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LITERATURE REVIEW

The Role of Doulas in Addressing Disparities, Barriers, and Potential Solutions to Navigating Reproductive Loss

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Reproductive loss can take many forms. Common experiences include abortions, stillbirths, or miscarriages. Especially in a post-Roe time and space, the health disparities and stigmas that exist surrounding reproductive loss and those experiencing pregnancy loss have become even more apparent. Health disparities continue to exist through sociodemographic factors such as ethnicity, gender, race, and socioeconomic status. As found in existing literature on individuals' experiences with reproductive healthcare, each person's experiences strongly correlate with their identities. The level of reproductive care and compassion received vary dramatically as a result, with people of color and lower socioeconomic statuses receiving lower quality of care when seeking it out. Trends in unintended pregnancies and access to support resources also reinforce the idea that health disparities are at play. Additionally, intersectionality, or the overlapping of an individual's multiple identities, plays an important role in the disparities seen within reproductive healthcare as discrimination and other structural factors are designed to benefit certain groups of individuals while putting others at a disadvantage. Studies and surveys of individuals who have experienced pregnancy loss have addressed the existence of these inequalities within reproductive healthcare. Through a reproductive justice perspective, this literature review aims to bring attention to the disparities present in reproductive healthcare and how the work of reproductive loss doulas, who are full-spectrum doulas who honor all reproductive experiences, may address these disparities with sensitive and compassionate care. While addressing nationwide disparities in pregnancy loss, this literature review uses the state of Michigan to also analyze the current legislative efforts designed to expand access to critical reproductive healthcare services.

Keywords

reproductive justice • reproductive loss doula • reproductive loss • health disparities

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Introduction

The term "reproductive loss" can be used to describe loss in many forms, be it from abortion, stillbirth, or miscarriage. Pregnancy loss in all its forms is unfortunately a common event that does not biologically discriminate between race, socioeconomic status (SES), or ethnicity. Regardless, using social determinants of health to pinpoint disparities in access and quality of reproductive grief care helps loss workers like doulas determine where resources are most needed (Chor et al., 2018). Health disparities, as defined by the Centers for Disease Control and Prevention (CDC), "are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (Health Disparities | DASH | CDC, n.d.). Sociodemographic features like SES, language, and age can all have physical effects on health outcomes, with systemic issues like racism even causing measurable changes in pathophysiology. These identities do not exist in a vacuum, and different identities interact to produce unique experiences with abortion and loss.

Rooting the discussion of pregnancy loss in the reproductive justice framework helps identify and address disparities as they intersect to create individual experiences with oppression. The term "reproductive justice," coined by the group Women of African Descent for Reproductive Justice in 1984, is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Williams, 2019). Therefore, reproductive justice shifts the conversation from one of choice to that of access in order to maintain an individual's bodily autonomy. One way in which current models of health can promote this reproductive justice framework is through the integration of reproductive loss doulas during pregnancy loss experiences.

A reproductive loss doula seeks to support a person's unique pregnancy loss journey while prioritizing this individual's safety and bodily autonomy (Taylor, 2021). Therefore, reproductive loss doulas may address the stark disparities that exist within reproductive loss experiences by supporting a person's social identity while offering affirmative and inclusive care during these outcomes. Reproductive loss doulas may serve as community-based resources that assist clients in navigating economic, medical, and social challenges that arise from reproductive loss (Chor et al., 2018). The objective of this article is to not only identify reproductive loss disparities and the structural barriers that perpetuate these health inequities but also apply a reproductive justice framework to advocate for the important work that loss doulas provide in addressing these disparities.

Stigma and Reproductive Loss

The stigma surrounding reproductive loss prevents those who have experienced it from speaking about it in both social and medical discourse. This stigma not only perpetuates the widespread belief that reproductive loss is a rare occurrence but also further isolates those who experience it. Further, the misinformation and lack of reliable statistics on reproductive loss incidence reinforce the misconception that reproductive loss is a deviant and unusual pregnancy outcome (Kumar et al., 2009). In actuality, reproductive loss is a common occurrence: nearly one in five pregnancies will end in abortion in the United States (Jones, 2019). Further, one in four pregnancies is estimated to be affected by miscarriage (Miscarriage – Symptoms and Causes, 2021). Openly discussing reproductive loss in its many states could help reduce stigma and allow those experiencing loss to find community within each other.

Miscarriage and Stillbirth Disparities

Despite the common frequency of reproductive loss, certain communities disproportionately demonstrate higher rates of loss and pregnancy termination (Pregnancy and Infant Loss | CDC, 2020). People of color and other marginalized identities also face reduced access to resources and services that can provide the proper care to individuals experiencing reproductive loss. Miscarriage is defined as fetal death before the twentieth week of gestation, whereas stillbirth is defined as fetal death after the twentieth week of gestation (Pregnancy and Infant Loss | CDC, 2020). Black birthing women have a nearly two-time greater risk of miscarriage and stillbirth relative to White birthing women (Stillbirth | CDC, 2020).

There are certain risk factors that heighten an individual's likelihood of experiencing miscarriage, which are disproportionately experienced by minoritized communities. For instance, stress, abuse, chronic exposure to social and economic disadvantage, and legal stressors contribute to higher rates of miscarriage (Mukherjee et al., 2013). These factors contribute to the weathering of communities of color and/or lower SES, which may induce imbalances in inflammatory and neuroendocrine pathways that result in miscarriage (Li et al., 2018).

Miscarriage and stillbirth are associated with poor care of the pregnant person during the pregnancy (Bommaraju et al., 2016). Therefore, miscarriage and stillbirth evoke feelings of guilt and emptiness for the birthing individual and result in emotional trauma and higher levels of stress and anxiety (Corcoran et al., 2017). Due to this stigmatization, an individual's support system may avoid conversations surrounding miscarriage and stillbirth, which results in feelings of "disenfranchised grief" (Burden et al., 2016). This term describes the feeling that the birthing individual's grief is not validated by their friends, family, and health professionals. Nevertheless, research demonstrates that feelings of isolation subside once people become aware that miscarriage and stillbirth are common experiences (Fairchild & Arrington, 2022). A strong connection to the roles of loss doulas and this important validation of feelings can thus be made, as loss doulas play a large part in supporting and validating the experiences of individuals undergoing pregnancy to further destigmatize miscarriage on a larger scale.

Stratified reproduction reveals that people experience reproduction differently based on sociodemographic factors, such as race and income. For instance, due to intrusive surveillance, people of color and/or lower SES may perceive miscarriage as a personal wrongdoing that is indicative of poor care during pregnancy (Bommaraju et al., 2016). Nevertheless, due to the value of childbearing adorned onto wealthy White individuals, these individuals are more likely to receive the benefit of the doubt regarding the miscarriage (Bommaraju et al., 2016). This difference in treatment is especially jarring given that approximately 90% of unintentional pregnancy loss is due to genetic abnormalities, which are frequently undiagnosed (Baldwin, 2022). Therefore, by understanding how reproductive loss is rooted in stratified reproduction, loss doulas can avoid generalized attitudes toward this experience and offer care that is responsive to individual needs. Overall, reproductive loss doulas can practice cultural humility and patient-centered care to address the effects of discrimination on the reproductive loss experiences of people of color and/or lower SES (Chor et al., 2018).

Medical Racism and Coercion

In addition to miscarriage and stillbirth, people of color and people of lower SES have disproportionately higher rates of unintended pregnancies. For instance, 63% of surveyed pregnancies among Black women and 48% of those among Hispanic women are unintended, compared with the 42%

among White women (Troutman et al., 2020). Further, 64% of women with an income below the Federal Poverty Level reported an unintended pregnancy, compared to the 37% of women with an income 200% above the Federal Poverty Level who reported an unintended pregnancy (Dehlendorf et al., 2013). These higher rates of unintended pregnancy may reflect the access to and use of contraception for people of color and/or lower SES as related to the history of medical abuse and reproductive coercion against these communities.

Beginning in the early twentieth century, the eugenics movement imposed draconian efforts to eradicate "undesirable" traits from the human gene pool (Stern, 2020). Historically, poor and minority women were forced and/or coerced to be sterilized by the government while being encouraged to use contraception in efforts to restrict childbearing within these communities (Stern, 2020). The eugenics movement used compulsory sterilization to restrict the reproductive capacity of people of color and/or lower SES (Stern, 2020). In the early twentieth century, California's Asexualization Acts allowed for the sterilization of 20,000 Black and Mexican individuals (*America's Forgotten History of Forced Sterilization*, 2020). The goal of these laws was to "protect society from deleterious genes and the social and economic costs of managing 'degenerate stock'." By 1970, nearly 70,000 Americans – overwhelmingly working class people of color – had been forcibly sterilized (America's *Forgotten History of Forced Sterilization*, 2020).

During the 1990s and continuing in the twenty-first century, coercive federal and state policies encouraged sterilization in exchange for welfare benefits and/or sentence reduction. These policies sought to restrict the fertility of those who relied on government assistance as an effort to reduce poverty (Romero & Agénor, 2009). Commonly referred to as "child-exclusion policies," these government regulations limited additional income support to families who birthed an additional child while enrolled in Temporary Assistance to Needy Families (TANF). TANF predominantly services Black and Hispanic women, suggesting that these family-cap regulations disproportionately infringe on the sexual, reproductive, and privacy rights of these welfare recipients.

These aforementioned factors all contribute to overall distrust of the healthcare system, as well as possible skepticism about the intention of contraception. Nearly twice as many Black and Hispanic individuals believed that government uses birth control to limit minority population relative to White respondents (Harper, 2012). This finding highlights that improving knowledge of the efficacy and safety of birth control options may ameliorate race-based disparities in contraceptive usage and unintended pregnancy rates.

This history of reproductive coercion, partnered with modern-day financial barriers may explain differences in contraceptive adherence and preferences between people of color and white individuals, resulting in higher rates of unintended pregnancies (Dehlendorf et al., 2013). While medical distrust is still prevalent, it is not a valid excuse to blame patients for reproductive decisions when the medical system and government at-large should be responsible for healing past wounds and ensuring equitable access to care.

Unintended births have been associated with poor medical and social outcomes, such as preeclampsia, preterm birth, hindrance of educational goals, and increased risk of poverty (Health Disparities in Abortion and Family Planning Workshop, 2019). Long-acting reversible contraceptives (LARCs) have the lowest failure rate of any reversible birth control method; however, people of color are less likely to use LARCs, compared to White individuals ("Seeking Causes for Race-Related Disparities in Contraceptive Use," 2014).

The lack of awareness of different contraceptive methods and options and prevalent medical mistrust is an issue that can be addressed through the work of loss doulas as well. By increasing awareness and knowledge regarding different contraceptive methods, loss doulas may work to reduce exposure to the medical and social risk factors associated with unintended pregnancies, especially for people of color and/or lower SES. In addition to providing emotional and physical support during the pregnancy loss experience, loss doulas may also provide information surrounding contraception to empower clients to make informed decisions about their reproductive capacity.

Unintended Pregnancy and Reproductive Loss

Discussion of reproductive loss disparities cannot occur without recognizing the role of unintended pregnancy in reproductive decision-making. As mentioned previously, approximately half of unintended pregnancies end in abortion (Unintended Pregnancy and Abortion Worldwide, 2022). Further, the trends in unintended pregnancies closely mirror the rates of pregnancy loss. For instance, Black and Hispanic women have significantly higher abortion rates relative to White women (Kortsmit, 2021). Surveyed women with incomes less than 100% of the Federal Poverty Level have an abortion rate that is nearly six times higher than the rate of women with incomes greater than 200% of the Federal Poverty Level (*Abortion in the Lives of Women Struggling Financially*, 2022). Further, the Guttmacher Institute revealed that 75% of abortion patients across the United States identify as poor or low-income (Jerman, 2022). Lastly, surveyed women who do not have a college education also demonstrate higher abortion rates relative to women with college degrees (Jones & Jerman, 2017).

Overall, these findings reveal that minoritized communities experience pregnancy termination at higher rates than socially advantaged communities. This may be due to the higher rates of unintended pregnancies among people of color and/or lower SES (Jones & Finer, 2012). Further, people of color and/or lower SES face systemic hardships such as exposure to higher levels of stress and discrimination along with lower qualities of living and working conditions, which may offer potential reasons for why these individuals decide to seek abortion care at higher rates (Jones & Finer, 2012).

While loss doulas are generally thought of as a support system for lost intended pregnancies, their expertise as reproductive health educators and trained emotional support personnel can be used for unintended pregnancy loss as well. Loss doulas focus on the emotional and overall wellbeing of their clients with no judgment, no matter if the pregnancy ended in abortion or miscarriage.

LGBTQ+ Community and Reproductive Loss

LGBTQ+ individuals also experience disparities in reproductive loss. For instance, heteronormative conceptualizations of pregnancy continue to exclude transgender men and nonbinary individuals from conversations surrounding miscarriage, stillbirth, and abortion (Zucker, 2020). Fifty-six percent of LGBTQ+ patients report blatant discrimination in medical settings (including harassment and lack of provider knowledge), with nearly 20% of transgender individuals being denied healthcare due to their gender identity (Zucker, 2020). Despite a subset of sexual minority groups demonstrating higher rates of pregnancy termination relative to heterosexual individuals, only 23% of surveyed abortion clinics in 2017 provided transgender-specific or gender-affirming care (Jones et al., 2020). Therefore, the systemic erasure of queer pregnancy experiences from medical care and social discourse may contribute to higher rates of substance abuse and negative mental health outcomes among LGBTQ+ individuals following reproductive loss (Zucker, 2020).

Denial of reproductive health services to queer patients may also contribute to adverse clinical outcomes following reproductive loss. For instance, nearly half of documented miscarriages result in a dilation and curettage procedure, which is a surgical procedure. If the placental and fetal tissue are not completely removed during this surgery, an infection that may induce septic shock can occur (American Pregnancy Association, 2022). This is especially significant for queer patients as inaccessibility to gender-affirming and competent medical care may result in unsafe miscarriage management, which can increase the likelihood of medical complications like septic shock (Zucker, 2020). Loss doulas who can focus on all-encompassing and individual care may be some of the best candidates for focusing on gender-affirming care in reproductive experiences. Working alongside medical professionals to ensure all of a patient's needs are met appropriately is of the utmost importance to doulas.

Structural Factors Contributing to Reproductive Loss Disparities

Structural factors play a prominent role in contributing to reproductive loss disparities. A 2005 study measured discrimination against African American women while receiving family planning services and defined race-based discrimination as a provider not listening to the patient, the patient receiving sub-optimal service compared to others, and providers making assumptions about sexual history. Of the 79% of women who reported experiences with healthcare providers regarding family planning or birth control services, 67% reported race-based discrimination when obtaining such services (Thorburn & Bogart, 2005). Physicians and nurses often fall prey to inaccurate stereotypes that patients of color have more sexual partners than their white counterparts, further discouraging patients of color from seeking preventative reproductive care. Furthermore, studies have shown that Black individuals who outwardly express their Afrocentrism more directly in regard to fashion, dress, and mannerisms face higher rates of discrimination (Williams & Mohammed, 2008). This only furthers the lack of access to reproductive care and mistrust for the medical system that African Americans experience (Williams & Mohammed, 2008).

Other structural barriers, such as difficulty in accessing transportation and affording abortion care, contribute to delaying this care. In addition to demonstrating higher rates of pregnancy termination, people of color are more likely to have late-term abortions, which exposes these individuals to greater medical risks (Jones & Finer, 2012). While major abortion complications occur in less than 1% of reported cases, the safety of this procedure does significantly decrease with increasing gestational age (Jones & Finer, 2012). In fact, the University of California–San Francisco revealed that Black women are more than twice as likely as White women to experience abortion-related mortality (Health Disparities in Abortion and Family Planning Workshop, 2019). This finding suggests that because minoritized identities obtain higher rates of late-term abortion, these same individuals may be subject to higher rates of mortality due to the medical complications that arise from a late-term abortion.

Further, individuals with limited education demonstrate higher levels of late-term abortion, which may be due to a lack of knowledge of reproduction and lower levels of health literacy (Jones & Finer, 2012). This may contribute to these individuals experiencing increased difficulty in obtaining necessary information about pregnancy termination options and/or finding a healthcare provider (Jones & Finer, 2012). Depending on the unique circumstances of the individual's reproductive loss experience, loss doulas may address this gap in knowledge by assisting these individuals in understanding and accessing the different options available for pregnancy termination and management. Focusing on cultural competence and person-first reproductive education is just one way loss doulas can provide services that are mindful of each client's needs and the systemic barriers they face when accessing reproductive care. Overall, these findings reveal that minoritized communities may have more negative reproductive loss experiences in the clinical environment due to discrimination and inaccessible medical information.

Structural Barriers to Abortion Care

Structural barriers to abortion care create substantial long-term effects that disproportionately target minoritized communities. One in four women with Medicaid coverage who seek an abortion are forced to continue the pregnancy due to the restrictions imposed by the Hyde Amendment (The Hyde Amendment, n.d.). Compulsory childbirth presents much more serious public health and economic issues when compared to abortion. Carrying a pregnancy is nearly 14 times riskier than receiving an abortion. Further, individuals who do not obtain a desired abortion are four times more likely to live in poverty and three times more likely to experience unemployment (*Findings from the Turnaway Study*, 2020). The self-perpetuating cycle enforced by the expense of abortion is extended when abortions are removed as an option altogether, impacting the financial stability and educational opportunities of the birthing individual (*Findings from the Turnaway Study*, 2020).

Further, when compared to individuals who received desired abortion care, those who were denied this care demonstrated a higher risk for eclampsia and postpartum hemorrhage (*Findings from the Turnaway Study*, 2020). Given that Black maternal mortality is nearly five times greater than that of White birthing individuals, these medical complications disproportionately affect people of color (Pregnancy and Infant Loss | CDC, 2020). This highlights that allowing individuals to receive timely and safe abortion care may prevent these individuals from experiencing the adverse health outcomes associated with unintended childbirth (Dehlendorf et al., 2013).

In addition to a heightened risk for medical complications, individuals who are denied access to abortion care are more likely to stay in contact with abusive partners (*Findings from the Turnaway Study*, 2020). This is especially significant for people with disabilities and people of color, who are already much more likely to experience sexual assault or intimate partner violence (*Findings from the Turnaway Study*, 2020). Restricting access to abortion care not only prevents individuals from receiving necessary medical intervention but also directs minoritized individuals to sustained violence. Consequently, abortion-seeking individuals will experience higher rates of psychological abuse, rape, reproductive coercion, and pregnancy-related homicide if they are forced into childbirth (*Findings from the Turnaway Study*, 2020). Overall, barriers to reproductive care can result in a multitude of repercussions, including economic and employment consequences, that can perpetuate already-existing instabilities.

Socio-economic Disparities in Reproductive Loss

Economic hardship is also a significant structural barrier that limits access to safe and desired abortion care. A first trimester abortion costs around $500, whereas second and third trimester abortions can cost more than $3,000 (Pregnancy Decision Line, 2022). In 2021, the Federal Reserve estimated that one out of three Americans do not have the financial means to cover unexpected expenses, such as abortion care (Abortions Later in Pregnancy, 2019). Therefore, financial insecurity functions as a critical barrier that may prevent people from obtaining on-time abortion care.

Nearly 28% of women of reproductive age and 40% of low-income women rely on Medicaid (Coverage for Abortion Services in Medicaid, 2022). Further, women of color are more likely than White women to be enrolled in Medicaid (*For Women of Color, Access Is Threatened,* 2022). In 2015, 31% of Black women and 27% of Hispanic women of reproductive age were enrolled in Medicaid, compared with 16% of White women (*For Women of Color, Access is Threatened*, 2022). Nevertheless, there are substantial efforts aimed at restricting the scope of Medicaid coverage.

The Hyde Amendment severely limits the use of federal funds for abortion care in Medicaid (The Hyde Amendment). It also limits abortion coverage by other federally funded programs, including the Indian Health Reserve, Medicare, Americans with Disability Act, and health insurance for federal employees (The Hyde Amendment). Further, the Affordable Care Act does not require insurance plans to cover abortion, resulting in 25 states passing laws that restrict abortion coverage in their health insurance marketplaces except in the specific situations of incest, rape, and life endangerment (Coverage for Abortion Services in Medicaid, 2022). As a result, safe and legal abortion care becomes an unaffordable option for minoritized communities, which comprise a significant share of Medicaid programs.

Additionally, the Turnaway Study – a national longitudinal study involving 1,000 women seeking abortion care – reported that the total out-of-pocket costs for an abortion procedure are equivalent to one-third of the personal monthly income of more than half of the surveyed individuals (Roberts et al., 2014). This finding suggests that financial barriers to abortion care trap minoritized communities in a self-perpetuating cycle of economic hardship, resulting in individuals forgoing food, rent, and utilities to afford an abortion (Roberts et al., 2014).

Transportation represents another significant barrier to abortion care access, especially for those of lower SES status, and has been sustained by the overturn of *Roe v. Wade*. Nearly 20% of individuals across the United States would need to travel at least 43 miles to reach the nearest abortion clinic (Travel Far to Access Services, 2022). This distance is particularly relevant to the substantial minority of lower-income individuals who live in rural areas as they travel longer distances to access abortion care (Travel Far to Access Services, 2022).

Following the recent rollback of *Roe v. Wade*, most individuals seeking abortions will travel farther than they would have previously to reach the nearest abortion clinic (*Travel Far to Access Services*, 2022). For these individuals, the travel distance will increase on average from 36 miles to 274 miles to their nearest abortion provider (*After Roe V. Wade*, 2022). Further, 72% of abortion facilities offer abortion up to 12 weeks of gestation, whereas only 34% of facilities offer abortion up to 20 weeks, and only 16% provide abortion up to 24 weeks (Jerman & Jones, 2014). Therefore, minoritized individuals – who already demonstrate higher rates of late-term abortion – may need to travel longer distances to access necessary abortion care in this post-Roe environment given the stark reduction in clinics offering late-term abortions (Jones & Finer, 2012). Living further away from an abortion clinic corresponds to increased travel and lodging costs, which contributes to an individual's inability to receive abortion care at the time they seek out these services (*After Roe V. Wade,* 2022). Socio-economic barriers to doula care.

Legislative Barriers

In Michigan, there are state-specific abortion regulations that further create structural barriers to accessing abortion care (Michigan's 24-Hour Waiting Law., n.d.). For instance, Michigan Medicaid and private health insurance coverage of abortion is prohibited in all cases except life endangerment

(Guttmacher Institute., n.d.). These regulations can be interpreted as violations of the reproductive right to not bear children by using insurance restrictions to create barriers to receiving reproductive care.

Additionally, Michigan's 24-Hour Waiting Law requires that medical information must be disclosed to individuals seeking an abortion 24 hours before the procedure (Michigan's 24-Hour Waiting Law., n.d.). This information includes depictions of fetal development corresponding to gestational age, prenatal and parenting services, and a written summary of the abortion procedure; however, portions of this State-mandated information are misleading and not supported by scientific evidence (Michigan Abortion Wait Time., n.d.).

These waiting periods create substantial logistical obstacles that the abortion-seeking individual must oftentimes navigate alone. For instance, Michigan's 24-Hour Waiting Law represents 24 hours where the individual must find childcare services – if they already have children. Further, these waiting periods are also 24 hours, during which the individual must pay for lodging, food, and any additional expenses that may arise when obtaining abortion care (Michigan Abortion Wait Time, n.d.). People of lower SES are disproportionately affected by these state-specific restrictions as they are less likely to have substantial savings to cover these necessary expenses.

Post-Roe Implications

The recent overturning of *Roe v. Wade* has further exacerbated barriers to reproductive healthcare (*After Roe V. Wade*, 2022). With *Roe v. Wade's* reversal, individuals need to travel longer distances to access abortion-providing clinics. Further, state-mandated waiting periods force individuals to make multiple medically unnecessary visits to abortion providers, forcing them to stay away from work and/or caregiving responsibilities. (Michigan Abortion Wait Time., n.d.). *Roe v. Wade* disproportionately harms minoritized communities, which already face substantial burdens when seeking reproductive healthcare.

The post-Roe environment has also exposed those seeking abortion care to criminalization which has contributed to miscarriage rates and stillbirth experiences (Hurtado & Maglione., n.d.). Currently, 38 states have laws that criminalize harm to the fetus that may have resulted in miscarriage or stillbirth. These laws ascribe separate victim status to the fetus, indicating that self-induced abortions, drug use during pregnancy, and child endangerment can be used to prosecute miscarriage and stillbirth (Hurtado & Maglione., n.d.). Now that reproductive rights are no longer constitutionally protected, individuals may seek dangerous and unsafe alternatives for pregnancy termination that may result in a greater risk of miscarriage and stillbirth. Given that people of color and/or lower SES demonstrate higher rates of miscarriage and stillbirth, this exposes these communities to increased criminalization and violence following *Roe's* overturning (Hurtado & Maglione., n.d.).

In this post-Roe environment, reproductive loss doulas may be of particular importance to these communities (*Importance of Doulas*, 2021). Loss doulas can assist individuals in navigating barriers to reproductive healthcare and limiting the harm and trauma caused by these barriers. Given that 13 states currently ban abortion, reproductive loss doulas can provide logistical support by picking up out-of-state clients from airports and arranging accommodations to ensure that clients can safely arrive to their appointments (*After Roe V. Wade*, 2022). Further, loss doulas can connect clients to resources – such as abortion funds – that cover travel costs associated with abortion care, including childcare, hotels, and gas money. Reproductive loss doulas can also help clients navigate the complex legal requirements to access an abortion, along with correcting any inaccurate information about pregnancy termination (*Our Communities Hold the Solutions*, 2022). Using both nonjudgmental and affirmative care, reproductive loss doulas can empower the autonomy and dignity of their clients as they navigate the best option for managing their pregnancy during this particularly hostile time for reproductive rights (*Our Communities Hold the Solutions*, 2022).

Role of Doulas in Reproductive Loss Disparities

Recent over-medicalization of abortion may interfere with the emotional processing of this experience, especially as surgical abortions account for most of the pregnancy termination procedures (Diamant & Mohamed, 2022). Further, minoritized communities are subject to greater medical risks following this procedure due to their higher rates of late-term abortion (Jones & Finer, 2012). Therefore, reproductive loss doulas may provide compassionate support to these individuals to ameliorate feelings of fear and anxiety during pregnancy termination. For instance, the integration of a loss doula in the clinical setting can assist with processing patient emotions through dedicated care, listening sessions, grief counseling, resource referral and promoting physical wellbeing, which reduces patient pre- and post-procedure anxiety (Chor et al., 2018). Consequently, this may allow the medical staff to better focus on the technical aspects of the surgical procedure to prioritize patient safety. Overall, this highlights the beneficial impact of doulas on the patient's experience during an abortion procedure (Chor et al., 2018).

Compassionate support has also been shown to induce positive effects on the wellbeing of an individual experiencing reproductive loss (Chor et al., 2018). Therefore, reproductive loss doulas may be important to people who experience higher rates of miscarriage and stillbirth. One way in which loss doulas can address the stigmatization and isolation of pregnancy loss is by accompanying clients to appointments to confirm the miscarriage or stillbirth and offering nonjudgmental support to assist with the emotional processing of these events (Chor et al., 2018). Further, loss doulas can work with clients to create unique grieving rituals through creative expression and/or engaging in spiritual activities to honor the loss (*Importance of Doulas,* 2021). These strategies highlight how loss doulas can serve as social support systems to minoritized individuals who experience higher rates of reproductive loss (*Importance of Doulas,* 2021).

Expanding Access to Reproductive Loss Doulas

Despite the documented importance of reproductive loss doulas in managing reproductive loss, current models of health and policy continue to exclude loss doulas from healthcare settings (Chen & Fradet., n.d.). The National Health Law Program revealed that hospitals and medical providers may not always understand the scope of doula care, resulting in strained relationships between doulas and the clinical staff (Chen & Fradet., n.d.). Further, during the COVID-19 pandemic, doula work was frequently referred to as "non-essential," which allowed healthcare providers and policymakers to restrict doula accompaniment during pregnancy termination. These interpersonal and institutional barriers to doula work serve as reflections of the targeted erasure of community-based birth workers by a patriarchal medical system (Chen & Fradet., n.d.).

Financial barriers also limit the accessibility of doula services. Healthcare payers largely restrict adequate compensation for doula services (Chen & Fradet., n.d.). This results in out-of-pocket remuneration for doulas, which is a feasible option for mainly White and/or higher SES individuals. Doula services can cost from $500 to $2,000, and compounded with the costs of abortion, these services may be financially inaccessible to people of color and/or lower SES (Chen & Fradet., n.d.). Nevertheless, there are current federal and state policy efforts that seek to expand insurance coverage of doula care (Robles-Fradet, 2021). Specifically, these legislative efforts seek to mitigate the financial barriers that restrict access to support services for minoritized communities.

As of 2022, states are in various stages of planning and implementing Medicaid coverage of doula services to improve the birthing experience and outcomes for people of color (Robles-Fradet, 2021). Currently, six states allow for reimbursement of doula work through Medicaid, while six other states plan to acquire Centers of Medicare and Medicaid Services approval to allow Medicaid to cover doula services (Robles-Fradet, 2021). The Michigan Department of Health and Human Services recently proposed a policy to allow Medicaid coverage of community-based, prenatal, labor and delivery, and postpartum services as an attempt to address racial disparities that exist within pregnancy and childbirth (*MDHHS Proposes to Cover*).

Despite efforts to implement doula coverage in Medicaid, these proposed plans exclusively focus on providing doula support to individuals throughout their pregnancy, childbirth, and postpartum experience. These state policies fail to identify reproductive loss support as a service that doulas can provide, revealing a gap in current legislation as policymakers fail to proactively address the diversity of experience in reproductive loss by dismissing the need for reproductive grief support in the scope of doula services (*Our Communities Hold the Solutions*, 2022). This exclusion further perpetuates the stigma surrounding reproductive loss, potentially resulting in delay of care, isolation, and clinical complications that arise from the unsafe management of reproductive loss experiences. Therefore, policy efforts should identify reproductive grief care as a tenet of doula work to more comprehensively address the stark disparities in reproductive healthcare (Chen & Fradet., n.d.).

Current policies should include federal and state-wide insurance coverage for support for all pregnancy outcomes, including abortion, miscarriage, and stillbirth. Further, policies should address the disconnect between doula work and clinician knowledge by educating both clients and medical providers on the benefits of doula support during reproductive loss (*Our Communities Hold the Solutions*, 2022). Given the limited number of reproductive loss doula training programs, states should also invest in resources to support community-based models of support, trauma-informed care, and reproductive justice to expand and strengthen the doula workforce (*Our Communities Hold the Solutions*, 2022).

Integrating the reproductive justice framework into loss doula care is crucial to dismantling the systems of discrimination, oppression, and power that contribute to reproductive loss disparities (*Our Communities Hold the Solutions*, 2022). Loss doulas expand upon standard knowledge of providing informational, physical, and emotional support by centering pregnancy loss in the reproductive justice framework (*Importance of Doulas*, 2021). This framework gives loss doulas the ability to understand how systems of medical racism, economic oppression, and policy discrimination intersect to violate the reproductive rights of minoritized communities (*Importance of Doulas*, 2021).

The structural barriers that limit access to safe and affordable reproductive healthcare highlight the specific need for loss doulas to serve as community assets. Through this framework, loss doulas can use their community-based knowledge to connect clients to local resources that address the wider economic and social issues within the community that contribute to disparities in reproductive loss (*Our Communities Hold the Solutions*, 2022). Broadly, loss doulas can assist individuals in navigating unstable housing and working conditions, food insecurity, caregiving responsibilities, and transportation.

No individual should have to make the decision as to whether to maintain their personal well-being or carry a fetus to term despite having decided themselves that they are unable to or do not want to continue the pregnancy. Therefore, expanding access to loss doulas may mobilize individuals to pursue their desired option for pregnancy management.

Conclusion

Overall, reproductive loss doulas provide emotional, physical, and informational support for anyone experiencing reproductive loss (Chor et al., 2018). However, like other forms of reproductive health, access is limited only to those who can afford it and those who feel safe and unjudged in obtaining care (Chen & Fradet., n.d.). In addition to demonstrating higher levels of reproductive loss, minoritized communities also disproportionately face barriers in accessing the proper resources to manage their pregnancy outcomes. Therefore, to promote reproductive justice, current models of health must emphasize a person's social identity when counseling patients on reproductive loss of all kinds. Overall, loss doulas may serve as community-based resources to affirm and validate the reproductive autonomy of marginalized communities through person-centered support (*Our Communities Hold the Solutions*, 2022).

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