

The role of doulas and community birth workers in abortion and contraception care: An international scoping review^{☆,☆,☆}

Clare Heggie^{a,*}, Lin Tong^b, Aishwarya Heran^c, Ishika Bhambhani^d, Shelley McKibbin^e, Martha Paynter^b

^a University of New Brunswick Department of Interdisciplinary Studies, Fredericton, New Brunswick, Canada

^b University of New Brunswick Faculty of Nursing, Fredericton, New Brunswick, Canada

^c Department of Physiology, McGill University Faculty of Science, Montreal, Quebec, Canada

^d University of British Columbia Faculty of Medicine, Vancouver, British Columbia, Canada

^e Dalhousie University WK Kellogg Health Sciences Library, Halifax, Nova Scotia, Canada

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ABSTRACT

Objectives: Equitable and safe access to abortion and contraception is essential to protecting reproductive autonomy. Despite this, barriers to access remain. Nonclinical support people, may be able to facilitate access to abortion and contraception services and care, but evidence on the scope and efficacy of doulas in abortion and contraception care is lacking. The aim of this scoping review was to synthesize what is known about the role of doulas in abortion and contraception care.

Study design: We followed the Joanna Briggs Institute methodology for scoping reviews. A clinical librarian performed an initial search of all relevant databases. Three reviewers independently screened the titles and abstracts for assessment against the inclusion and exclusion criteria. The populations of interest included doulas, and/or untrained birth attendants and birth companions, and patients who use doula services. The concept of interest was the doula and the context was access to abortion or contraception.

Results: Our review identified relevant studies conducted in different countries, published between 1976 and 2023. Studies broadly focused on three key themes: doulas performing procedural abortions, doulas supporting abortion care, and doulas supporting contraception. Outcomes of interest included client outcomes, barriers to access, doula training, and attitudes.

Conclusions: Doulas have the potential to improve client satisfaction and mitigate barriers to accessing abortion and contraception services. Further research is needed to identify the training needs of doulas, the potential for their integration into interdisciplinary care teams, and the role in supporting medication abortion.

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1. Introduction

Equitable and safe access to abortion and contraception is essential to promoting and protecting reproductive autonomy, defined as “having the power to decide about and control matters associated with contraceptive use, pregnancy, and childbearing” [1]. Access to

abortion and contraception care can reduce poverty, maternal and child mortality, increase economic and educational opportunities for women and children, and reduce the lifetime risk of sexual and intimate partner violence for women and girls [2–7]. Abortion is a safe and common health care procedure and has been affirmed globally as essential health care that is fundamental to the promotion of the UN Sustainable Development Goals [8–10]. Despite global calls to protect abortion access, the legal status of abortion access varies internationally. As of 2020, 41% of women of reproductive age live in countries with restrictive abortion laws [11]. Restrictive laws increase the rate of unsafe abortion [12]; unsafe abortion is defined by the World Health Organization as a procedure carried out by “... persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both” [13]. Unsafe abortion accounts for approximately 7.9% of maternal deaths

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* Corresponding author.

E-mail address: clare.heggie@unb.ca (C. Heggie).

globally [14], and 97% of unsafe abortions are performed in developing countries [15].

Even in countries with liberal and/or protective abortion laws, barriers to access remain. Barriers include gestational age limits [16,17], geographical and travel barriers [18,19], provider availability [20], cost of procedure [21,22], and long wait times [23]. These barriers may be exacerbated for people experiencing poverty, racism, and sexual discrimination [21,24,25]. In both restrictive and less restrictive jurisdictions, doulas—nonclinical support people—may facilitate access to abortion and contraception services, but evidence on the scope and efficacy of doulas in abortion and contraception care is lacking [26].

The term “doula” is used commonly in North America to refer to a support person who provides emotional, physical, and informational support throughout the perinatal period [27]. In this review, we do not address other types of doulas such as death doulas, although we acknowledge that other types of doulas exist. Training and certification processes vary, but the role is nonclinical in scope. Doula practice is unregulated and unregistered. Doula support has been associated with evidence of increased birth weight [28], reduced risk of cesarean delivery [29,30], increased breastfeeding initiation [31], lower rates of postpartum depression and anxiety [32], and increased patient satisfaction with the birth experience [33]. Doula support may be especially beneficial for pregnant people who are at a higher risk of poor labor outcomes due to racism, poverty, or homophobia/transphobia [34]. Doulas may act as cultural navigators for newcomers to a jurisdiction [35]. The term “full-spectrum doula” refers to doulas who provide support to clients through all pregnancy outcomes, including assisted reproduction, labor/birth, abortion, miscarriage, and adoption [26,36].

Outside of North America, nonclinical support people may be referred to as traditional birth attendants (TBAs), defined as a person who assists an individual throughout pregnancy and the perinatal period [37]. TBAs are common in rural and remote areas of low-income countries and, in contrast to doulas, may be performing clinical roles in the management of pregnancy in the absence of formal health care services [38,39]. TBAs receive training from apprenticeships with other TBAs or untrained lay midwives [40]. There have been efforts to train and integrate TBAs into formal maternal health care systems [40–42], and the World Health Organization has called for the promotion of “skilled birth attendants” and a clear definition of scope for TBAs [43].

The aim of this scoping review is to synthesize what is known about the role of doulas and unregulated birth attendants in abortion and contraception care. Findings will inform future research to examine the impact of doulas, policies to support the integration of doula support in abortion and contraception care, interdisciplinary practices among the health care team to collaborate with doulas, and the development of resources to support abortion doulas.

2. Methods

We used the Joanna Briggs Institute methodology for scoping reviews [44]. The populations of interest included doulas, non-clinical and/or untrained birth attendants and birth companions, and patients who use doula services. The concept of interest was the doula role, and the context was access to abortion or contraception care.

2.1. Inclusion criteria

This scoping review included studies with participants who met the following criteria: doulas (or lay support people) who supported people in abortion and contraception care and/or clients of doulas who sought abortion and contraception care. We included contraception as an outcome of interest in recognition that postabortion

contraception is an essential part of abortion care. We aimed to be very inclusive regarding the roles that fell under the umbrella concept of “doula support,” and as such, we included studies with TBAs, birth companions, and community birth workers. We included studies set in community or clinical settings. We included both experimental and quasi-experimental research study designs, including randomized controlled trials, nonrandomized controlled trials, before and after studies, interrupted time-series studies, analytical and descriptive observational studies, and qualitative research using various methodologies.

2.2. Exclusion criteria

The review excluded any articles where the full text version was not available in English or French. When an article had no readily available full text version, we searched all included databases and institutional library holdings. If we could not identify a full text version, it was excluded. We could not include articles only available in a language other than English or French due to the languages spoken by the research team. It also excluded nonresearch (e.g., commentaries, opinion pieces) and articles that focused solely on labor, birthing, or parenting, with no outcomes related to abortion or contraception. We excluded conference abstracts. We excluded single-case studies and systematic reviews. We excluded articles that did not explicitly mention doulas, TBAs, or birth companions.

2.3. Search strategy

We used the Joanna Briggs Institute method, which employs a three-step comprehensive search strategy. First, a clinical librarian (SM) performed a limited initial search of CINAHL to identify articles on the topic. The librarian then used the text words contained in the titles and abstracts of relevant articles and the index terms used to describe the articles to develop a full search strategy in the following databases: CINAHL, APA PsycInfo, PopLine, PubMed, Gender Studies, Medline (Ovid), Embase, Sociological Abstracts, Cochrane, and Social Services Abstracts. The search strategy included all identified keywords and index terms and was adapted for each database and/or information source. Please see [Appendix A](#) for a representative search strategy.

2.4. Study selection

Following the search, all identified citations were uploaded into Covidence software. Duplicates were removed. Three reviewers (LT, AH, and IB) independently screened the titles and abstracts for assessment against the inclusion and exclusion criteria. Titles and abstracts that met the inclusion criteria were retrieved in full and assessed by the three independent reviewers using the inclusion criteria. A fourth reviewer was available to resolve conflicts. Full text studies that did not meet the inclusion criteria were excluded. Reasons for study exclusion were recorded. See PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) diagram in [Figure 1](#).

2.5. Data extraction

Three independent reviewers (LT, AH, and IB) extracted data from included papers using a spreadsheet data extraction tool developed by the research team. The data extracted included setting, study design, sample size, type of participants (doulas, patients, community members), research question, results, key outcomes, and language used for doulas (e.g., doula, TBA, companion, “dai,” “hilot”).

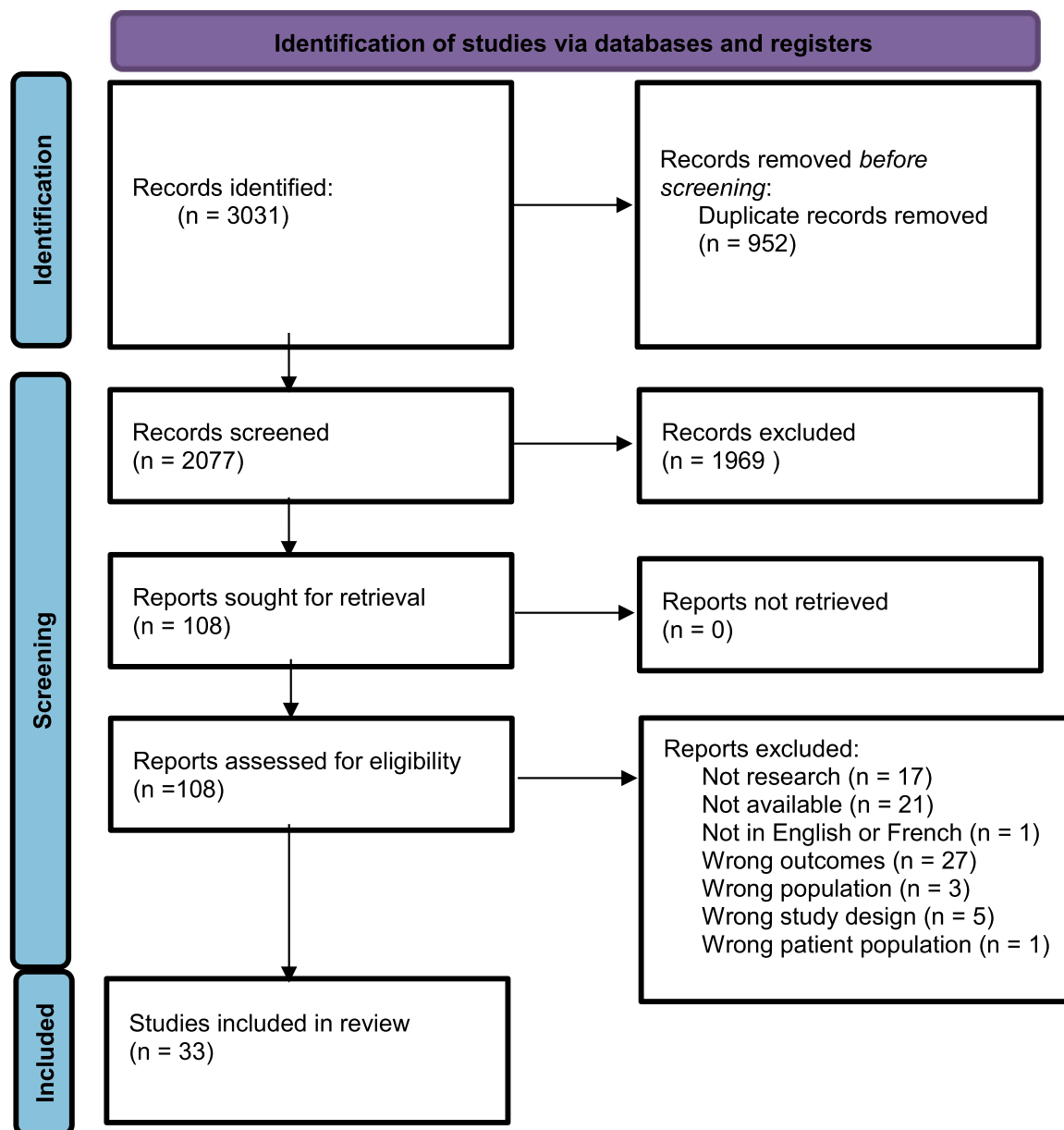


Fig. 1. PRISMA diagram. PRISMA 2020 flow diagram for new systematic reviews, which included searches of databases and registers only. PRISMA = Preferred Reporting Items for Systematic reviews and Meta-Analyses. From [45]

3. Results

3.1. Study characteristics

The 33 included studies published between 1976 and 2023. See Table 1. The settings represented 16 different countries, with seven studies in the United States [46–52], six studies in Pakistan [53–58], four studies in Nigeria [59–62], two studies in Ethiopia [63,64], two studies in Ghana [65,66], two studies in Kenya [67,68], and one study each in Iraq [69], Indonesia [70], India [71], Myanmar [72], Nepal [73], Mozambique [74], Benin [75], the Philippines [76], Cambodia [77], and Bangladesh [78]. Overall, there were 14 studies in Asia, 12 studies in Africa, seven studies in North America, and none in Europe, Oceania, or South America.

In 13 studies, the population of study included doulas [48,49,60–62,64–67,69,71,75,76]. Twenty-three studies included patients [47,48,50–64,67,68,73,74,77,78]. Five studies included both

doulas and patients [60–62,64,67]. Nine studies also included health care providers [48,50,52,62,64,67,70,72,78], and two studies also included community stakeholders/leaders [50,64]. All 33 included studies focused on women. One study included men [64]. No studies specified if trans or nonbinary people were included. Sample sizes ranged from 14 participants [48] to 1696 [63].

Seventeen studies used qualitative methodologies [47,48,50,52,58,59,61,64–70,73,75,78]. Eleven studies used quantitative methodologies, including two randomized control trials [46,76], seven surveys [51,54,62,71,74,77], one retrospective cohort study [63], and two medical record assessments [56,57]. The review included five mixed-methods studies: three studies used both quantitative surveys and qualitative interviews [49,60,72] and two used both qualitative interviews and medical records assessment [53,55].

We grouped studies into three key themes: doulas performing abortions, doulas supporting abortion care, and doulas supporting

Table 1
Study characteristics

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Abed et al. (2018)	Iraq	Doulas supporting family planning	To compare the attitude, knowledge, and practices of family planning between trained and untrained TBAs.	90 TBAs	Interviews	Knowledge	15.56% of trained TBAs and 22.22% of untrained TBAs had good practice scores regarding family planning. However, 95.56% of trained TBAs and 88.89% of untrained TBAs had positive outlooks on family planning.
Bhutta et al. (2003)	Pakistan	Doulas performing abortion	To determine the severity of complications of unsafe abortion and optimum ways of managing them.	93 patients	Interviews, medical records	Abortion complications	Untrained birth attendants performed abortion in 32% of patients and doctors in 30%. In 65% of cases, instrumentation of the uterus was used. Surgical intervention was required in 90% of cases. Septicemia, bowel injury, and hemorrhagic shock were significant complications, while the mortality rate was 10%.
Chor et al. (2015)	USA	Doulas supporting abortion	To evaluate the impact of doula support on first-trimester abortion care.	214 abortion patients	RCT	Patient experiences	Pain scores, procedure duration, and patient satisfaction did not differ between doula and control groups. However, 96.2% of those who received doula support recommended doula support for abortion, and 60.4% were interested in training as doulas. 71.6% of those who did not receive doula support indicated wanting one. Additional clinical staff provided support to 2.9% of women in the doula group and 14.7% of controls.
Chor et al. (2016)	USA	Doulas supporting abortion	To explore how doula support influences women's experiences with first-trimester surgical abortion.	30 abortion patients	Interviews	Patient experiences	Abortion patients accepted doula support due to wanting companionship and being concerned about the procedure. Doula's support was declined due to not wanting to add emotion to the abortion or the patient desiring pregnancy. Women with doula support reported positive experiences, while most women who declined doula support regretted not having a doula. Many patients desired roles for doulas in abortion care.
Chor et al. (2018)	USA	Doulas supporting abortion	To explore physician, staff, and specially trained abortion doula perspectives on doula support, one approach to patient support.	14 physicians, doulas, staff	Focus groups	Doula experiences	Doulas drew on personal skills and experiences as well as their abortion doula training to provide support. Physicians and staff were able to focus on the technical aspects of the procedure with the presence of doulas for emotional care. Physicians and staff believed that doulas meant more patient-centered care.
Djohan et al. (1993)	Indonesia	Doulas supporting/	To assess the attitudes of health providers toward abortion.	14 general practitioners, 16 gynecologists, 16	Interviews	Attitudes toward abortion	Religion was the strongest determining factor influencing

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Table 1 (continued)

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Ebuehi and Akintujoye (2012)	Nigeria	Doulas performing family planning	To explore pregnant women's perceptions and utilization of TBA services in a rural local government area.	midwives, 16 TBAs, and 16 family planning field workers	Interviews	Attitudes toward TBAs	views on abortion of TBAs, PLKB, trained midwives, GPs, and gynecologists. However, most midwives, PLKB, and TBAs believed that abortion was valid if a woman could not afford to have more children, and if she was in poor health. Half of the TBAs said they would do an abortion; however, four TBAs said that they would refuse to help if women presented with a botched abortion. Pregnant people identified TBA functions as providing non complicated delivery, antenatal services, cesarean section, family planning services, and performing surgeries. Services obtained from TBAs included routine antenatal care, normal delivery, "special maternal bath to ward off evil spirits," and family planning services.
Imogie et al. (2002)	Nigeria	Doulas supporting family planning	To assess the role of TBAs in modern health care delivery.	48 TBAs, 309 childbearing mothers, and 34 medical and para-medical professionals	Questionnaire, interview	TBA roles	Interviewees believe that TBAs have important roles in family planning, screening of high-risk pregnant mothers, (in)fertility treatment, and maternal and child care services. People in rural areas were more likely to use TBAs.
Izugbara and Ukwanyi (2003)	Nigeria	Doulas performing abortion/family planning	To profile the characteristics and health conditions of the clientele of TBHs in four rural communities.	13 TBAs and 147 users of TBHs	Interviews	Patient outcomes	The patients of TBHs are mainly less educated women and girls. TBHs provide services, including delivery, abortion, family planning services, sex selection, and vaginal bleeding treatment. TBH services were preferred by some due to their lower cost, privacy, geographical proximity, and abilities. Poverty, culture, and local values impact the decisions women make regarding their use of services.
Jacinto et al. (2016)	Mozambique	Doulas supporting family planning	To explore the safety and effectiveness of training TBAs and polyvalent elementary health workers (APEs), to administer an injectable contraceptive, and to provide evidence on the feasibility of expanding community-based distribution of the contraceptive in areas where TBAs and APEs are present.	1432 women	Questionnaire	Contraception satisfaction and continuation/adherence	TBAs provided contraception to women; 63%–66% of women in the study used contraception for the first time during the study period. TBA and APE performance satisfaction was high, and the women had a high continuation rate of 81/1% (with TBA patients being more likely to continue). Satisfaction with performance.
Kaysin et al. (2020)	Benin	Doulas supporting	To further the understanding of TBA's scope of practice for	109 TBAs	Interviews	TBA experiences	TBAs perform antenatal and newborn care counseling, family

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Table 1 (continued)

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Khan et al. (2016)	Pakistan	family planning	developing appropriate strategies to strengthen MNCH services at the community level.	86 people who have had abortions in the last 5 y	Questionnaire	Abortion outcomes/mortality	planning, and immunizations. The TBAs document a maternal mortality ratio of 790/100,000 and neonatal mortality rate of 12.2/1000, both higher than the national average. TBAs provide a variety of services, but more information is needed on community preferences, training, and roles of TBAs within the health system. Out of 120 abortions included in the study, 38.3% were unsafe, 73.3% of abortion cases used health care services; specifically, 40.9% of abortions were performed by Dai. Post-abortion morbidity was common at 61.7%. Per study inclusion criterion, unsafe abortions were 46/120 (38.3%). 18/20 doulas were interested in learning about abortion and contraception for their work. Findings include that doulas center reproductive autonomy, abortion doulas are important to reproductive autonomy, some doulas are unsure about contraceptive counseling, abortion doulas provide diversity, and abortion doulas experience challenges such as stigma.
Lindsey et al. (2023)	USA	Doulas supporting abortion/family planning	To identify the prevalence of post-abortion morbidity in unsafe and safe abortions in ever-married women of reproductive age group. To examine the scope of work of community-based doulas regarding full spectrum and abortion services, doula opinions on full spectrum and abortion work, and potential barriers and facilitators for full spectrum doula care.	20 community-based doulas	Surveys	Doula experiences	Few women practiced family planning, due to reasons such as lack of services. With TBA and VHV education, the fear of contraception use side effects decreased. Out of 1590 cases of abortion complications, Dais performed 42.1% of procedures, and traditional practitioners 18.1%. 498 abortion deaths were reported. Medically approved abortions account for 4.9% of this number, while about half of the complications came from "inserting a foreign object, such as a stick or root, into the uterus and leaving it until either abortion or complications ensued." Training including lectures, scenarios, and AV demonstrations resulted in better field and test performance for hilots. Those who were supervised recruited twice as many acceptors of family planning than those who received only the training input.
Main et al. (2001)	Cambodia	Doulas supporting family planning	To examine variations in antenatal care and family planning between 1996 and 1998.	291 women in 1996 and 211 women in 1998	Population-based survey interviews	Rate and type of contraception use	
Measham et al. (1981)	Bangladesh	Doulas performing abortion	To characterize abortion practitioners and women obtaining abortions and estimate the number of abortions that occurred in 1978.	1590 patients and providers	Interviews of health workers, case studies	Abortion complications	
Morisky (1985)	Philippines	Doulas supporting family planning	To measure the effectiveness of utilizing TBAs (hilots) as family planning motivators.	482 hilots	RCT	Knowledge of hilots	

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Table 1 (continued)

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Mosley et al. (2022)	USA	Doulas supporting abortion	To conduct key informant interviews with 20 abortion providers and CBO leaders, 32 in-depth interviews, and six focus groups (n = 30) with Black and Latinx women.	82 community leaders, abortion providers, Black and Latinx women	Focus groups, individual interviews	Barriers to abortion access, role of doula support	Barriers for abortion include intersectional oppression/stigma, government policies, lack of diverse clinic staff, waiting times, and lack of knowledge/social support. This could be improved by the addition of abortion doulas, social media campaigns, RJ-based policy advocacy, diversifying clinic staff, offering flexible scheduling and fees, community integration of abortion, and sex education.
Naanyu et al. (2013)	Kenya	Doulas supporting family planning	To identify the most widely used types of FP, intent, and unmet needs among women, FP counseling, and barriers to FP uptake.	175 TBAs, mothers, health care providers	Interviews	Contraception use, intent, and unmet need	TBAs, community members, and formal health services provide FP counseling. Postpartum FP includes injectable contraceptives, oral contraceptives, coils, condoms, and calendar methods and is common practice.
Najmi (1998)	Pakistan	Doulas performing abortion	To determine the incidence and types of complications of illegally induced abortions as well as those of therapeutic ones.	72 abortion patients	Interviews, medical records	Abortion complications	In 43.25% of women, illegal abortions were performed by TBAs. The most common abortion method was instrumentation, and common complications include hemorrhage, sepsis, and trauma.
Nicholas et al. (1976)	Ghana	Doulas performing family planning	To describe the results of a survey of TBAs. The survey was designed to elicit current information about the technical nature of their practices and their attitudes toward training and family planning.	82 TBAs	Interviews	TBA role	95% of TBAs believed women should space their births to protect the health of the mother and child; 81% approved of couples doing something to postpone pregnancy; 83% had heard of "family planning," and 70% approved of it. Half had advised women to postpone pregnancy, and 13% had prescribed a method.
Okubagzhi (1988)	Ethiopia	Doulas supporting family planning	To examine the standard of care available to mothers and babies after TBAs had been given a 2-wk training course.	1696 patients	Retrospective cohort	Knowledge of FP	13.8% of women had knowledge of family planning methods. After TBA training, 43.4% of women who delivered were aware of the possibilities of family planning.
Satishchandra et al. (2013)	India	Doulas supporting family planning	To study the impact of TBAs on maternal health care in a rural area.	50 TBAs	Training pre-postsurvey	TBA knowledge	Training increased the knowledge of TBAs regarding maternal health care, ANC care, identification of danger signals during antenatal period, maintenance of all the five cleans and family planning methods.
Shaikh et al. (2014)	Pakistan	Doulas performing abortion	To determine the frequency, demographics, type of abortionist, method used, and morbidity associated with complicated cases of unsafe abortion admitted to a tertiary care hospital.	452 abortion patients	Examination of medical records	TBA knowledge	33.3% of abortions were performed by Dai, 33.3% by a doctor, 26.7% by a lady health visitor, and 6.7% by a TBA. Methods used were dilatation and evacuation (55%), and oral misoprostol (45%).
Shaikh et al. (2010)	Pakistan		To determine the frequency of women who had undergone an	230 patients	Medical records	Abortion complications	Of 230 patients, 21.7% underwent an unsafe abortion and came to the

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Table 1 (continued)

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Sheehy et al. (2015)	Myanmar	Doulas performing abortion	unsafe abortion and attended a tertiary care hospital with associated complications.	18 individuals working in reproductive health, seven focus group discussions with two health service providers, and five adult women	A systematic review of published articles, gray literature, and data provided by local organizations; interviews; surveys; discussions; service mapping exercise	Attitudes toward contraception, contraception use, unmet need for contraception.	hospital with associated complications. 36% of abortions were performed by doctors, 36% by lady health visitors, 20% by an untrained birth attendant (Dai), and 8.0% by nurses. Unsafe abortion appears to be common. It is largely performed by TBAs, with a variety of methods—mechanical, medication, and traditional methods. Postabortion care is often not accessed due to misinformation and harassment.
Smith (1996)	Ghana	Doulas supporting family planning	To investigate the behavioral underpinnings of TBA intention to promote family planning services.	354 TBAs	Interviews	TBA experiences	A TBA's intention to promote family planning can be predicted by a positive TBA attitude toward family planning and favorable TBA perceived behavioral control over promoting family planning.
Temesgen et al. (2012)	Ethiopia	Doulas supporting family planning	To assess the role of trained TBAs in maternal and newborn health care.	21 interviews; six focus groups with health providers, TBAs, mothers, men, Kebele leaders, and district health managers	Interviews	TBA role	TBAs are the backbone of maternal and child health development in pastoralist communities. However, the current TBA numbers are minimal and do not meet the antenatal care, delivery, postnatal care, and family planning needs of the community.
Thapa et al. (1992)	Nepal	Doulas performing abortion	To present the major findings of a study of induced abortion, based on those identified as having abortion-related complications who were admitted to five major urban hospitals during a 1-year study.	165 patients having abortion/possible abortion	Interviews	Abortion complications, mortality	TBAs provided abortion for two-fifths of women. 12 of the 165 women died in the hospital, mainly from tetanus. More than half of all maternity-related deaths in hospitals were abortion-related.
Uhuo et al. (2020)	Nigeria	Doulas supporting family planning	To assess the availability, uptake, and male partner consent for postpartum family planning amongst rural and semiurban dwellers.	205 postpartum women, 40 health workers at the primary health centers, and TBAs	Questionnaire	Uptake of contraception	38.1% of women received antenatal care or had their last delivery with TBAs (42.4%). Only 60% of the TBAs are aware of modern family planning methods, and none of them offer family planning services.
Wilson et al. (2017)	USA	Doulas supporting abortion	To evaluate the impact of doulas on patients' physical and emotional responses to surgical management of a first trimester failed or undesired pregnancy under local anesthesia.	70 abortion patients	Questionnaire	Pain score, satisfaction with abortion	There was no statistical difference between the satisfaction, emotional response, sense of empowerment, or ability to cope between those with and without doula support. However, 97% of women who had doula support reported that this helped with their abortion experience. 72% of all respondents declared that it was important to have someone with them during the procedure, but they did not have to be a doula.
Wong et al. (2022)	USA				Interviews	Contraception	

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Table 1 (continued)

Author and year	Jurisdiction	Theme/Issue	Aim	Participants	Methods	Outcomes	Results
Yegon et al. (2016)	Kenya	Doulas supporting family planning	To assess patient and provider experiences with hospital transparency around postpartum contraceptive care in Catholic hospitals.	44 patients and providers	Interviews	Patient experiences, barriers	Few patients knew that Catholic policies in the hospital limited their health care options. Patients did not have information to make contraceptive decisions, and some lost continuity with trusted providers.
Zia (2012)	Pakistan	Doulas performing abortion	To explore abortion-related stigma as a barrier to women realizing their rights to a safe, legal abortion and compare manifestations of abortion stigma at two communities from regions with high and low incidences of unsafe abortion. To evaluate the morbidity, mortality and sociodemographic characteristics of illegally induced, unsafe abortion and their relationship with different modes of management.	26 patient focus groups 105 abortion cases	Interviews	Abortion complications, mortality	Abortion is seen as common, yet it is stigmatized. Women are labeled as killers and/or bad influences. Women are also treated poorly in health facilities. The removal of guidelines and standards by the Ministry of Health pushed women to TBAs who offer unsafe abortions. Out of 105 cases, 32.4% of abortions were performed by untrained birth attendants. 31.4% were performed by LHV's/nurses. 60.5% of patients had some knowledge of contraception. 41% of patients who underwent laparotomy had abortions by untrained providers.

ANC, antenatal care; APE, agentes polivalentes elementares; AV, audiovisual; CBO, community based organization; FP, family planning; GP, general practitioner; LHV, lady health visitors; RCT, randomized control trial; RJ, reproductive justice; TBA, traditional birth attendants.

contraception. Ten studies focused on doulas performing abortions [53–58,68,72,73,78]. Six studies focused on doulas supporting abortion care [46–48,50,51,70]. Sixteen studies focused on doulas supporting contraception [52,59,60,62–67,69,71,74–77]. Three studies focused on multiple themes: one focused on doulas who both perform and support abortions [70], one focused on doulas who perform abortions and support contraception [61], and one focused on doulas who may support both abortions and support contraception [49].

Studies used a range of terminologies to refer to doulas. Seven used the term doula [46–52]. All of the studies using the term doula were set in the United States. Twenty-two used the term TBA [53,55–57,59–75,77,78].

Five studies used the term dai [53,54,56–58]; these studies were all located in Pakistan. One study located in the Philippines used the term hilot [76]. Both dai and hilot describe an untrained TBA or an untrained community midwife [79–81].

3.2. Outcomes

The main outcomes of interest are broadly divided into the experiences of clients and the experiences of doulas/traditional birth attendants.

3.2.1. Experiences of clients

Twenty articles focused on the experiences and outcomes of clients accessing doula/TBA support for abortion and/or contraceptive care.

3.2.2. Client outcomes

Two studies focused on the outcomes of clients with doula support during their abortion. In a randomized control trial comparing abortion patient experiences with and without doula support, Chor et al. [46] found that, while there was no significant difference in pain scores, patient satisfaction, or procedure duration between groups, 96.2% of patients with a doula recommended doula support for abortion, and 71.6% of patients who did not have doula support wanted one. In a similar study, Wilson et al. [51] also reported no significant difference in pain scores, satisfaction, emotional response, perceived ability to cope with the procedure, or recovery between patients with doula support and without doula support. Similarly to Chor et al.'s findings, Wilson et al. reported that 97% of patients with doula support said it helped their experience, and 72% of all participants said that having someone with them during the procedure was important.

Two studies examined qualitative patient experiences with doula support. Chor et al. [47] reported that patients who had doula support reported positive experiences, and patients who did not have doula support regretted not having a doula. Izugbara et al. [61] interviewed women in Nigeria who sought abortion care from TBAs and reported their support was low cost, offered geographical proximity, and alleviated concerns about confidentiality with formal health services.

Nine studies focused specifically on measuring the frequency, type, and mortality rate of complications when doula/TBAs were performing the procedural abortion [53–58,72,73,78].

Reported complications of TBA performed abortion included hemorrhage [53–58], sepsis [53,55,57,58,73], bowel injury [53,55,56,58], and uterine perforation [54–58].

3.2.3. Client experiences with doula support for contraception

Five articles focused on client experiences using doula support to access contraception. Jacinto et al. [74] reported high satisfaction with receiving contraception care from TBAs and that women who used TBAs were significantly more likely to continue contraception. Main et al. [77] found that TBA-led contraception counseling

reduced fears of side effects preventing women from using contraception in Cambodia. Similarly, Naanyu et al. [67] reported that TBA utilization, along with family support and literacy, has a positive impact on contraceptive use in Kenya. Uhuro et al. [62] reported high contraceptive use among participants in Nigeria but no positive impact of TBAs, who reported little awareness of contraceptive methods.

3.2.4. Barriers to care

Three studies focused on client- and patient-level barriers to abortion and contraception care. Mosley et al. [50] focused on barriers to medication abortion access for Black and Latinx women in a southern state in the United States. Participants suggested abortion doulas as a strategy to mitigate identified barriers, which included lack of support, long wait times, and lack of diverse clinic staff. Yegon et al. [68] identified barriers to access in Kenya, including stigma, poor treatment in health care facilities, and a lack of guidelines and standards for performing abortion. These barriers influenced patients to choose TBAs as abortion providers. Wong et al. [52] interviewed doulas supporting clients in accessing postpartum contraceptive care in Catholic hospitals in Illinois, identifying barriers to uptake as long wait times and judgment from staff/community.

3.3. Experiences of doulas/TBAs

Thirteen articles focused on the role, attitudes, and training of doulas/TBAs.

3.3.1. Role

Six articles identified the roles that doulas/TBAs can perform in the provision and support of abortion and contraception. Imogie et al. [60] reported that TBAs in Nigeria may provide contraception care alongside formal health care services, particularly for rural women. In Ghana, Nicholas et al. [65] similarly reported that 50% of TBA participants had counseled women to prevent pregnancy, and 13% had “prescribed” contraceptive methods themselves. In Ethiopia, Temesgen et al. [64] reported that TBAs were the “backbone” of all maternal health in rural areas, including contraception and abortion care. Lindsey et al. [49] interviewed community-based doulas in Georgia—an American state with heavy abortion restrictions—who identified their role in providing support for both medication and procedural abortion while helping clients navigate informational and financial barriers to access. Chor et al. [48] interviewed providers at an American abortion clinic on the value of doula support; participants reported that doula's role was to provide emotional support, which allowed for the provision of patient-centered care while providers focused on the technical aspects of procedural care. Kaysin et al. [75] reported that TBAs in Benin provided counseling that promoted contraception use and birth spacing.

3.3.2. Education

Four articles measured the impact of training and education on doula/TBA knowledge and practice. Abed et al. [69], Morisky [76], Okubagzhi [63], and Satishchandra [71] all reported that formal training of TBAs resulted in better support for both abortion and contraception care.

3.3.3. Attitudes

Three studies measured predictive factors of TBA attitudes toward providing abortion and contraceptive care. Primary influences on TBA attitudes included religion [70], fear of abortion-related complications [59], and personal attitudes toward contraception and abortion [66]. Lindsey et al. [49] asked doulas about their perspectives on contraceptive counseling as a part of their scope. Doulas reported mixed feelings on supporting contraception, citing

concerns about perceived reproductive coercion, particularly with Black and Brown clients.

4. Discussion

To our knowledge, this is the first scoping review to synthesize research about the role of doulas in abortion and contraception care. Previous studies have identified the positive impact of doulas on labor and postpartum outcomes [32–34]. Evidence of the impact of doulas on abortion and contraception care outcomes is limited. Researchers have called for further research on this topic in order to support the effective integration of doulas into abortion and contraception care [26,36]. Our review found that doulas can play a variety of roles in abortion and contraception care, including providing information, navigating access to care, and physical and emotional support during procedural abortion. TBAs in Africa and Asia sometimes directly provide procedural abortion, particularly in rural areas. Doulas can improve client satisfaction with care and mitigate barriers to access. These findings begin to fill an identified knowledge gap about the impact of doulas in abortion and contraception care.

We used the term “doula” because we are based in Canada, and the term is used commonly in North America to refer to nonclinical perinatal support roles. “Doula” is, however, not a universal term. Of the 33 studies we identified, only the seven U.S.-based studies actually used the term “doula.” In North America, the doula’s scope of practice is defined as “nonclinical” [48]; direct provision of procedural care, medication abortion pills, or prescription contraception would fall outside of this scope. The majority of studies in the review used the term “TBA,” were conducted in African or Asian countries, and spoke to the importance of TBAs in providing care, especially in jurisdictions with restrictive abortion laws. The term “doula” may also be limiting within North America. Previous studies have identified that Indigenous and Black people in roles understood to be doulas do not necessarily use or relate to the term doula and may be providing birth support regardless of doula training and/or designation [82,83]. Nonclinical abortion and contraception support may also be provided through accompaniment models [84,85], abortion hotlines [86], the US, abortion funds [87], and familial support [88]. While our search terms did not identify articles on these accompaniment, hotlines, or abortion funds, future research on the role of nonclinical support people in abortion and contraception care should consider these models of support, and any integration of doulas into abortion and contraception care and the development of abortion doula training programs should take into consideration the myriad ways in which support people define themselves.

We were surprised that most of the included studies focused on procedural abortion; only two studies explicitly addressed doulas supporting clients accessing medication abortion [49,50]. Medication abortion accounts for over half of all abortions in the United States [89] and is approved for use in over 90 countries [90]. Access to medication abortion improves abortion safety in countries with restricted access to legal abortion [91]. It is possible that, because medication abortion is less invasive [92,93], is “self-managed” [94], and is experienced at home, potential clients may perceive less need for doula support. However, doulas have the potential to play a stronger, unrealized role in the medication abortion context because many procedural abortion facilities do not allow support people of any type (family, friend, partner, or doula) for security reasons. Doulas can support people seeking a medication abortion in navigating public information; offer information about medication sequence; when to expect cramping, bleeding, and pain; what degree of cramping, bleeding, or pain would constitute a concern; and how to determine if the abortion was complete. There are virtual applications, such as Aya Contigo in Venezuela, that offer doula-like companionship and support [95]. Given the increasing use of

medication abortion globally and the significant increase in telemedicine medication abortion since COVID-19 [96], further research on the potential and realized roles of doulas in medication abortion is necessary to identify ways to integrate doula support into current abortion policy and practice, including in countries and jurisdictions with restricted access to legal abortion where doulas and TBAs may have to consider legal obligations and risks [97]. Future research on ways to integrate doula support into current abortion policy and practice can also consider compensation models and the sustainability of volunteer doula networks.

Only four articles explicitly addressed training for abortion doulas [63,69,71,76]. Similar to perinatal doulas, there is no one regulatory or certifying body for abortion doula practice. Several perinatal doula organizations offer continuing education modules on abortion [98–100]. There are also a growing number of stand-alone abortion doula trainings that do not require experience or interest in practicing as a perinatal doula [101–104]. Further research on training program availability, content, uptake, and efficacy could identify key education and mentorship needs and priorities for abortion doulas.

Finally, we noticed a lack of attention to the potential role for doulas in public political or legal advocacy [105]. While the role of doulas as advocates for individual clients—and the importance of that role for clients facing intersecting forces of oppression, including colonialism and racism [82]—may be well-established in the realm of perinatal care, in the realm of abortion and contraception, doulas may take on public roles to advocate for decriminalization, public funding, and related progressive change.

4.1. Limitations

Our review has several limitations. We only included articles available in full text in English or French, a significant limitation for an international review. Although we used a generous definition of what would constitute a doula-type role, the search terms we chose may have been limiting. Several identified studies used regional terms for doula roles: articles from Pakistan used the South Asian “dai,” while articles from the Philippines used the regional “hilot.” The search terms we chose did also not include accompaniment or abortion hotline models of nonclinical support. Future reviews should include a broader definition of nonclinical support.

Strengths of the study include the international scope and inclusion of both contraception and abortion care, both often absent from doula-related research.

In this international scoping review, we identified that nonclinical support people, such as doulas and TBAs, can play an important role in abortion and contraception care. Doulas provide emotional, physical, and informational support and support clients in navigating barriers to accessing care. They have the potential to positively impact patient satisfaction and clinical outcomes. The majority of studies in the review are from regions with restrictive abortion policies. In several of these studies, TBAs themselves performed procedural abortion. Although nonclinical support people may mitigate barriers to accessing abortion, these roles cannot replace access to well-trained, safe provision of procedural services. Further research is needed to identify the training needs of doulas, the potential for their integration into interdisciplinary abortion and contraception care teams, their role in politico-legal advocacy for abortion decriminalization, and their roles in self-managed medication abortion.

Data availability statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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Supplementary material

Supplementary material associated with this article can be found in the online version at [doi:10.1016/j.contraception.2024.110482](https://doi.org/10.1016/j.contraception.2024.110482).

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