



**Evaluation of trained volunteer doula services for disadvantaged women in five areas in England: women's experiences**

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Peer Review

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3 1 **Evaluation of trained volunteer doula services for disadvantaged women in five areas in**  
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5 2 **England: women’s experiences**  
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11 5 **Abstract**  
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16 7 Disadvantaged childbearing women experience barriers to accessing health and social care  
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18 8 services and face greater risk of adverse medical, social and emotional outcomes. Support  
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20 9 from doulas (trained lay women) has been identified as a way to improve outcomes; however  
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22 10 in the UK doula support is usually paid-for privately by the individual, limiting access among  
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24 11 disadvantaged groups. As part of an independent multi-site evaluation of a volunteer doula  
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26 12 service this study examined women's experiences of one-to-one support from a trained  
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28 13 volunteer doula during pregnancy, labour and the postnatal period among women living in  
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30 14 five low-income communities in England.  
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36 16 A mixed methods multi-site evaluation was conducted with women (total n=137) who  
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38 17 received the service before December 2012, using a combination of questionnaires (n=136),  
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40 18 and individual or group interviews (n=12).  
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45 20 Topics explored with women included the timing and nature of support, its impact, the  
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47 21 relationship with the doula, and negative experiences. Most women valued volunteer support,  
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49 22 describing positive impacts for emotional health and well-being, and their relationships with  
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51 23 their partners. Such impacts did not depend upon the volunteer’s presence during labour and  
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53 24 birth. Indeed, only half (75/137; 54.7%) had a doula attend their birth. Many experienced  
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55 25 volunteer support as a friendship, distinct from the relationships offered by healthcare  
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professionals and family. This led to potential feelings of loss in these often isolated women when the relationship ended.

Volunteer doula support that supplements routine maternity services is potentially beneficial for disadvantaged women in the UK even when it does not involve birth support. However, the distress experienced by some women at the conclusion of their relationship with their volunteer doula may compromise the service's impact. Greater consideration is needed for managing the ending of a one-to-one relationship with a volunteer, particularly given the likelihood of it coinciding with a period of heightened emotional vulnerability.

## Bullet points

### *What is known about this topic*

- Disadvantaged childbearing women are at greater risk of adverse outcomes, partly reflecting barriers to accessing services
- Support from doulas (trained lay women) has been associated with improved outcomes; however doula support is usually paid-for in the UK, limiting access among disadvantaged groups
- Few studies have explored doula support in settings where midwives are the lead health professionals.

### *What this paper adds*

- Women from low-income communities using a volunteer doula service alongside routine maternity services reported predominantly positive impacts that did not depend upon volunteers attending labour
- Women described feelings of loss when the relationship ended

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51       • Managing the ending of a one-to-one relationship with a volunteer requires greater  
52       consideration **given its potential to compromise impact.**  
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55       **Introduction**  
56       In the UK, most women access maternity care through the National Health Service; this is  
57       free at the point of access. Midwives work across hospital and community settings,  
58       coordinate the care provided during pregnancy, birth and the early postnatal period and are  
59       the lead healthcare professionals for women whose pregnancies are considered low risk.  
60       Women may also receive other statutory services e.g. from General Practitioners, health  
61       visitors, and social services. Disadvantaged women (including those with complex social  
62       needs such as social deprivation, lone parenting, substance misuse, mental illness, domestic  
63       abuse, asylum seekers and refugees) are less likely to access routine services and face  
64       increased risk of poorer maternal and child health outcomes (Downe et al., 2009, Hodnett et  
65       al., 2010, O'hara and McCabe, 2013, Confidential Enquiry into Maternal and Child Health,  
66       2009, Centre for Maternal and Child Enquiries, 2011).  
67  
68       The National Institute for Health and Care Excellence (NICE) in England and Wales  
69       recommended that service provision for pregnant women with complex social **needs be better**  
70       **integrated both within the NHS and between the NHS and those services provided in the**  
71       **community by not-for-profit organisations (described in the UK as the voluntary or third**  
72       **sector)** (National Institute for Health and Care Excellence, 2010). This fits with a move in  
73       high-income countries towards using lay health workers **(i.e. those with some training, but no**  
74       **formal professional training or qualification)** to engage minority communities and support  
75       those with complex needs (Glenton et al., 2013). Recognising the limited evidence base,

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3 76 NICE identified two research questions that related to this: *What effect does involving third*  
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5 77 *[voluntary] sector agencies in providing support and coordination of care for vulnerable*  
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7 78 *women have on outcomes? Is intervention and/or family support provided by statutory and*  
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9 79 *third [voluntary] sector agencies effective in improving outcomes for women and their*  
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11 80 *babies? (National Institute for Health and Care Excellence, 2010).*  
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16 82 The research reported here examined a voluntary sector service where disadvantaged  
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18 83 childbearing women are allocated a volunteer 'doula' (the term adopted by the service) with  
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20 84 the aim of enhancing support and wellbeing, and improving the uptake of health and social  
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22 85 services. The doulas are volunteers from the local community who receive accredited  
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24 86 training, funded by the service; as such they are considered lay rather than professional.  
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26 87 Training covers preparation for and support during labour and birth, breastfeeding, child  
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28 88 protection, domestic abuse awareness, cultural diversity and communication skills. Salaried  
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30 89 service staff match a volunteer (and, sometimes, a back-up volunteer) to each woman  
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32 90 according to needs and practicalities; facilitate an initial meeting between the woman and  
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34 91 volunteer and mentor the volunteer throughout the support period, typically from the sixth  
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36 92 month of pregnancy until six weeks postpartum. Service policy stipulates that doulas and  
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38 93 women do not have continued contact beyond the ending of the support period.  
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45 95 In common with models of doula support in previously published research (Hodnett et al.,  
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47 96 2007, Sosa et al., 1980, Steel et al., 2014) the volunteers offer emotional support,  
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49 97 information and physical support, but do not provide clinical care. The volunteer doulas  
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51 98 differ from traditional schemes in two main ways. Firstly, support extends over a long period  
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53 99 rather than being focused on birth and the immediate postpartum; the birth may or may not be  
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55 100 attended by the doula. Secondly, the support offered is more diverse and seeks to optimise  
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101 women’s use of both health and social care services; thus the role includes working closely  
102 with existing services, facilitating communications between the woman, her partner and  
103 health and social care providers, and signposting to other services, including voluntary and  
104 community organisations. In these respects, the closest similar model is the community-based  
105 doulas, an extended doula model which has largely focused on supporting young mothers or  
106 those from ethnic minorities (e.g. (Akhavan and Edge, 2012, Breedlove, 2005, Gentry et al.,  
107 2010, Wen et al., 2010)). Support in the scheme evaluated here can include: home visits;  
108 telephone contact; giving information about services and accompanying to appointments;  
109 going for walks and trips to cafes (to reduce social isolation); giving information about  
110 pregnancy, labour, birth and looking after the baby; providing physical and emotional support  
111 during labour and birth; giving practical help with baby equipment; breastfeeding support.  
112  
113 Previous research has shown doula support to be associated with more positive feelings about  
114 labour, increased feelings of control and confidence as a mother and less postnatal depression  
115 and anxiety (Gordon et al., 1999, Hofmeyr et al., 1991, Langer et al., 1998, Wolman et al.,  
116 1993, Scott et al., 1999). However, research gaps remain. Several studies focused on  
117 intrapartum in-hospital support. A recent critical review (Steel et al., 2014) identified the  
118 relative absence of research examining the outcomes for women receiving doula support in  
119 home or community settings. The review, which focused on 'fee-for-service' doulas, also  
120 noted that, despite the focus of doula care being on social and emotional support, research has  
121 focused on medical outcomes (i.e. pregnancy and birth outcomes). Alongside the relative  
122 dearth of qualitative evidence around recipients' experiences of support is a lack of research  
123 into *how* change is achieved; a notable exception being a grounded theory study identifying  
124 the use of several problem-solving strategies used by community-based doulas working with

adolescent mothers (Gentry et al., 2010). In addition, there is a paucity of UK evidence, where doula support is offered alongside midwifery care.

We conducted an independent multi-site evaluation, informed by Realistic Evaluation (Pawson and Tilley, 1997), which was funded by the National Institute of Health Research. The full report is available (Xxxxxxxx, 2015) [blinded for purpose of peer review]. One of the aims of the evaluation was to examine the health and psychosocial impacts for women who used the volunteer doula service. Analysis of the service databases suggested some clinical outcomes of doula supported women were improved relative to the local population; the caveats around those findings are discussed elsewhere (Xxxxxxxx, 2015) [blinded for purpose of peer review]. This paper focuses on the experiences of the women who used the service; specifically, the areas of impact and the nature of the relationship that may offer insights into how such outcomes occur.

## Methods

### *Settings*

The doula service was originally set up in site A in 2006 and subsequently in 2011 rolled-out to four other sites (W, X, Y and Z); all of which are low-income communities. The services are predominately run by voluntary sector organisations. Volunteer doula support is provided free of charge to women and is additional to routine statutory and voluntary services. Women may self-refer but are typically referred by another statutory or voluntary agency, usually due to: being unsupported and potentially birthing alone; experiencing health or social problems; or having particular concerns about labour and birth. At two sites services are restricted to

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150 women from ethnic minority groups and a third serves an area with a very large ethnic  
151 minority population.  
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153 *Ethics and governance*  
154 Approval for the study was obtained from the West Midlands Research Ethics Committee  
155 (reference 12/WM/0342) and governance permissions were obtained at each research site.  
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157 *Eligibility*  
158 All women who had used the service and whose support had ceased prior to the period of  
159 data collection (December 2012-April 2013) were potentially eligible. Exceptions were those  
160 whose personal circumstances (for example, stillbirth or certain welfare concerns) meant that  
161 contact might increase stress or vulnerability.  
162  
163 *Procedure*  
164 Women were invited to complete a questionnaire and/or be interviewed. Questionnaires were  
165 completed with the assistance of a researcher or interpreter (by telephone) or self-completed  
166 (by post). Interpreter services were favoured over written translation due to the large number  
167 of languages used and because service staff indicated that literacy barriers were not limited to  
168 English language.  
169  
170 Service staff approached women using the recruitment procedure shown in Figure 1 and  
171 completed anonymised monitoring logs detailing the dates of contact, reasons for non-  
172 approach and reasons for not sending out research packs. Reminder postcards were sent out  
173 three weeks after the initial packs. Women were able to ask questions about the research  
174 before deciding whether to participate. All women indicating interest in being interviewed



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3 175 were provided with further information and written informed consent was secured prior to  
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5 176 interview. Interviews were audio-recorded and transcribed.  
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12 179 *[Figure 1 around here]*  
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16 181 *Development of data collection materials*  
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18 182 Following a Realistic Evaluation perspective, literature review and early discussions with key  
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20 183 informants were used to develop topics of interest and *a priori* hypotheses concerning 'what  
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22 184 works for whom, in what circumstances' (Pawson and Tilley, 1997); key informants included  
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24 185 service staff and reference panels comprised of volunteer doulas and women who had used  
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26 186 the service. The topics and hypotheses were subsequently explored by questionnaire and  
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28 187 interviews with participants. No validated questionnaires exist that would enable evaluation  
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30 188 of all aspects identified for investigation. A questionnaire was developed and piloted with the  
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32 189 women's reference panel. The questionnaire included both open and closed question formats.  
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34 190 Due to length, women using assisted telephone completion were asked a reduced set of  
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36 191 questions. A semi-structured interview topic guide was developed, to explore in greater detail  
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38 192 women's experiences of some of the issues raised by key informants, including how the  
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40 193 volunteer role was similar to and contrasted with support from family, partner and  
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42 194 professionals.  
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52 196 *Analysis*  
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54 197 A mixed methods evaluation was used whereby the method was considered secondary to the  
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56 198 research question, reflecting a pragmatic perspective (Johnson et al., 2007, Morgan, 2007).  
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58 199 Quantitative questionnaire data were analysed using descriptive statistics and chi-squared  
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3 200 with Yates' continuity correction using SPSS version 20 (Spss Ibm Corp, 2011). Qualitative  
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5 201 data (including open-ended questionnaire comments and transcription data) were analysed  
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7 202 using content analysis (Grbich, 1999). Anonymous participant identifiers were assigned in  
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9 203 the format: data source (Q for questionnaire and I for interview), identification number, study  
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11 204 site. The open text questionnaire responses were tabulated to show horizontally all of an  
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13 205 individual's responses to the questions and vertically all of the responses received to any  
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15 206 question. This facilitated coding of themes on a question-by-question basis, identification of  
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17 207 disconfirming responses and the exploration of linked patterns between questions. The  
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19 208 transcripts from the interviews were read and reread to gain a detailed familiarity with the  
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21 209 overall accounts, and then systematically coded manually both deductively to identify themes  
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23 210 related to survey questions and *a priori* hypotheses and inductively to identify emerging  
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25 211 themes (Elo and Kyngäs, 2008). These themes were grouped and collapsed into higher-order  
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27 212 conceptual themes with subthemes. The findings of the qualitative and quantitative analyses  
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29 213 were integrated to provide a comprehensive narrative of women's experiences.  
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36 215 Impacts presented here include: emotional health and well-being; supporting partners and  
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38 216 women's relationships with their partners; endings and loss. Insights into the nature of the  
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40 217 relationship that may inform how these impacts occur are also presented.  
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47 220 **Findings**

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49 222 *Questionnaire response rate*

50 223 In total, 627 women had used the service. Of these, 578 (92.2%) were sent a postal  
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52 224 questionnaire for self-completion or were contacted by an interpreter or researcher for  
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assisted telephone completion (see Table 1). Reasons for not making contact or sending the questionnaire were women's circumstances (e.g. stillbirth) and failure to make telephone contact with women who required an interpreter or did not have address details held by the services.

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Questionnaires were completed by 136 women; this represented 21.7% of women who had used the service. One in eight questionnaires were completed by telephone; the majority using an interpreter (see Table 1). Most women who were interviewed (11/12) also completed a questionnaire.

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[Table 1 around here]

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### 238 *Sample characteristics*

Sample characteristics were gathered by questionnaire and are reported in Table 2. This was an ethnically diverse sample with 33 countries of birth and 29 main languages listed; 41.0% did not have English as a main language. Reflecting the service's emphasis on women in situations of disadvantage, including a lack of support, 52.9% reported not having a supportive partner at the time of the pregnancy and 16.8% reported having no supportive friends or family at all. Less than half of the women (40.7%) were primiparous. Site A's service database indicated that multiparous women and older women were overrepresented amongst questionnaire respondents. The majority of women had been introduced to the service between 2010 and 2012; earlier introductions (n=23) were limited to the original site, reflecting the service's histories.

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6[Table 2 around here]

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Impact: Emotional health and well-being

The qualitative data illustrated the significance of volunteer support for emotional health and well-being and this was not dependent on the doula being present for labour and birth.

Benefits were particularly evident for women with little other support, but were also found

for women who had involved partners or mothers, particularly those women with previous negative experiences of childbearing. Many described the ways in which change occurred, offering insights into mechanisms. The volunteer was someone to talk to and to listen to their concerns in a non-judgemental way, which was important for building confidence and overcoming feelings of isolation, depression, pregnancy worries and birth fears:

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*... the service should be there for all mothers so won't feel scared or lonely, or ... that's the end of life...I really needed them and they came straight to see me. That's when I saw hope. (Q369Z)*

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Many women commented on how volunteer support helped them to feel more in control of their maternity care through becoming more aware of their choices; influenced their beliefs in their own physical abilities around birth and confidence for parenting by supporting their choices; and facilitated communication with health professionals, helping to navigate services. Such mechanisms were found both for first-time mothers and mothers who had previously experienced a difficult birth:

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*Gained confidence and belief in myself to deliver naturally and once my baby was born to get out the house with two babies. (Q334A)*

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*She was my second voice ... she would say, well we could do this, well we could do that... She gave me the confidence to say, no, I don't want to do that, or, yes, I want to do this, or, this is how I'm feeling right now. (I337A)*

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*Impact: Helping women through supporting women's relationships with their partners*

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300 Women's comments illustrated several ways in which doulas had a positive influence on the  
301 partner or on the woman-partner relationship through the sharing of roles, alleviating worries  
302 and promoting communication. During pregnancy, confiding in a volunteer could mean the  
303 woman felt she did not burden her partner with her concerns. Attending the birth could free  
304 the woman's partner to care for older children enabling the woman to focus on the birth or  
305 the doula could support a partner who also attended (which happened in 36 cases) by  
306 explaining things, motivating or reassuring him. Postnatally, the volunteer could help the  
307 couple's communication and emotional processing of the birth:

308  
309 *You don't have to worry about looking after him, because you're both just sort of*  
310 *looked after. (I315A)*

311  
312 *Helped him to understand what I had been through. (Q339X)*

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314 *Impact: Endings and loss*

315 The ending of doula support was perceived as a loss for some women. One-third of women  
316 (n=42; 33.1%) felt that support had ended too soon and often at a difficult time where there  
317 were continuing practical or emotional needs:

318  
319 *I had a caesarean section, so somewhat depressed at times. Wish the official time ...*  
320 *should be longer than a mother who had a natural birth. (Q409Y)*

321  
322 *It happened too soon, I felt I bonded well with my doula and you get used to seeing*  
323 *them and receiving support and then it all stops. (Q332A)*

324

325 Many spoke of their sadness about the ending of a close relationship. Some felt 'a little  
326 discarded' (Q380Y) by this 'temporary friendship' (I337A):

327

328 *I found it really hard actually, I kept asking if I could keep in touch with her ... but we*  
329 *couldn't... once a friend they become a friend don't they and that's it. (I319A)*

330

331 *There was a day she told me that I'm not allowed to get in contact with her, that is not*  
332 *how they do their services, I cried ... oh, I really miss her. (I366Y)*

333

334 *And is not fair according to [service] policy, that when you finish the last day that's it*  
335 *... She was more than a doula - like family. (Q336X)*

336

337 By contrast, other women found that the support had ended at the right time:

338

339 *The ending was in the right time, after I felt confident with my baby. (Q408W)*

340

341

342 This was particularly likely for women who primarily wanted information from their doula,  
343 rather than emotional support, and women at the one site with an extended postnatal support  
344 period of three months.

345

346 We hypothesised that endings would be facilitated by having greater preparation. Key  
347 informants identified various ways in which doulas prepared women for the ending of the  
348 service such as providing an account of their time together or photos. Women for whom a  
349 memento had been provided were not less likely to feel that support had ended too soon

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350 (31.0% vs. 37.5%;  $\chi^2=0.24$ ,  $df=110$ ,  $p=0.63$ ). The relationship between having something  
351 provided and wanting to stay in touch with their volunteer reached borderline significance  
352 (72.5% vs. 52.4%;  $\chi^2=3.78$ ,  $df=110$ ,  $p=0.05$ ). The finding that mementos did not appear to  
353 facilitate endings or reduce feelings of loss may suggest that these acts reflected the quality of  
354 the relationship rather than *preparation* per se.

355

356 Women proposed two ways to improve endings: timing the ending to woman's needs (for  
357 example following operative birth), or permitting some contact beyond the ending of support;  
358 for example, a one-to-one informal meeting, or a reunion attended by several women and  
359 their volunteers. Some women framed this in terms of wanting to be able to thank the  
360 volunteer by showing her the long-term impact of her support:

361

362 *So I could show her my perfect family because of her and her help. (Q427A)*

363

364

365 *Just to let her know how I was coping with baby through all her advice. (Q367A)*

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367

368 Understanding the relationship

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370 *Understanding the relationship: How the volunteer is viewed*

371 Women were asked to choose all that applied from a list describing how they viewed their  
372 volunteer. Most saw her 'as a friend' (88/118; 74.6%); other answers were 'like a professional'  
373 (32.2%), 'like a family member' (31.4%; 'like a sister' 21.2%; 'like a mother' 17.8%), 'like an  
374 advocate' (17.8%), 'someone like me' (16.9%), 'like a role model' (14.4%).



375

376 Most of those viewing the volunteer as 'like a family member' had wanted to stay in touch  
377 (mother: 90.5%; sister: 91.7%; friend 69.0%; professional 59.5%). Viewing the doula as like  
378 a mother appeared strongly linked to whether that role was missing in the woman's own  
379 network. None of the 21 women likening the volunteer to a mother had a supportive mother  
380 available during their pregnancy and no-one with a supportive mother described the role in  
381 this way. Women with supportive family or friends nonetheless valued their volunteer's  
382 support; volunteers were better informed about pregnancy and birth, talked through options  
383 and supported the woman's choice in a non-directive way, whereas family and friends may  
384 have their own needs and agenda.

385

386 During interview discussions women contrasted volunteer support with health professionals'.  
387 They valued the greater accessibility and continuity offered by volunteers, considered 'the  
388 one constant person' (I315A). Volunteers were largely viewed as focused completely on the  
389 woman ('just there for you', I341Y) with no competing agenda, promoting trust. Many  
390 women felt that they could ask their volunteer about anything, including beyond the 'medical  
391 things' (I486W), whereas they sometimes felt embarrassed or lacked confidence to ask health  
392 professionals who were perceived to be busy or dismissive.

393

394 *Understanding the relationship: Timing of support*

395 We hypothesised that the volunteer support may not 'work' where a match happened late in  
396 the antenatal period and there was not time to establish a relationship. One-third (38/115;  
397 33.0%) felt the relationship would have been different if they had met sooner and 22.6%  
398 (26/115) felt that the relationship would have been different if they had met later. Some  
399 women felt that meeting later would not have influenced the relationship because they met

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400 relatively late anyway, just shortly before the birth. Overwhelmingly, women felt that the  
401 relationship would have been better for meeting sooner; either to gain the benefits of support  
402 earlier in pregnancy or establish the relationship sooner, ensuring the opportunity to develop  
403 'trust' (Q332A), get to know each other (Q448A) and 'bond' (Q423A). Consistent with this,  
404 some women reported feeling less comfortable with the back-up doula because of lacking the  
405 opportunity to develop a relationship.

406  
407 *Negative experiences*

408 A small proportion of women reported negative experiences. Fifteen out of 129 women  
409 (11.6%) reported that the service had not helped them in the way they had hoped. Rating their  
410 experience of support from zero (very poor) to five (very good), 11.4% (15/132) rated at  
411 three and 2.3% (3/132) rated less than three. Most commonly it was the volunteer's  
412 unreliability or inability to provide continuity that was criticised. Some women had been  
413 disappointed at the limitations of the service (for example, not assisting with household  
414 chores or providing care for older children) and some felt inhibited about asking for more  
415 support, knowing that volunteers were unpaid. Indeed, several women, including those  
416 reporting positive experiences overall, expressed feelings of guilt about accepting support  
417 from a volunteer without the ability to reciprocate.

418  
419 **Discussion**

420 Most women reported positive impacts on their emotional well-being; including combating  
421 feelings of depression, having fears allayed, and building confidence and self-esteem. Whilst  
422 similar benefits have been reported elsewhere (Gordon et al., 1999, Hofmeyr et al., 1991,  
423 Langer et al., 1998, Scott et al., 1999, Wolman et al., 1993), a key finding of this study is that  
424 such benefits did not depend upon doulas being involved in the labour and birth. Benefits

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3 425 appeared to be achieved through listening by someone who was non-judgemental and non-  
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5 426 directive, relief of isolation, information provision, supporting women's choices and help  
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7 427 navigating statutory and other services. These findings resonate with Gentry and colleagues  
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9 428 (2010) who through interviewing adolescent mothers supported by community-based doulas  
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11 429 identified the use of problem-solving strategies including active listening, assuring, affirming,  
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13 430 advising and advocating,  
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19 432 Women also described the mechanisms by which woman-partner relationships were  
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21 433 strengthened; including through the sharing of roles, alleviating concerns and promoting  
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23 434 communication. The need to involve fathers in pregnancy, childbirth and the transition to  
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25 435 parenthood is increasingly recognised by national UK and international policy (Steen et al.,  
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27 436 2012). The current research suggests that volunteer doula services may offer a route to  
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29 437 supporting involvement, consistent with reports of the Ounce Home Visiting and Doula  
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31 438 Program in the US (The Ounce, 2014). Research is needed on perceptions of doula support  
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33 439 from the perspectives of partners and other family members (Steel et al., 2014) and how these  
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35 440 family relationships may interact with the impacts of the support (Wen et al., 2010)  
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41 442 Few women reported negative experiences or dissatisfaction although we recognise that this  
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43 443 may partly reflect self-selection sampling bias and that women are often reluctant to be  
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45 444 critical of their care (Green, 2012). Whilst there were instances of disappointment with the  
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47 445 lack of assistance with household chores, as has been reported with lay workers in the context  
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49 446 of health visiting (Mackenzie, 2006), dissatisfaction was mainly related to perceiving the  
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51 447 volunteer as unreliable or not having as much contact with the volunteers as they wished;  
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53 448 something that women felt was harder to negotiate when support was delivered by a  
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55 449 volunteer.  
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5 451 Understanding how women viewed their volunteers offered insights into how support  
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7 452 ‘worked’, from a theoretical perspective (Pawson and Tilley, 1997). Women frequently  
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9 453 likened the volunteer to a family member or friend, consistent with the literature on  
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11 454 volunteers and lay workers in the context of childbearing (Hazard et al., 2009, Meier et al.,  
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13 455 2007, Perkins and Macfarlane, 2001, Taggart et al., 2000, Gentry et al., 2010). Friendship  
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15 456 was a central theme here and we note the overlaps between the current volunteer role and  
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17 457 other community-based support programmes, such as those that use volunteer befrienders for  
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19 458 women who may find it difficult to access or engage with services (Coe and Barlow, 2013).  
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21 459 For some women however the concept of friendship was challenged by the unidirectional and  
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23 460 unbalanced nature of this relationship; an observation lacking in the doula literature.  
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29 462 Few studies have explored doula support in settings where the midwife is the lead health  
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31 463 professional. Here, support from volunteers was contrasted with health professionals’ with  
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33 464 distinctive features of doula support being continuity, not feeling time pressured, feeling able  
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35 465 to ‘ask anything’, feeling their choices were supported and seeing the doulas as more  
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37 466 reliable and trustworthy. These findings resonate with studies of lay support for  
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39 467 disadvantaged childbearing women in high-income countries; including, community-based  
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41 468 doulas in the USA (Gentry et al., 2010), home visits in Australia (Taggart et al., 2000) and  
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43 469 the USA (Sheppard et al., 2004) and infant feeding support in the UK (Beake et al., 2005).  
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45 470 The greater continuity afforded by doulas compared with midwives has been reported  
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47 471 elsewhere in a Swedish study (Lundgren, 2010).  
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53 473 While participants were largely favourable towards the volunteer doula support and valued  
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55 474 the continuity provided, it was striking that women commonly reported feelings of loss  
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3 475 around the ending of support, which could constitute a negative impact. Volunteer support  
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5 476 was valued regardless of whether women had support from their friends or family. The aspect  
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7 477 of support often valued most highly was the one-to-one relationship. Its ending could be  
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10 478 particularly difficult for some women, particularly those who viewed the volunteer as like a  
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12 479 mother or where there were continuing practical needs, for instance, following an operative  
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14 480 birth. Even women who felt well-prepared to move on independently and did not have  
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16 481 continuing support needs could still feel saddened by the absence of opportunity for any  
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18 482 contact with the volunteer in the future.  
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23 484 These findings highlight the challenges noted elsewhere in the volunteer and lay worker  
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25 485 literature around ways of working that hinge on a close relationship between worker and  
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27 486 recipient and the need to consider further the management of emotional relationships and  
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29 487 boundaries (Glenton et al., 2013, Heslop, 2006, Mitchell and Pistrang, 2011, Gillard et al.,  
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31 488 2014, Perkins and Macfarlane, 2001, Simpson et al., 2014). These challenges are not limited  
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33 489 to relationships with volunteer and lay workers. Similar experiences have been reported with  
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35 490 caseload midwifery with women reporting 'midwife grief' and feeling lost or abandoned at  
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37 491 the end of the period of support (Walsh, 1999).  
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43 493 It is feasible that such endings may compromise the impact of the period of support. In social  
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45 494 work, concerns have been expressed that endings may reinforce previous negative separation  
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47 495 experiences (Huntley, 2002). In psychotherapy it is recognised that abrupt endings and forced  
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49 496 endings have the potential to be harmful (Gelso and Woodhouse, 2002). A recent systematic  
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51 497 review of befriending in mental health (Thompson et al., 2015) argued that experiencing  
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53 498 some of the qualities of friendship accompanied by an enforced ending could lead to the  
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499 intervention failing, calling for clearer expectations for support recipients about the nature of  
500 what is being offered.  
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502 Continuing doula support beyond six weeks postpartum should be considered, especially  
503 since this coincides with a time of peak incidence of postnatal depression (Cox et al., 1993).  
504 There was some indication that endings may have been easier at the one site where postnatal  
505 contact extended until 12 weeks after birth although sample sizes precluded definitive  
506 comparisons. Regardless of the length of postnatal support, the ending itself still requires  
507 planning and appropriate management, with support from service staff, as required. Several  
508 women suggested changing the service to offer an informal meeting to provide an update,  
509 group-based, if necessary. Other evaluations of peer support have recommended using more  
510 teamwork, using goals and being problem-focused to minimise dependency in a one-to-one  
511 relationship (Perkins and Macfarlane, 2001, Repper and Watson, 2012); such ways of  
512 working may help to enable a transition from the one-to-one relationship but it is unknown  
513 how this would influence the impact of support.

514  
515 *Strengths and Limitations*

516 This is the largest independent evaluation of trained volunteer doula support in the UK and  
517 our findings reflect those of another independent evaluation of one doula service (Granville  
518 and Sugarman, 2012). Questionnaire data were complemented by interviews, which offered  
519 opportunities for more detailed exploration, including the ways in which the volunteer role  
520 was similar to and contrasted with support from family, partner and professionals. A strength  
521 of our evaluation was the representation of women of non-English speaking background;  
522 however the questionnaire was only completed by 21.7% of women who had used the  
523 service, posing some concerns around sampling bias and transferability of findings. A low

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3 524 response was anticipated because support recipients were in situations of disadvantage with  
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5 525 high mobility and in groups traditionally hard to engage in research. In addition, some  
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7 526 recipients had accessed the service several years previously and could no longer be contacted.  
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9 527 It was not possible to determine from the information provided by the services the extent to  
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11 528 which participants were representative in terms of time since using the service and we  
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13 529 acknowledge that there is potential impact for memory bias that was not explored here. A  
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15 530 higher response rate would be necessary to explore fully the influence of the ending of the  
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17 531 relationship on the overall impact of a volunteer doula service.  
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23 533 Efforts to maximise responding included approach via a known service (also essential due to  
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25 534 confidentiality) and assisted questionnaire completion. However any positive impacts from  
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27 535 these efforts was possibly limited by language needs being under-recognised by the services,  
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29 536 who documented the need for an interpreter, rather than the main language(s) spoken and it  
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31 537 appeared that some women may have been sent written information that did not meet their  
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33 538 language needs. Unfortunately, fewer data were available for those women using assisted  
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35 539 completion because of the need to ensure that the questionnaire length remained acceptable.  
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#### 41 *Conclusion*

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43 542 The UK NICE guidance for the care of Pregnant women with Complex Social Factors  
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45 543 (National Institute for Health and Care Excellence, 2010) calls for models that overcome  
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47 544 barriers and facilitate access to improve women's outcomes. It would appear that volunteer  
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49 545 doula services have the potential to make a contribution to this. Of note, the benefits reported  
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51 546 by women did not always involve direct support during the labour and birth. An approach  
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53 547 akin to friendship and based on building trust, listening and enabling appears to be  
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55 548 fundamental; in some circumstances this can be strengthened by actively supporting  
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involvement of family, including partners. Critically, the ending of the close one-to-one relationship carries the potential for feelings of loss and distress which could undermine the benefits experienced. The timing and management of endings warrant further exploration, particularly given the potential for coinciding with a period of heightened vulnerability for mental health problems. Further longitudinal research is needed to gather women's views and experiences through the period of support, and the ending, to further elucidate the mechanisms by which positive impacts of doula support are achieved and may be threatened.

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3 684 **Figure 1 Procedure**

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7 686 **Table 1 Questionnaires distributed and received for women who used the volunteer**  
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14 689 **Table 2 Sample characteristics**

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18 691 **Table 3 Description of volunteer support intervention**

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**Table 1 Questionnaires distributed and received for women who used the volunteer doula service**

Study	Women	Sent or	Self-completion	Assisted	Assisted	Total	Percentage of	Response rate
Site	supported by	approached by		completion	completion	completed (any	those supported	of those
	the service	interpreter/ researcher		with interpreter	with researcher	method)	by the service	approached (%)
							(%)	
A	446	417	83	7	0	90	20.2	21.6
W	51	50	13	1	0	14	27.5	28.0
X	29	26	8	1	0	9	31.0	34.6
Y	75	68	14	0	0	14	18.7	20.6
Z	26	17	1	6	2	9	34.6	52.9
Total	627	578	119	15	2	136	21.7	23.5

1      1    **Table 2 Sample characteristics**

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Variable		N for which data available	N (%)
Current age (years)		132	Mean 30.9, SD 6.1, range 16-45
Age at introduction to volunteer service (years)		128	Mean 28.4, SD 6.1, range 15-44
Parity <sup>1</sup>	<i>Primiparous</i>	113	46 (40.7)
Ethnicity		134	
	<i>White</i>		73 (54.5)
	<i>Mixed</i>		0 (0.0)
	<i>Asian / Asian British</i>		26 (19.4)
	<i>Black/ Black British</i>		22 (16.4)
	<i>Other</i>		13 (9.7)
Time in UK at introduction to doula service		130	
	<i>Since birth</i>		66 (50.8)
	<i>&gt;5 years</i>		20 (15.4)
	<i>1-5 years</i>		30 (23.1)
	<i>&lt;1 year</i>		14 (10.8)
Main language		134	
	<i>English</i>		73 (54.5)
	<i>English and another</i>		6 (4.5)
	<i>non-English</i>		55 (41.0)
Age left school or college (years)		119	



$\leq 15$	12 (10.1)
16	37 (31.1)
17-19	35 (29.4)
$\geq 20$	35 (29.4)
Household <sup>1</sup>	119
<i>lives with partner</i>	63 (52.9)
<i>lives with other(s)</i>	33 (27.7)
<i>lives alone</i>	23 (19.3)
Support available <sup>1</sup>	119
<i>partner/husband</i>	56 (47.1)
<i>other</i>	43 (36.1)
<i>none</i>	20 (16.8)
Social complexity <sup>2</sup>	136
	46 (33.8)

Notes: <sup>1</sup>Variables that were omitted from the assisted completion questionnaires, due to length. <sup>2</sup>Social complexity was derived from coding services in contact with women at time of introduction to service, based on descriptions given in the guidance on women with complex social factors (National Institute for Health and Care Excellence, 2010).

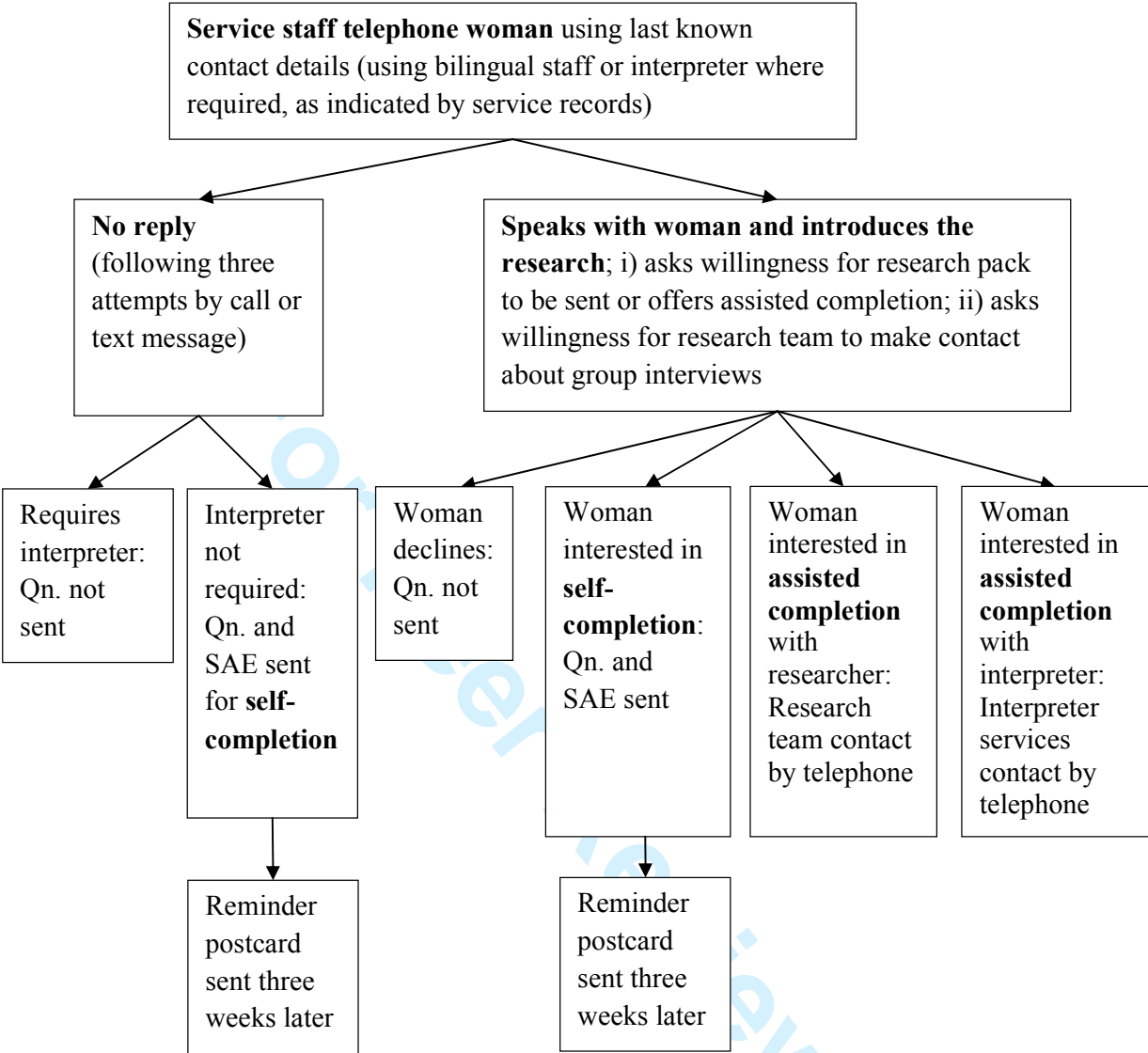
**Table 3 Description of volunteer support intervention**

Variable	N for which data available	N (%)
<i>Stages of support</i>	136	
Antenatal only		16 (11.8)
Antenatal and intrapartum		5 (3.7)
Antenatal and postnatal		36 (26.5)
Intrapartum only		3 (2.2)
Intrapartum and postnatal		2 (1.5)
Postnatal only		9 (6.6)
All three stages		65 (47.8)
<i>Intensity of support (hours per week)</i>	98	Median 2.0, IQR 1.5, range 0-10
<i>Antenatal support behaviours</i>	121	
Home visits		106 (87.6)
Telephone support		79 (65.3)
Information giving		87 (71.9)
Birth preparation		85 (70.2)
Practical help with baby equipment		51 (42.1)
Came to health/other appointments		51 (42.1)
Help find out about other services		66 (54.5)
Go for walks, trips to café etc		41 (33.9)
<i>Postnatal support behaviours</i>	112	
Home visits		104 (92.9)

Telephone support		62 (55.4)
Information giving		45 (40.2)
Breastfeeding support		56 (50.0)
Practical help with baby equipment		31 (27.7)
Came to health/other appointments		21 (18.8)
Help find out about other services		39 (34.8)
Go for walks, trips to café etc		20 (17.9)
<hr/>		
<i>Contact with a back-up volunteer</i>		
Allocated a back-up	119	52 (43.7)
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<i>Type of visits with a back-up volunteer</i>		
	51	
Back-up attended one joint visit		12 (23.5)
Back-up attended more than one joint visit		20 (39.2)
Back-up made separate visits		2 (3.9)
<hr/>		
<i>Preparation for ending</i>		
	115	
Prepared something (any)		71 (61.7)
Prepared account of time together		31 (27.0)
Prepared photographs		30 (26.1)
Prepared birth story		23 (20.0)
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Notes: IQR = inter-quartile range

1     **Figure 1 Procedure**



Where permission was obtained (via service staff or expression of interest when completing questionnaire), research team contacted women directly to provide further details about group interviews.

Interviews were held in community venues identified by service staff and were audio-recorded.

Shopping voucher sent to woman on receipt of completed questionnaire and/or provided at attendance of group interview, to thank for participation.

*Qn.* = questionnaire  
*SAE* = stamped addressed envelope, returned directly to research team

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