomes, and stakes of each situation, and decide on the best course of action in order to meet the needs of the birthing person and their family.

We argue that doulas embody care ethics that are critical for reproductive justice as their work is about humanizing the birthing person, often in the face of a heavily medicalized or biomedical/technocratic approach to birth that is depersonalizing or worse (Davis 2019a, 2019b; Valdez and Deomampo 2019; Zavella 2020; Mullings and Wali 2001; Ross and Solinger 2017). Doulas are both attending to the context in which caring needs are met with a focus on reproductive
justice and are engaging in caregiving relations that meet the physical and emotional needs of birthing people at a vulnerable, frightening—and sometimes dangerous—moment in their lives. Their capacity to do this emerges from the liminal position they hold and the strategic advocacy they employ.

**Methods**

This research is part of a larger longitudinal ethnographic project on doula care that started in 2012. While the insights of this chapter are rooted in this longer project, this chapter is drawn primarily from 60 semi-structured interviews lasting between 45 and 90 min between May of 2022 and April of 2023 with doulas working in the USA. Interviews were conducted over Zoom by our research team, including the co-authors of this paper, as well as research associates and student research assistants. Interviewees were recruited as part of two separate ongoing projects by the research team. During a previous phase of one of the projects in 2020, over 500 doulas from around the world were surveyed about their experiences providing doula care during COVID-19. Thirty-four of the interviewees for this current phase of the project were recruited from US-based doulas who indicated in the initial global survey that they would be willing to be contacted for a follow-up interview. Of these 34 doulas, 71% were white, 18% were Black, 6% were Asian and Pacific Islander, and 3% were Indigenous and Latinx, respectively. In addition, twenty-six of the interviewees were recruited from another ongoing project that works with Black doulas based in Indiana. All findings were analyzed using Dedoose. The team developed coding by individually creating codes for the same three interviews and then coming together to collectively generating themes. We then used the themes to create codes that we then applied to another two interviews. When we saw that we had standardized coding across those interviews we applied the codes to the remaining interviews (Bernard et al. 2016).

Because racial inequities are so deeply rooted in US reproductive health, we include the racial identity as defined by each participant that we quote in this paper, recognizing that how doulas are racialized in the birth space affects their perspective and what they witness and experience. Doulas’ experience of their own racial identity also shapes their approach to providing support to birthing people both consciously and unconsciously.

**Doula Care: Liminality, Advocacy, and Reproductive Justice**

In this section, we use qualitative data to demonstrate the way doulas give voice to their liminal position. We then draw on this data to demonstrate the kind of advocacy doulas use in their work that supports the larger reproductive justice
movement in the USA. The doulas quoted in the article are describing their experiences in hospital births.

**Liminality of Doulas**

Doulas clearly still occupy a liminal position in the hierarchy of birth workers, especially in hospitals. While the national conversation has moved in favor of supporting doulas as a key to reducing maternal health inequalities, the ways doulas are treated by hospitals, doctors, and nurses varies widely from welcoming them as a central part of the care team, to hostility and suspicion. This liminality both enables and constrains their roles as advocates in various ways.

Many doulas feel as though they are not valued and respected in hospitals by the other members of the care team. Doulas are frequently asked to show their credentials, are often mistaken for family members with no professional qualifications or are treated poorly or simply ignored. As Joslyn, a Black doula, stated, “They have these hierarchies that keep doulas in this fourth-class citizen type of position.” While some doulas mentioned having positive relationships with nurses and doctors, many more felt as though they were treated with hostility. Desarae, a Black doula, explained, “I think it’s gonna take a lot more from the nurses and their attitudes to change you know, for us to even make a way inside that space. Sadly, you know, we’re at the bottom.” With their continuous presence and intimate knowledge of the birthing person, doulas have the potential to assist the care team and facilitate a smoother and more satisfying birth for all involved. Yet, many nurses have little experience working with a doula and do not know the value they can add. As Ana, another Black doula, explained:

At first, I can tell nurses who have not worked with a doula or who haven’t worked with me. They’re worried about you reporting on them. That’s what they think. They’re not really a hundred percent understanding that you’re there to actually be their second set of hands. And so it’s not until they see you doing your work…it’s not until then that it fully clicks.

A doula’s marginalized position on the birth team, and the lack of understanding nurses and doctors have about what they can contribute to the care of the birthing person, limits the role a doula can play as an advocate.

Doulas of color, and in particular Black doulas who participated in this research, experienced the double burden of marginalization as doulas, as well as racism from hospital staff. Regardless of the number of births a doula had attended, most Black doulas we interviewed felt as though their expertise was not recognized or valued. Tahara, a Black and Muslim doula with 4 years of experience explained:

As Black doulas or doulas of color in general, we’re not really taken as experts in the field. It’s just like, oh, this is more of a helper but she really doesn’t know what she’s talking about. She might not understand, you know, the medical terminology and what’s really happening with the body. She’s just a person there and not really a knowledgeable person in the field.
Forging close relationships with families is one of the key trust-building strategies doulas employ to effectively accompany birthing people through a deeply intimate life transition. This is particularly true for Black doulas who noted using kin terminology such as “sis” to connect with their clients. Nicole, a researcher on this project, said “I feel like in our culture and community, in the Black community, when another Black woman refers to me as ‘sis’ I immediately feel embraced.” The rapport doulas have with their clients, along with assumptions about the professional role of Black doulas made by hospital staff, leads doulas to be frequently mistaken for family and friends, further reinforcing their liminality and marginalization. Janeva, a Black doula, had been with a client in labor over a nursing shift change when she was challenged about her credentials. She said:

I’m a part of her birth team. I’m not a friend or her family member, I’m her doula. And this was a different nurse. So it was, ‘Well I need to see your letter.’ I said ‘I’ve already done that. I’ve already showed someone my letter. I’ve already done all those things before I came in here. So now I want to see your chart, your supervisor so we can have a conversation about why I’m getting harassed as a birth worker.’ You know, so for me, I don’t have a problem. I want to ask you a question now, because why? Why are you bothering me while I’m trying to massage her feet? You know?

In the interest of protecting the birth space for their clients, doulas often choose not to escalate conflicts with healthcare providers. Ana, mentioned earlier, who had been accompanying a woman in labor for several hours, was told not to use the staff bathroom until one nurse explained that she was a doula. She said: “I just brushed it off because I’m like, you know, you people see what [you] want to see.” Janeva uses deep breaths to navigate tense situations while providing doula care for hospital births. She explained, “I feel like that staff member or whoever is being rude, you know, I take some time to kind of take a breath, slow it down, and figure out what I need to say so that I can be productive and proactive for my family.” Breath work and slowing things down are common strategies used by doulas while assisting a person in labor. Janeva uses them here to ignore interactions she might otherwise engage with in order to maintain her focus on her clients.

While liminality was clearly a point of contention for doulas and in some cases made it difficult for them to advocate for clients, doulas also saw their liminal status as a distinct advantage because they are not beholden to hospital policies and regulations. Yenna explained how she, a Black doula, wanted to resist being too closely tied to the hospital system in order to maintain her ability to help her clients achieve their desired births:

Some hospitals are trying to incorporate us even as freelance doulas. It’s not just the doulas who are employed by the hospital, who are following hospital protocols who are afraid to speak up for people because they don’t want to lose their job as a hospital doula…I’ve had friends who were hospital doulas, and then kind of got out of that because of the medicalized birth…When you work for the system, you’re trying to make people feel better about systematic pro-
cedures instead of allowing them to make the best decisions for themselves, or you’re too afraid to do that because you could lose your job.

Yenna insightfully notes that doulas cannot work to counter unnecessarily medicalized births if they are part of the system that produces them. They need to remain outside the hospital system to be able to critique it using strategic forms of direct and indirect advocacy. Not being beholden to hospital policies also allowed doulas to provide continuous care to clients. As Jill, a white doula, explained:

I think specifically for hospital births, one of the most unique things that we can provide as doulas is a continuation of care. I’ve been to those marathon births before where we see multiple shift changes, right? You had the am nurse and then the pm nurse and then the am nurse again is coming back and they’re still pregnant. And doulas, a lot of times, we’re still here. If we’ve gotten a 20-minute nap in our car or whatever…We don’t work for the hospital systems. So we don’t care what hospital procedures are as much. We’re advocating for what your wishes are.

Ana, a Black doula who had previously worked for a hospital, left because she was not able to fulfill her obligations to her clients because of her ties to institutional policies and practices. She said:

I was in such an awkward space because I’m an employee of the hospital, so I have to watch myself, but then I also am hired to advocate for this family. So it was an uncomfortable game that I had to play. And I didn’t want to do it anymore.

The liminal status doulas occupy in the birthing space stems from the power structures that rank doulas as low on the hierarchy of birth workers and undervalues doulas’ often extensive knowledge and experience of birth and the birthing person. While most of the doulas we spoke with stated that their goals were to support the birthing person in achieving the birth they desired, many families turn to doulas to help them achieve vaginal births with fewer medical interventions. Thus, doulas’ marginalization in hospitals is also deeply tied to their ideological differences with biomedical providers and institutions, and their continued efforts to slow down biomedical interventions so that birthing people can have the time and space they need to safely achieve the births they desire.

Doulas work hard to establish positive relationships with healthcare providers in hospitals to facilitate a positive birthing experience for their clients. They often have nurses and doctors they know and like, and work hard to build rapport and mutual respect with them. Sonté, a Black doula, attributes her success as a doula to her ability to connect with the nurses. She said:

I always go in in a non-threatening way. You know, I always start off with a compliment to the nurse. ‘Oh, my goodness, honey, you workin’ that scrub!’ You know, ‘Oh, I love your shoes!’ or something like that to break the ice. ‘Oh, thank you so much.’ I’m like, ‘Yeah, so how’s your day been going so
far?’ You know, get them conversating. And when I do that, it typically goes smoothly.

A group of community doulas we spoke with has so successfully established good rapport with a hospital that they have monthly calls with the nursing team to share feedback and effective strategies for labor and delivery. While doulas wish to be more valued and respected by the birth team and believe that they could contribute more effectively as part of the care team if their role was better understood by healthcare providers, most doulas would prefer to stay outside of formal institutional structures in order to maintain the ability to advocate for their clients without feeling beholden to hospital policies and practices. Sonté said she tries hard not to overstep boundaries with healthcare providers and to let some disagreements go. Ultimately, she knows she will not always be liked. She explained, “There might be some [nurses and doctors] that are there who say, ‘Well, I don’t like that doula.’ But that’s fine. I’m not here to work for you.” As long as the biomedical interventionist model of birth exists in hospitals, doulas will maintain a liminal position because they will continue to practically and ideologically oppose this model of birth. This liminality presents challenges for doulas, but also allows them to strategically advocate for their clients with little risk to their jobs.

**Strategic Advocacy**

The liminal position doulas occupy in clinical spaces leaves a good deal of ambiguity among doulas and doula certifying organizations as to whether or not doulas should view themselves as advocates, and what that advocacy should look like. As mentioned earlier, DONA International, one of the primary doula certification organizations in North America, has historically shied away from encouraging doulas as advocates, claiming that direct advocacy is outside a doula’s scope of practice. DONA’s advocacy policy currently states that a doula should never speak for a client but should advocate for them by encouraging them to ask questions and providing them with informational support (DONA International 2017). While DONA’s statement on advocacy does recognize doulas as advocates, their prohibition on doulas speaking on behalf of their clients when needed has led many DONA trained doulas to feel as though advocacy is discouraged altogether. For many doulas, especially doulas of color and those with racially diverse clientele, sometimes direct advocacy is needed. For example, Jennifer, a white doula, explained, “All of the doulas out there that have gone through that [DONA] education have learned that their role is to not advocate, and Black women need nothing more than somebody who can advocate for them…Every single pregnant person needs somebody that will give them a voice when theirs isn’t heard.” However, in the face of glaring racial disparities in birth outcomes, DONA has moved towards rethinking their stance on advocacy. Newly appointed DONA president Dr. Hillary Melchior, a medical anthropologist and doula, has begun to grapple with DONA’s desire to maintain doulas’ standards of practice with the need for doulas to be advocates. In December 2022 she tweeted, “We must change how DONA Intl defines and teaches advocacy in the
birth space; this is a major priority of mine for 2023!” While DONA is only one of many doula certifying organizations, it remains one of the largest and most well-known. The confusion around the scope of advocacy for DONA doulas exemplifies this tension in the broader doula community. While many doulas view advocacy as within their scope of practice, there is the possibility that advocacy can cause conflict with healthcare providers or could be considered medical interference (Amram et al. 2014). We found that doulas use a nuanced form of advocacy, which we call strategic advocacy, in order to navigate the liminal position they occupy on a birthing person’s care team, particularly in hospitals during the intrapartum period.

Most of the doulas we spoke with clearly identified strongly as advocates both inside and outside the birthing space and did not shy away from using the term advocacy when describing their core values as a doula. Tara, a white doula, said “I know advocacy is really a touchy subject for doulas, but I’ve always been a very clear advocate for my people in that space.” Some doulas saw their advocacy role as largely indirect, which can include educational support, rhetorical question asking, helping the birthing person and their partner speak for themselves, and processing experiences with the birthing person at a later time. For example, Mayte, a Latinx doula from a rural area, explained:

Oh, lovely word advocacy. Personally, for me, and this is my value as a doula, I feel like I can be an advocate for families, I just don’t choose the birth space to be an advocate. And the reason for that is because I feel like when I come in as a doula, I want to protect that birth space, that birth energy. And so if I see things, I make note of them, okay, this is happening. And then I talk to my client about it.

Cherie, a Black doula from the southern US who serves a mostly Black clientele, explained how she has transformed her views on advocacy as a matter of necessity. She said:

When I first started doing this, I was like, that political stuff, that advocacy thing, nothing to do with me, right? But I have definitely kind of been thrusted into that space. And supporting Black birthing bodies is advocacy, especially in the hospital. There’s no way that you can say that that’s not what you do. If you’re supporting Black birthing bodies, it is advocacy at the end of the day.

Cherie’s sentiments reflect those of many of the doulas we spoke to, particularly those serving diverse clientele, who made it clear that it was not possible to do their job without being an advocate for their clients.

While COVID-era restrictions made it necessary for doulas to maintain their doula certification in order to be allowed entry into hospitals, some doulas felt that this restricted them in their role as advocates by tying them more closely to the standards of practice set by certifying organizations such as DONA. Ashley, a white doula, who considers herself both an advocate and an activist, explained:

I thought about going back and getting certified. In the end, I feel more free as a doula to do the kind of justice and radical doula work I do without a certifying body. I worry especially because I did my training through DONA. I don’t
want to be certified through DONA because they keep a firm grip on people and what they can do. And they are not interested in social justice. But I feel like I can be more of a renegade doula if I’m not certified.

While almost all the doulas we spoke with viewed themselves as advocates, there was clearly still a strong preference for what we are calling strategic advocacy—that is, the strategic evaluation of the context in order to determine the best advocacy strategy needed to serve the birthing person at the time. This strategic and nuanced evaluation includes consideration of the age, race, ability, and gender identity of the birthing person, doula, and providers; the location of the birth; relationship the doula has with the rest of the care team and the birthing person; and the particular circumstances of the birth and the urgency and severity of the issue at hand.

Strategic advocacy is a highly creative endeavor that requires a doula to be able to read a situation and weigh the costs and benefits of various forms of advocacy—both direct and indirect—that might help bring about a particular result. Doulas prefer an indirect form of advocacy, or what Yam (2020) calls “soft advocacy.” As Yam notes, soft advocacy allows doulas to help birthing people maintain their autonomy during birth but also allows the doula to “center the interests of their birthing clients while ensuring that the birthing room remains a calm environment for all” (2020, 199). Doulas lay the groundwork for soft advocacy by educating their clients and empowering them to speak for themselves while at doctors’ appointments and in the hospital.

Many of the doulas we spoke to explained that the primary purpose of the informational support and education they provided to clients was to inform them about all their options. For example, doulas provided information about birthing positions, continuous fetal monitoring, use of IVs, and timing of umbilical cord cutting, providing families with alternatives to an overmedicalized model of birth. However, doulas were clear that they did not push families towards a particular kind of birth, but simply wanted to educate them about their options. Mayte learned this lesson during her doula training. She said: “I remember when I first took my first doula training, I thought I was a doula to prevent epidurals, I was a doula to prevent cesareans, I was a doula to prevent interventions. And then I started realizing no, I’m a doula to support families and how they want their birth to happen.” For many doulas, education and empowerment are intimately linked. As Courtney, a Black doula, explained, “I want to make sure that moms understand that even in a hospital setting, that they still have a choice. They still have a right. So empowering them with education, empowering them with the knowledge that they have a choice.” Doulas hope that this education will allow families to advocate for themselves during birth, in part so they can avoid tense and unwelcome interactions with healthcare providers. Cieara, a Black doula, explains how this strategy is also more powerful and effective coming from the birthing person. She said:

I try to help build my client up before she even goes into that delivery room…I try to empower her and help her to be able to find her voice so she can be able to advocate for herself. A lot of times there’s a stronger presence in that room when there’s the client that’s actually speaking up for herself and then she has a backup, so it just makes the circle a little bit stronger.
Like many doulas, Cieara also used rhetorical question-asking during birth to remind families about their previously expressed wishes or what they had written on their birth plan. She explained, “I check in with all my clients. I say, ‘Is this something that you really want to do?’ if [the doctor is] explaining a procedure or something. I was like, ‘How do you feel about it? Do you want to learn more? Do you want to have it explained differently?’” Like Cieara, Jakara, a Black doula, preferred for her clients to communicate directly with the medical staff where possible so that they understood that she was not forcing her preferences on her clients. She said: “I typically don’t say much to the nurse as far as, ‘Well, why are we doing this?’ Or ‘Why are we doing that?’ I always advocate for the mom and the partner to be the ones to speak with the nursing staff or medical staff so that they know that that is what they want versus the doula suggesting.” Soft advocacy, including educating families, using rhetorical question asking, and reminding families about their choices while the medical staff was not present, was an effective strategy used by the majority of doulas we spoke with.

Many doulas also spoke powerfully about using soft advocacy to slow things down and give a birthing person time to process information, make careful decisions, and allow labor to progress naturally. As Veronica, a white doula, explained, “We slow things down. Most things are not an emergency.” Janeva, who previously discussed slowing things down when she was feeling frustrated or disrespected by healthcare providers, also talked about encouraging a similar slow approach with her clients. She explained how healthcare providers often explain things quickly and require a quick response, without giving the birthing person and their partner time to process the information. She said, “Sometimes when [doctors and nurses] come in and they ramp off medical jargon, right? They ask, ‘Do you understand?’ And they want the person to answer quickly. ‘Hey, do you understand what I just said? Do you have any questions?’” In these cases, she prepares her clients to ask for more time. She said, “We talked a lot about slow methods, slow doula methods, and holding space.” During labor, she asks her clients: “‘Hey, are they moving too quickly for you?’ You can say ‘Give me some time to think about it.’” These soft advocacy strategies serve to protect a positive and supportive environment in the birthing space, reduce the conflict between healthcare providers, doulas, and families, and make it clear that the expressed desires are coming from the birthing person and their family, not from the doula.

Doulas told many powerful stories of births where indirect strategies effectively helped families advocate for themselves. However, during active labor, especially near the end stages of labor, such forms of soft advocacy are not always possible. In such cases, more direct communication by doulas was at times necessary in order to help a birthing person have the kind of birth they desired or sometimes to prevent obstetric violence or harm. While Ashley preferred soft advocacy, she asked, “Who’s going to advocate for themselves mid contraction? There are times where I feel ethically as a doula it is my job to then advocate for them.” Similarly, Courtney described a time when her client was having unwanted cervical checks but was not being listened to by medical staff. She explained:
I’ve had to just speak up for my client, in terms of cervical checks. [I’ve said] ‘You know, that’s really uncomfortable for my client… They said several times that that’s uncomfortable for them, and they’d rather you not do that right now, come back later.’ I’ve done that before, or just wait until they’re done with the first [cervical check], and then talk to my client after the nurse leaves the room and say, ‘Remember our discussions on our prenatal visit? You don’t have to agree to a cervical check. If it’s that uncomfortable for you, you can say no. Or you can say not now or come back later.’ So I’ve had to do that, you know, remind the client to use their voice. You have to be careful to walk the fine line in some of those birthing spaces too. Clients always think the doula can advocate or speak for them, and I always tell my clients, I can’t speak for you, it has to be you speaking for yourself.

While in some cases, direct advocacy is needed, it is typically avoided if possible. Doulas who did directly contradict healthcare providers sometimes faced consequences that impacted them and the birthing person. Several doulas who worked for agencies or institutions reported being called after a birth and chastised for interfering too directly. One doula, after reminding a doctor several times that her client did not want a procedure she was about to perform, intervened by grabbing the doctor’s hand. The doula was physically removed from the room. Though infrequent, these instances are stressful and challenging for the doula and birthing person.

Doulas clearly see themselves as advocates. They strategically advocate for their clients by using a variety of strategies that entail a nuanced approach that requires doulas to effectively read and navigate a variety of tricky relationships and situations. While soft advocacy is strongly preferred by doulas, both as an empowerment strategy for birthing people and as a peacekeeping strategy, they use direct advocacy when needed to prevent harm and obstetric violence.

**Strategic Advocacy as Reproductive Justice**

Doulas help individuals navigate the healthcare system, advocate for their choices, and promote respectful and inclusive care. The relationship between doula care and reproductive justice lies in their shared dedication to fostering equal access to respectful, empowering, and culturally sensitive support throughout the reproductive process. Through an emphasis on individualized support, doula care is a critique of the “intersectional oppressions” (SisterSong 2022) found in an overmedicalized system, and our research found that doulas can use their liminal position to challenge systemic barriers and promote respectful care through strategic advocacy.

Reproductive justice is grounded in a human rights framework and doula care is about humanizing the whole birthing person (Morton and Clift 2014). Many of the doulas we heard from recognized and analyzed the power systems they work within, including Ashley, a white doula, who shared:

I strongly feel like if you’re a doula and you’re not interested or focused on health equity, you’re probably doing this wrong. That if as a doula you’re only interested in this one single person, and making sure that you know,
they have access to all of the things they need during birth, but you’re not thinking about folks who don’t have access to this, or how the system treats people so differently, then I feel like they’re missing part of the point. Because when we’re in those rooms, it’s impossible not to see the power dynamics, you know, between doctors and nurses, between nurses and patients. And we’re standing in between that system and our clients constantly.

Joslyn, a Black doula, also described how she understood working within a system rooted in racism:

To combat a lot of this, we got to start at the root...we have to really be honest … as Americans, we have to realize that so many of our systems were built on racism, that that continues to linger. A lot of people think that because they don’t see people calling other people slurs and they don’t see hate crimes, that racism does not exist when really it is literally embedded into our school system, is embedded into our healthcare systems.

In addition to identifying the systemic flaws of their work environments, doulas saw their care as having the potential to disrupt these systems. ArLydia, a Black doula, draws attention to the continued risks of giving birth for Black people, despite technological advances. She shared, “This is generational, you know. I don’t want [my children] to have to experience the same problems their grandparents experienced and, you know, with all this modern technology.” ArLydia expressed both a past and forward-looking approach to her doula care by recognizing the violence experienced by her ancestors which simultaneously motivates her to envision a future free from fear in birth.

The type of care provided by doulas is fundamental to their connection with a reproductive justice model of care. Doulas provide holistic care which translates into seeing the whole person across intersectional identities (Crenshaw 1989). This support extends throughout the entire reproductive journey, encompassing prenatal, childbirth, and postpartum experiences. Reproductive justice also offers insights into “pregnancy as a site of racialization,” (Bridges 2011, 8) highlighting the significance of doulas in challenging detrimental institutional practices associated with hospital births. Doulas recognize that representation matters, especially when working within a system of care that is rooted in racism. Birthing families want and need to see themselves reflected in their care team as Rachel, a white doula, confirmed with this example:

I can’t tell you how many times I had a birth with a BIPOC couple who ended in a cesarean and then the dad actually turned to a Black man that was working in the O.R. and was like, ‘I’m so happy to see you. I feel so much safer that you’re here.’ And that speaks volumes, you know? Of just having that representation.

Rachel continued to share how she sees her role advocating for clients prenatally to find the right care provider:
And so sometimes my role is just helping somebody to find a provider that they feel safe with beforehand. Like, I had a client who is Indigenous. She was going to give birth in a hospital she didn’t feel comfortable with. She was like something’s wrong. You know, this is not right. And she’s like, I really feel called to find a provider that is a better fit. So I helped her find someone who happened to be BIPOC herself.

Reproductive justice emphasizes centering and empowering the most marginalized individuals. Full-spectrum doula and reproductive justice advocate Sabia Wade clearly explains this:

We must also understand that centering the most marginalized means sharing power. It means giving back and returning power that rightfully belongs to the affected person. In giving a person’s power back to them in these power systems that we are all a part of, we most likely will have to go off route from these one-size-fits-all models of care and into more personalized and patient-centered approaches of care. That is the work. (Wade 2023, 83)

Doulas can help individuals explore a range of birthing options and advocate for their preferences, both directly and indirectly. They play a crucial role in ensuring that individuals’ autonomy and desires are respected throughout the birthing process.

We also heard from many doulas who shared the powerful connections they made serving as doulas in their own communities. Zuri, a Black doula, understood the emotional weight of performing a strong Black woman identity. She discussed her responsibilities and role as a doula:

Really helping them to connect with themselves and reaffirming them is a huge part of what I do. And also to ultimately let them know that the ball is always in their court, and that you know, my allegiance is with them… To just be there for you if you fall apart. I’ll be there to help you pick up the pieces…I think that that’s a huge, huge piece because unfortunately, I would say even in the Black community, so often Black women, we don’t get to fall apart. We are usually the ones that are strong. We are the backbones.

In another example, Ana, described her work at a birth where she centered the religious identity of a Black birthing mother. Ana shared, “Even when it came to her exercising her faith, she wanted to pray and it was kind of, sort of like this awkward stare. And so I just took her hand and I prayed with her because it’s like, you deserve that, you deserve that respect to exercise what’s going to make you feel comfortable during this uncertain time.” The observant care provided by doulas allows them to help birthing people feel able to bring their whole self to a birth. Joy, a Black doula, described how she connected with a laboring mother by using specific language cues. Just as Nicole explained the importance of creating kin-like connections among Black doulas and clients, in this example Joy uses the kin term “Hey, sis” to connect with her client. Joy recounted:
I definitely did say that [Hey, sis] a couple of times. And I think it is innate, [it] came out of habit like letting her know that I see you. I see myself in you, but I see you in this moment. And I’m empathizing with you, in this moment, because I had never been to a birth where a woman was treated like that. All the births I had gone to it was like, I don’t know, they were different. And I felt like the doctors weren’t really listening to her…It made me very uncomfortable. So I wanted to level with her in that moment. And let her know that I was on her team, I’m on her side, and I heard her.

Reproductive justice acknowledges and challenges the disparities and inequities faced by historically vulnerable and marginalized communities in accessing respectful reproductive healthcare. Doulas, particularly those who specialize in supporting specific historically marginalized communities, can help bridge these gaps by advocating for the needs and preferences of the people they serve.

By being present and observant, doulas gain insights into power dynamics and intersectional oppressions. One of the key components of being present and one of the primary ways that doulas support birthing people is by bearing witness to their experiences (Wint et al. 2019; Morton et al. 2018). Doula anthropologists and scholars have documented through ethnographic research the obstetric violence and medical racism that are witnessed and experienced by doulas (Basile 2015; Smith-Oka 2015; Davis 2019b; Melchiors and Castañeda 2022). This act of witnessing was cited as hauntingly powerful by several doulas in our project. Ana recalled the painful experience of witnessing obstetric violence:

This [birth] was an extremely tiring and traumatic experience that I’m having second hand because I’m watching someone who reflects the same demographics that I am being treated in this way. And then I reflected on how I was treated, you know, I am going through pain, I hadn’t had my epidural at the time, and so I’m having contractions, and I’m having a nurse grab my arm to tell me I need to be ‘tough to get this IV,’ and I’m like, where’s the compassion? Where’s the understanding? Where is the patience?

Doulas shared how the act of bearing witness was viewed as both a help and comfort to the birthing person and a way of ensuring that obstetric violence would not go unnoticed. Grace, a white doula, emphasized a doula’s unique ability to know what is taking place and what a person in labor might need. She said, “We as doulas witness labor in a way that no one else does. Nobody else in the birth team has that continuous observation of the unfolding of this hour by hour by hour. Without just coming in and getting a snapshot and going away and getting a snapshot and going away.” Lucy, a Black doula, is more explicit in explaining how her presence influences the other providers in the room. She said, “I cannot believe that our presence isn’t important. Whether it’s helping families or providers knowing that there was a witness.” Yenna described the advantages of a doula’s continuous presence, “I have felt like when there’s a doula present, clients are getting more information. They’re getting more options, and less of being told what to do for their births.” Lynette, a white doula, affirmed this by sharing, “People get better treatment if I’m in the room with them. Even if I’m sitting in the corner doing nothing. I’m a witness and someone
who knows what’s going on and that tends to create a better situation for my clients versus families who go in and don’t have that, which is not fair. It’s a problem.”

While not all unwanted interventions or obstetric violence can be prevented by having a doula present, doulas felt as though their continuous presence created a sense of witnessing for the birthing person that other providers noted as well, and that influenced the care and attention they provided to the birthing person. Both Makayla and Emily talked specifically about the consequences of acting as witnesses at a birth. Makayla, a Black doula, shared how she was viewed, “But it was the look of you know, I’m watching you guys and seeing what you’re doing. You know, just because I’m this little Black girl over here doesn’t mean I don’t know what you’re doing. What you’re up to.” Emily, a white doula, affirmed, “I’m watching you, you know, and if you’re not doing this right, other people are going to hear about it. Because that’s the value that we have as doulas.” The act of witnessing allows doulas to acknowledge and validate birth experiences and in turn this connects them with a reproductive justice model as they gain a deeper understanding of the systemic barriers and injustices that exist and bear witness to the experience of marginalized people in vulnerable situations.

In these various ways, doulas support, enable, and embody reproductive justice through their care, information sharing, witnessing and strategic advocacy. Doula care exists in a liminal space, straddling the realms of medical and midwifery models of care (Everson and Cheney 2015). This unique position empowers doulas to engage in forms of “embodied resistance” through their practice (Castañeda and Searcy 2015). We heard stories from many doulas who performed acts of embodied resistance, including the prevention of harm by interrupting unwanted interventions. In other instances, doulas advocated for additional services in order to meet the needs of their clients. For example, Ashley talked about how she sees her role as a doula advocate, “There are times where I feel ethically as a doula it is my job to then advocate for them. And say, for example, you have to call the translation line, it’s actually illegal for you not to because she can’t consent to this procedure without understanding what you’re doing.” In addition to consenting for procedures, there are also examples of changing birth outcomes. Veronica shared, “And I’ve seen a doula stop a surgical birth. And she was the one who spoke and the family credits their vaginal birth to their doula saying, ‘Give us five more minutes’… So that’s a powerful place to be, to change someone’s complete birthing experience and their recovery.” Even more powerful is the ability to save a life, as Ana recounted, “I watched this lady hemorrhage, and I had to go and get someone because the nurse was there just trying to dab, and I’m like, this blood is flowing like water. Someone needs to come in here, because it’s not stopping.” In this example, Ana witnessed obstetric harm, used her expertise as a doula to recognize the necessary response, and used her voice to directly advocate for her client.

Doulas support reproductive justice by humanizing the birthing process, honoring and validating intersectional identities, empowering birthing families through educational support, and acknowledging the systemic injustices that exist as they advocate for a more just and equitable model of birth. We argue that strategic advocacy entails (1) forms of indirect advocacy like emotional support and rhetorical questions, (2) forms of direct advocacy like asking for more time, and (3) bearing witness in the form of presence and observant care.
Conclusion

Twenty years ago, Lynn Freedman (2003) argued that thoughtful advocacy would be necessary to maintain a focus on maternal health while implementing the Millennium Development Goals (MDG). Freedman worried that the MDG had the potential to draw attention away from the critical need for reproductive care as articulated by the ICPD. Freedman pushed for strategic advocacy to center reproductive care in a moment where other debates and goals could crowd that focus out. In a similar way, we argue that doulas use strategic advocacy, both necessitated and made possible by their liminal position in the birth world, to support reproductive justice for people giving birth.

In a 2020 report comparing maternal health outcomes in the USA to ten other high resource countries, the USA fared worse by every measure: maternal mortality, perinatal care, ratios of healthcare providers to patients, access to midwives, and parental leave (Tikkanen et al. 2020). Given the lack of support birthing people in the USA receive, it is no surprise that the patient-centered, continuous, and hands-on support that doulas offer would have a notable positive impact on the health and wellbeing of birthing people. Research consistently shows that doula care leads to improved maternal health outcomes in the USA (Sobczak et al. 2023; Gruber et al. 2013). Doula care also improves birth outcomes for Black birthing people and reduces racial inequalities in maternal mortality and other markers associated with a positive birth experience (Ramey-Collier et al. 2023). Reproductive justice emphasizes the importance of access to support services throughout the reproductive journey. Doulas offer continuous support that is often lacking within biomedical/technocratic healthcare systems, particularly for historically marginalized communities. Drawing on the power of a liminal space, doulas utilize a personalized approach centered on the birthing person that challenges systemic barriers and promotes respectful care, in part through strategic advocacy.

Given doulas’ professional precarity within the maternal healthcare system in the USA, it is reasonable to consider to what extent doulas will be able to impact maternal health outcomes. At this moment, the national attention on doulas means that doulas may be positioned to move out of their liminal role in hospitals and on maternal care teams. However, doulas feel deeply ambivalent about this shift. On the one hand, they seek greater recognition of their knowledge and value in clinical spaces. On the other hand, they are apprehensive about how this might impact their working conditions, their ability to provide care that is centered on the birthing person, and their role as advocates. Specifically, doulas worry that outside entities could have increased control over what it means to be a doula. Doulas worry that this might alter both their working conditions and their ability to provide optimal care.

One significant risk is that the bureaucratic and institutional requirements of doula work could be much more burdensome. For example, hospitals have increasingly been requiring doulas to have certain kinds of certification, even though there are many doula certifying organizations, none of which are regulated by a larger body. Maintaining such certification is often prohibitively expensive and does not account for the level of experience a doula has. Doulas have increasingly been able to bill for...
services through Medicaid in many states. However, unless doulas have an organization that assists them with the billing process, the compensation is low and the process is prohibitively cumbersome, making it difficult for doulas to make a living wage serving Medicaid clients. While doulas desire more legitimacy from the individuals and institutions they work with, they also worry that increased recognition might mean they lose their ability to advocate for their clients by being increasingly beholden to hospital policies and procedures. Doulas engage in strategic advocacy, a highly nuanced and complex form of reproductive care that centers the family giving birth. To do this well, doulas must analyze power systems and address the reality of intersecting oppression the families they work with may experience. This is the work of reproductive justice and while doulas desire acceptance and recognition of their professional knowledge and skills, they are determined to protect their roles as advocates for birthing people, even if this means accepting their liminal position in clinical spaces. Unless doulas are intimately involved in any kind of advocacy or policy change relating to their work, doulas risk becoming a key part of the hierarchical and highly technocratic birth machine that they are trying to oppose by their very presence in the birthing space.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article’s Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article’s Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

References


Studies in Comparative International Development


**Publisher's Note** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

**Julie Johnson Searcy** is an Assistant Professor of Anthropology at Butler University. Her research examines the intersections between birth, disease, reproduction and race in the US and South Africa. She also looks at the embodied labor of doulas and was recently awarded the Wilma Gibbs Moore Fellowship to collect the stories of Black doulas in Indiana. She is co-editor of two volumes with Demeter Press: *Doulas and Intimate Labour: Boundaries, Bodies and Birth (2015)* and *Obstetric Violence: Realities and Resistance from around the World (2022).*

**Ellen Block** is an Associate Professor of Anthropology at the College of St. Benedict and St. John’s University. Her work centers on the intersections of health, kinship and care in sub-Saharan Africa and the United States. She has worked on HIV/AIDS and orphan care, aging, COVID-19 and healthcare provider experiences, and doula care. Her first book, *Infected Kin: Orphan Care and AIDS in Lesotho* (co-authored with Will McGrath), was published in 2019 with Rutgers University Press.

**Angela N. Castañeda** is the Lester Martin Jones Professor of Anthropology at DePauw University. Her
research in Brazil, Colombia, Mexico, and the U.S. focuses on religion, ritual, expressive culture as well as the cultural politics of reproduction, birth and motherhood. More specifically, her current research explores the intimate labor of doulas; unpacking the cultural meanings of attending to birthing people during the transition to parenthood. She is co-editor for two volumes with Demeter Press: Doulas and Intimate Labour: Boundaries, Bodies and Birth (2015) and Obstetric Violence: Realities and Resistance from around the World (2022).