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Attitudes towards Doula Support during Pregnancy by Clients, Doulas, and Labor-and-Delivery Nurses: A Case Study from Tampa, Florida

Lynn M. Deitrick and Patrick R. Draves

Introduction: This study evaluated the supportive role of doulas provided by The Central Hillsborough Healthy Start (CHHS) Program to inner city women during pregnancy and delivery and assessed the reaction of labor and delivery (L&D) nurses to the presence of the doulas. The personal benefits of being a doula are also reported. Through surveys with 142 doula clients at the two participating hospitals and interviews with 18 doula clients, 9 doulas, and 10 L&D nurses from both hospitals, the authors found that 91 percent of women credited doulas with enhancing their birth experience and 87 percent reported that they would use a doula again. Women found the doula experience positive, although lack of doula continuity reduced the level of satisfaction. Doulas themselves reported both increased personal self-esteem and confidence as parents. L&D nurses reported that doulas were competent, helpful, and able to fit into the hospital environment. Doulas were found to provide four kinds of support including physical comfort, physical assistance, socioemotional support, and verbal support.

Key words: Doula, at-risk women, labor, delivery

Introduction

New approaches to health care delivery are important in this era of rising health care costs and disparities in health care among various social and ethnic groups. Gaps in health care access and utilization persist in some parts of the United States, particularly between the rich and poor and between ethnic minorities and non-minorities. Even political candidates today point out the need for affordable and accessible health care for many, especially the disadvantaged. Poor pregnant women often do not have the resources to obtain adequate prenatal care services and thus are at special risk for delivering infants that are pre-term, underweight, small for gestational age, or sick. In addition, poor women often experience more stress, physical illness, domestic violence, and dysfunctional or non-existent social support than do other women (Bailey 1991; Baranowski et al. 1983; Bayne-Smith 1996; Boone 1985; Gale, Fothergill-Bourbonnais, and Chamberlain 2001; Kayne, Greulich, and Albers 2001; Lazarus 1997; MacCormack 1994; McBarnette 1996; Sanders-Phillips and Davis 1998). A doula, a woman trained to comfort and support women during labor and delivery, can help augment pregnancy care for these at-risk women by encouraging pregnant women to complete prenatal care, help women have a more positive labor and delivery, teach them things necessary in the transition to motherhood, and assist new mothers in breast-feeding and caring for their infants. (Raphael 1973; Raphael and Davis 1985)

Medical anthropologists have begun to look critically at the American model of childbirth and suggest alternatives or compromises that consider the social and cultural as well as the physical needs of pregnant women (Kitzinger 1995; Raphael 1973; Raphael and Davis 1985). Often missing from the modern day childbirth experience are the caring, the mothering, and respect for other traditions and ways of thinking (Kitzinger 1995; Klaus, Kennell, and Klaus 1993).

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This support for pregnant women during pregnancy, birth, and the immediate postpartum period by experienced women was a traditional pattern of childbirth support used in other cultures for generations (Campero et al. 1998; Jordan 1993; MacCormack 1994; Raphael and Davis 1985).

Today, anthropologists (Kitzinger 1995; Raphael 1973; Raphael and Davis 1985) use the term doula for this "mother's caretaker." Raphael (1973:24) notes that in the original Greek during the time of Aristotle, the word doula, meant slave. She points out, however, that later the term was used in Greece to refer to a woman who assists a new mother after childbirth. Raphael (1973:24) coined the term doula to refer to "those individuals who surround, interact with, and aid the mother at any time within the prenatal period, which includes pregnancy, birth, and lactation."

Aware of the high rates of infant morbidity and mortality as well as inadequacies in access to health care services faced by urban women in Tampa, Florida, The Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida put together a coalition of community service partners at the local, state, and federal levels to address the health care needs of poor pregnant women in 17 census tracts in Tampa. The Central Hillsborough Healthy Start Program (CHHS), which began in 1999, is one of 92 federally funded programs developed to address the needs of poor, pregnant women in urban areas of the United States. The doula component of the CHHS program was designed to mimic the relationship between pregnant women and supportive female companions, doulas, seen in traditional cultures in order to provide "mothering" support during the intrapartum period. This report relates to the first eight months of doula program services, from May to December of 1999.

Female Authoritative Knowledge

Childbirth has been a perennial rite of passage in a woman's life. It is a time when she assumes a new role as a mother. In many cultures, ancient and modern, such as villages in Greece, India, Turkey, the Yucatan, and elsewhere, older, experienced women, doulas, have been assisting with childbirth for generations (Jordan 1993; Kay 1982; Kitzinger 1995; Lozoff, Jordan and Malone 1988; MacCormack 1994; Raphael 1973; Raphael and Davis 1985).

Birth is a social and cultural event as well as a physiological one. As such, Jordan (1993) suggests that birth should be studied using a holistic, bio-social perspective, since separating the physiological from the cultural or social would result in an incomplete picture. She (Jordan 1993:xi) indicates that "childbirth is culturally grounded, bio-socially mediated, and inter-actionally achieved." Kitzinger (1995:1) similarly notes that "becoming a mother is a biological process: but it is also a social transformation, and one of the most dramatic and far-reaching that a woman may ever experience in her life." In the traditional model of birth, women supported other women. Older experienced midwives helped the young women give birth, provided social and emotional support, and aided a woman in her passage from woman to mother. This female authoritative knowledge, support, and caring, nurturing pregnancy and birth process was the norm until the medicalization of birth in the United States in the early 20th century (Jordan 1993; Kitzinger 1995; MacCormack 1994; Raphael 1973; Raphael and Davis 1985).

In many parts of the modern world, childbirth has become a medical event instead of a natural process. Paired with this is the change in the way women experience birth. With the switch to a technocratic model of birth, that is birth in a hospital supported by professional personnel, technology, and machines, some women may feel disempowered from the whole birth process (Davis-Floyd and Davis 1996; Kitzinger 1995). With this switch to hospital birth, women lost the traditional female support system. Labor-and-delivery nurses try to provide support, but with responsibility for multiple patients on a single shift, it is often impossible for nurses to provide the continuous one-on-one support that many laboring women would desire during this traumatic event.

Social Support

Social support is an important component of the prenatal care a pregnant woman receives. This support can be provided by family, friends, significant others, or professionals. It is from these links that a woman receives emotional and physical reassurance, comfort, and encouragement during pregnancy. Studies indicate that the quality and quantity of social support a pregnant woman receives can impact the quality of the relationship the woman has with her new infant (Cobb 1976; Kennell and Klaus 1991; Klaus, Kennell, and Klaus 1993; Oakley 1992; Perez and Snedeker 1994; Sosa, Kennell, et al 1980).

According to Cobb (1976:300) social support can be defined as "information leading the subject to believe that he [*sic*] is cared for and loved...esteemed and valued...[and] that he belongs to a network of communication and mutual obligation." This definition is important because it attributes emotional ties to social support, which, the authors assert, is the most important component of this concept. Kahn and Antonucci (1980) divide social support into three categories. These include emotional support, information support, and instrumental support. They (Kahn and Antonucci) call these categories the three A's—affect, affirmation, and aid, which correspond in order to Schaefer, Coyne, and Lazarus (1981:385-386) categories.

Similarly, Schaefer, Coyne, and Lazarus (1981:385-386) suggest that a person's sense of well-being is related to his/her perceptions of social support. The three categories of social support defined by Schaefer, Coyne, and Lazarus are as follows: *Emotional support*, which includes things such as attachment, intimacy, reassurance, and the ability to confide in and rely on another person. These all contribute to the person's sense of well-being—that he/she is cared for or loved. *Informational support* includes giving the person meaningful information and advice that can assist in solving a problem or providing information regarding how the person is doing in a certain situation. This can be in the form of verbal communication, written

materials, or both. The third category of Schaefer, Coyne, and Lazarus's social support model, *instrumental or tangible support*, involves providing direct assistance or a service to a person. This can take the form of money, gifts, goods, loans, or services such as babysitting or doing chores.

The concept of social support is important when discussing support during pregnancy and childbirth since how a woman copes with stressors in her life during the intrapartum period can impact her confidence and feelings of self worth as well as her ability to parent her infant. Nuckolls, Cassel and Kaplan (1972) point out that women with few psychological resources (emotional support) and a number of recent stressful life events such as relocation, poverty, or divorce, had three times as many pregnancy complications as did women with stressful lives but good psychological support. The Nuckolls, Cassel and Kaplan (1972) study was one of the first to demonstrate a link between the presence of an emotional support system and a woman's ability to cope well with major life changes such as pregnancy.

Support during Labor and Delivery

The importance of social support during pregnancy and labor has been documented by Kayne et al. (2001) and others. The support process can help a woman transition to the role of mother and also help her feel good about herself so that she may become a good mother. Unlike in past times, women today often do not have the support of older women who have experienced the birth process. Therefore, the hospital labor and delivery suite can seem strange and an almost forbidding place, especially for a woman who is not knowledgeable about the labor and delivery process in the hospital (Campero et al. 1998; Gale, Fothergill-Bourbonnais, and Chamberlain 2001; Kayne, Greulich, and Albers 2001; Kitzinger 1995).

Researchers have found that women whose needs for comfort, support, information, and caring have been met while in the hospital begin their transition into motherhood more effectively (Kitzinger 1995). In addition, women with a strong system of social support can recover from stress and trauma better than women without it (Baumeister, Faber, and Wallace 1999; Kitzinger 1995; Klaus, Kennell, and Klaus 1993). This may be critical in the immediate postpartum period, especially when the mother suffers postpartum depression or the birth outcome was poor.

Our research, conducted as part of the evaluation of the first eight months of the CHHS Program in Tampa, identifies and categorizes the key components of doula support that laboring women found effective. We gained insights into the value of doula support from the perspectives of patients, labor and delivery nurses, as well as from the doulas themselves.

The Central Hillsborough Healthy Start Program

The demonstration phase of the CHHS Project that began in 1999 was a four-year, federally funded, multi-million dollar program that provided education, referrals, home visitation, case management, and doula services to at-risk pregnant women in 17 census tracts in inner city Tampa, Florida. The CHHS project goal was to reduce the overall incidence of poor birth and infant health outcomes by providing intensive prenatal interventions, including doula services, beginning early in the third trimester.

Services were targeted to women living in the 17 census tracts who were determined to be at-risk for poor birth outcomes because of race, substance abuse, age, income, previous high-risk pregnancies, marital status, education, or other factors. The CHHS Program, through the use of doulas, provided emotional and social support services for pregnant clients from the prenatal period through the sixth week postpartum. The service population was 77 percent African American, 15 percent Hispanic or Latino and 3 percent Haitian. The other 5 percent were Caucasians and people who did not report their ethnicity. Eighty percent of the women in the program service group were between the ages of 16 and 29.

The CHHS program was organized into a consortium model through which personnel from several different community social service agencies cooperated to provide a number of services. Collaborative partners included the Hillsborough County Health Department, the Healthy Start Coalition of Hillsborough County, the Ounce of Prevention Fund of Florida, the Child Abuse Council, Tampa General Hospital, St. Joseph's Women's Hospital, and six area churches (LRCCHMB 1998). The Lawton and Rhea Chiles Center for Healthy Mothers and Babies in the College of Public Health at the University of South Florida administered the grant money and coordinated project services.

Services provided by the program included prenatal and postpartum home visits by Hillsborough County Health Department nurses, transportation to medical appointments, a variety of prenatal and postpartum classes at the six participating churches, and doula support beginning around the 32nd week of pregnancy and continuing through the sixth postpartum week. While all pregnant Hillsborough County Healthy Start clients received regular prenatal visits from nurses and home visitors, the doula component of the program also offered free doula services to women living in the 17 project census tracts through the CHHS program.

The Doulas

Fifteen doulas were recruited from the project census tracts as well as from the greater Tampa Bay area. Seven were assigned to the first project hospital and eight to the second hospital. The doulas for the first hospital were assigned as follows: four worked full-time, one worked part-time, and two were on call as needed. The eight assigned to the second hospital included three working full-time, two part-time and three on call. Each doula was assigned her own patient caseload. The on-call doulas were used to cover for regular doulas who were sick, on vacation, or attending to other laboring clients.

Table 1. Client Satisfaction Survey Results, Combined Sample (N=142)

Question	Yes n/%	No n/%	No Response n/%
Did having a doula result in a better birth experience for you?	129/91%	7/5%	6/4%
Were you satisfied with amount of time doula stayed with you during labor and birth?	126/89%	7/5%	9/6%
Would you use a doula again?	124/87%	7/5%	11/8%
Were prenatal visits helpful?	111/78%	14/10%	17/12%
Were you satisfied with amount of time doula stayed with you after birth?	102/72%	9/6%	31/22%

The doulas were ethnically diverse. Doulas assigned to the first project hospital included three African Americans, one Afro Jamaican, one Costa Rican, and two Caucasians. The Costa Rican doula was bilingual and was assigned to work with most of the Spanish-speaking clients at her hospital. The doulas ranged in age from mid-20s to early 50s. All were high school graduates, and six had some college credit. Five lived in the project neighborhoods, and two others lived in the greater Tampa area.

The doulas assigned to the other project hospital also ranged in age from mid-20s to mid- 50s. Five were African American, one was Puerto Rican, and two were Caucasian. The Puerto Rican doula was bilingual and was assigned to work with most of the Spanish-speaking clients at her hospital. All of the doulas were high school graduates. One doula had a degree in social work, and four others had some college credits. Only one of these doulas lived in a project neighborhood, while the rest lived in the greater Tampa area.

All doulas were given classroom training as well as orientation in their assigned hospital's labor and delivery unit. The doula met with a client prenatally at around the 32nd week of pregnancy to teach her about pregnancy, labor, and delivery. In addition, the doula helped the woman create a birth plan that outlined her wishes regarding what should happen when she goes into labor. When labor began, the doula stayed with the laboring woman the entire time and provided encouragement, emotional support, and physical assistance. The doula did not make any medical decisions or assist with any medical procedures. After delivery, the doula continued to assist the new mother. Mothers wishing to breast-feed could receive help placing the baby to the breast. The doula continued to visit the new mother regularly at her home for six weeks after delivery.

At the end of the sixth postpartum week, the doula visits ceased. Mothers continued to receive follow-up Healthy Start services from home visitors and Health Department nurses until the infant became one year old. Home visitation services from the Hillsborough County Health Department nurses and social workers provided the mother with access to a team of professionals and paraprofessionals who would help determine and meet client needs. For example, some mothers desired mental health counseling, some needed help qualifying for Medicaid, and some had more immediate needs like food, clothing, emergency shelter, or baby supplies. When the infant reached one year old, both mother and infant were discharged from the Healthy Start program.

Methods

Data were collected during the first eight months of doula services, May through December of 1999. Surveys and interviews were used to gather information about the doula care and support process, the patient's experience with the doula, and the labor and delivery nurses' perceptions about the doula. Survey results were tabulated, and interview results were analyzed for content and themes. Ideally, a project such as this should include ethnographic observation of doula activities in the hospital setting in order to verify or cross-check the interview and survey findings. Researchers for this project did not have access to either of the two hospitals' labor and delivery suites; so ethnographic observations of doula–client interactions could not be conducted. We were, however, permitted to conduct telephone interviews with nurses from both hospitals. The project received Institutional Review Board (IRB) clearance from the University of South Florida IRB, as well as from the IRBs of both project hospitals.

Client Satisfaction Survey

The Client Satisfaction Survey was administered to the 142 doula clients the day after delivery. The survey gathered information regarding the client's opinion about the doula services she received and whether she would use a doula again, as well as demographic data, prenatal class attendance, and family and friends present during birth. Data from questions related to the value of doula services are presented in Table 1.

Birth Log

The Birth Log was a checklist completed by each doula after each delivery to ascertain what kinds of comfort measures the doulas were providing to their patients. The goal of this form was to compile a listing of most frequently used

comfort measures in order to understand the components of doula support. Data from the categories of physical comfort and psycho-social comfort are presented in Table 2.

Client Interviews

Personal interviews were conducted with 18 doula clients from both project hospitals. Interview candidates were chosen from among women who had consented and provided a contact telephone number on the interview request form that was attached to the Client Satisfaction Survey. CHHS paid each interview client a $10 gratuity.

Written informed consents were obtained from those clients who were interviewed in person. Some interviews were conducted by telephone for the convenience of the client. Oral informed consent was obtained prior to the start of each telephone interview.

The interviewer asked questions about topics such as what the client thought about her experience with the doula, what she did or did not like about her doula experience, how the doula-assisted birth differed from prior non-doula births that she had, what changes, if any, she would suggest for the program based on her experience with a doula, what her partner, family, or friends who were at the birth thought about the doula, and whether or not she would use a doula again.

Nurse Interviews

Telephone interviews were conducted with ten labor-and-delivery nurses from all three shifts at both project hospitals. Oral informed consent was obtained prior to the start of each interview. Nurses were asked about how the doulas were functioning on the unit and whether they [the nurses] were satisfied with the care patients were receiving from doulas. The nurses were invited to make any other comments they wished about the doulas or the doula program.

Doula Interviews

Interviews were conducted with nine doulas, five from one project hospital and four from the other. Written informed consents were obtained from each doula prior to her interview. Both full-time and part-time doulas were interviewed. Doulas were asked about their experiences as doulas, any benefits they gained from their work, and whether they liked their work.

Results

Client Perspectives

Results from the surveys and 18 doula client interviews provided data about a number of doula activities that clients felt were supportive during labor. Most (91%) of the women credited the doulas with enhancing their birth experience, and 87 percent said they would use a CHHS doula again. Doula client interviews shed light into the kinds of doula behaviors that women thought were supportive. One woman said, "With the doula it took a lot of stress away and it made me feel like someone cared." Another client said, "The pain was so horrendous: I felt like I was losing control. She [the doula] helped me stay in control, which made it so much easier." A different woman said, "The doula was a big help, because I was like 'I'm going to die' and she said 'no you're not.' She helped me all the way through it."

Table 2. Birth Log Comfort Measures (N=104)

Physical Comfort	n/%
Gave water/juice/ice	104/100%
Eye contact with mom	102/98%
Breathing Techniques	100/96%
Position changes	95/91%
Linen/Underpad change	94/90%
Relaxation techniques	77/74%
Massage/backrubs	41/39%
Assistance with walking	8/7%
Shower/bath	5/5%

Psycho-social Comfort	n/%
Verbal encouragement	102/98%
Eased Fear	98/94%
Explained/ provided info.	94/90%
Encouraged support person how to help client	66/63%
Showed support person how to help client	44/42%

Several women said that they found the doula experience to be positive although the lack of continuity (the same doula before and during labor) somewhat reduced their level of satisfaction. One woman said, "At first I was skeptical about having a stranger in there. You know what I'm saying? But once she was there and you are in labor and you are going through it, it's great. If you ever have the chance, try it because I liked the experience having her there. Just try it. It's a great experience."

All 18 women from both hospitals indicated that having a doula was a good experience for them. In addition, all of the women reported satisfaction with their doula. Only one client reported a problem but said that otherwise she was satisfied with services received. All of the respondents said they would recommend doula services to their friends and family. They also said they felt this was a good program. Other comments worth noting came from 2 informants who said they would pay for doula services if they had to. Several clients said they maintained contact with their doula and have become personal friends.

Labor-and-Delivery Nurse Perspectives

Nurses from both hospitals consistently reported that the doulas were competent, caring, compassionate, and helpful to laboring patients. One nurse said,"I think it [the program] is wonderful." Another nurse said, "It [the CHHS doula program]

Table 3. Checklist of Doula Activities During Labor (N=127)

Techniques	Responses				
	Things that helped most	Things I liked	Things I would have liked	Things I didn't like	No response
Physical Comfort	n/%	n/%	n/%	n/%	n/%
Helped me change position	38/29.9%	67/52.8%	2/1.6%	1/0.8%	19/15%
Held my hand	37/29.1%	73/57.5%	2/1.6%	2/1.6%	13/10.2%
Breathing techniques	35/27.6%	74/58.3%	3/2.4%	2/1.6%	13/10.2%
Gave me water/ice/juice	31/24.4%	77/60.6%	3/2.4%	0/0%	16/12.6%
Made eye contact	27/21.3%	79/62.2%	2/1.6%	3/2.4%	16/12.6%
Massage	26/20.5%	56/44.1%	7/5.5%	0/0%	38/29.9%
Back rubs	26/20.5%	63/49.6%	9//7.1%	1/0.8%	28/22%
Changed linen	21/16.5%	69/54.3%	4/3.1%	0/0%	33/26%
Cold/hot packs	20/15.7%	50/39.4%	13/10.2%	0/0%	83/65.4%
Helped me walk	11/8.7%	36/28.3%	13/10.2%	1/0.8%	66/52%
Gave me shower/bath	5/3.9%	16/12.6%	22/17.3%	1/0.8%	83/65.4%
	Things that helped most	Things I liked	Things I would have liked	Things I didn't like	No response
Psycho-Social Comfort	n/%	n/%	n/%	n/%	n/%
Answered questions	27/78.7%	72/56.7%	1/0.8%	0/0%	27/21.3%
Friendly to my support person	47/37%	71/40.2%	0/0%	0/0%	9/7.1%
Stayed with me	45/35.4%	67/52.8%	2/1.6%	0/0%	13/10.2%
Was friendly to me	44/34.6%	68/53.5%	0/0%	0/0%	15/11.8%
Gave verbal encouragement	43/33.9%	64/50.4%	2/1.6%	0/0%	18/14.2%
Eased my fears	42/33.1%	66/52%	5/3.9%	0/0%	14/11%
Helped me to relax	39/30.7%	67/52.8%	3/2.4%	0/0%	18/14.2%
Gave me information	34/26.8%	72/56.7%	3/2.4%	1/0.8%	17/13.4%
Helped my support person	31/24.4%	51/40.2%	8/6.3%	1/0.8%	36/28.3%
Followed my wishes	25/19.7%	78/61.4%	4/3.1%	0/0%	20/15.7%

is pretty good. It gives support, especially when a woman comes in alone without anyone else." Several nurses said that more women should have access to doulas during labor, not just those living in the project census tracts. One nurse said that if the patient has family with her for support, then her doula should be reassigned to anyone who is laboring alone.

Nurses were unanimous that there were not enough doulas available for all of the women who needed them. Further, one nurse said, "We get a lot of women who could benefit from a doula, but the doulas aren't allowed to work with them, even though they would like to do so." A common theme among the nurses from both hospitals is that the program is good and should be expanded. The biggest complaint was that there were not enough doulas for all of the women who needed them. Nurses generally viewed the role of the doula as supportive, especially for women who came in to the hospital in labor alone. In other words, nurses did not seem to separate the supportive role of the doula from the supportive role of family or friends.

Doula Perspectives

Interviews suggest that doulas saw their role as one of support and empowerment for their clients. One doula who worked with teenage clients said, "I just try to teach them that having a baby is not a sin." Another doula said, "I've come to realize that support is the key to success in everyone's life, and everyone needs it at one point in time." A different doula said,"I am empowering the clients I work with. This is a life changing experience for them, whether it [the delivery] is medicated or not. I am here to enhance what they want to do." A fourth doula said she "empowers the mother by making sure she [the mother] is well educated. I make sure they [mothers] know they can voice their opinions."

Interviews revealed that doulas also benefit personally from their work. Some reported that being doulas increased their own personal self-esteem and confidence as parents. One said being a doula "has opened my eyes up to other people's situations and things around me. It has helped me be more

understanding; to be a better person." A different woman said that being a doula enhanced her people skills and helped her become more compassionate towards others. Another doula summed up her work by saying, "I like everything about it [being a doula] all the time, even when the births get hairy and I wonder what I'm doing here; I even like that part."

The doula role, several said, also provided them with a career rather than just a job. One doula said that the nurses are always happy to show her things, and have encouraged her to become a nurse. Another said, "It's a great feeling being in the doula program, I love working in labor and delivery." One doula summed up her thoughts about being a doula by saying, "I think my becoming a doula has been a stepping stone for things I am about to do in my life. It's really rewarding, it's like instant gratification.... So it's really wonderful."

Several of the CHHS doulas interviewed went on to pursue further education including attending nursing school or advanced nurses aide training, something that they might not have done had they not had the opportunity to become doulas. This is an unexpected outcome, since some of the doulas were from the project census tracts and, for the first time, had the opportunity to have a career and educational opportunities instead of just the usual minimum wage jobs that were the norm in their neighborhoods.

Discussion

The Role of the Doula

One purpose of this evaluation was to identify specific doula techniques that clients found most helpful during labor and birth. CHHS doula clients identified a number of doula activities as supportive, as noted in Tables 2 and 3. Initially, results from the Birth Log (Table 2) and Checklist of Doula Activities (Table 3) were grouped into two categories of support; *physical comfort* and *psycho-social comfort*. However, after examining the results, we broke the findings down into the four categories of support presented in Figure 1. Our categories of *physical comfort measures*, *physical assistance*, *emotional/social supportive measures*, and *verbal supportive measures*, differ somewhat from the components of doula support identified by other researchers. (Gale, Fothergill-Bourbonnais, and Chamberlain 2001; Kayne, Greulich, and Albers 2001). Kayne et al's (2001) and Gale et al's (2001) categories of *physical assistance*, *advice and information*, and *tangible assistance/physical comfort* are similar to our findings. Also, both of those authors added a category of *advocacy* that was similar to our category of *verbal supportive measures*.

Gale, Fothergill-Bourbonnais, and Chamberlain (2001) have identified nursing behaviors during labor that can be categorized as supportive to laboring women. In their study of 12 labor-and-delivery nurses (Ibid. 268), researchers found that those nurses spent approximately 27.8 percent of their time in contact with laboring women. Most (70%) of the total support provided by nurses fell into the category of *information/instructional support*.

Figure 1. Taxonomy of Doula Support During Labor

Physical Comfort Measures	*Physical Assistance*
Massage: back, feet, legs Other comfort measures: Wiped forehead Held hand Used birthing ball	Breathing Relaxation Provided ice chips/ water Gave client gum
Emotional/ Social Supportive Measures	*Verbal Supportive Measures*
Explained/ answered questions Emotional assistance: Calmed me down Provided reassurance Provided encouragement Comforted me Presence: Stayed with me Being there for me Female support Like a second mom Personal attention Helped baby father	Information: Gave advice Explained things Answered questions Provided information Talked with client Talked with baby's father Talked with client's family/ friends

This emphasis on informational support is similar to our findings, where 78.7 percent of CHHS doula clients said that the doula's answering of questions helped them the most. In addition, we found that within our category of *psycho-social comfort*, 61 percent liked the fact that the doula followed her wishes, and 56.7 percent said that they liked the fact that their doulas provided information. These items are included in the *advocacy* category as presented by Kayne et al (2001) and Gale et al (2001). We grouped *answered questions* into both the *emotional/social support measures* and *verbal support* categories because giving information, following a woman's wishes, and getting questions answered can help promote a person's sense of emotional well-being and comfort as well as being verbally supportive, or being an advocate.

Findings presented in Table 3 suggest that women liked best the doula's making eye contact, followed by giving water, helping with breathing techniques, hand holding, and changing linens. In the *psycho-social comfort* category, a friendly demeanor, answering questions, friendliness to the woman's significant other or support person, and staying during labor were identified as most supportive by laboring women. Verbal supportive measures were important, but advocacy did not stand out as a category that should be separated from the other components included in our verbal supportive measures category.

Doula support was also important to CHHS clients' significant others. One woman said that her husband liked having the doula in the labor room since it meant he could leave and go check on their other child without worrying that she was alone. She said, "He [husband] enjoyed and benefited from her [the doula]. The doula enhanced our birth experience." Another respondent said that both her uncle and the baby's father were in the labor room with her. She explained that "the dad especially benefited since he had no clue about kids. He

liked it and he asked the doula questions." A different client said the doula helped her husband during labor. Her husband told her he "wanted her [the doula] to come up before I had the baby to tell him what he should do in the situation since this was his first baby."

Our findings coincide with those of Campero et al. (1998), Abramson (2004) and Koumouitzes-Douvia and Carr (2006). Campero (1998) studied doula use in Mexican hospitals, Abramson (2004) reported on a community doula program in Chicago, and Koumouitzes-Douvia and Carr (2006) looked at doula use among private pay clients. Doula clients in all three samples expressed a high degree of satisfaction with doulas and, in those studies, information, physical comfort, emotional support, and presence were identified as key components of doula support, especially for first-time mothers.

Several examples from the CHHS project support the notion concerning the importance of the presence of a knowledgeable, supportive woman during labor. One CHHS doula client said that her first labor was harder because "I didn't have anyone there to explain things to me or to comfort me." Another client said that her doula-assisted birth experience was better than her first non-doula delivery because her doula helped her stay in control and delay the need for an epidural until much later in the labor.

Our nurse interviews reinforced the importance of continuous presence for laboring women, so that a woman did not have to be in labor alone. Nurses acknowledged that they usually had too many patients to care for to be able to spend much one-on-one time with their patients. Nurses spoke of not wanting patients to labor alone, but did suggest that if a woman had a support person with them then the doula should be re-assigned to a woman who was alone in labor. Interestingly, our results suggest that nurses at the two CHHS project hospitals viewed the continued presence of someone in the labor room as more important than whether that person was a doula.

Social Support

The care provided by the CHHS doulas during labor seems to fit within Schaefer, Coyne, and Lazarus's (1981:385-6) framework of social support. For example, *emotional support*, the first level of Schaefer, Coyne and Lazarus's model, is fulfilled because the doula provides things such as reassurance. This includes the ability of a person to confide in and rely on another. The second level, *informational support,* is also a component of the doula program. The doulas answered questions and provided information and advice to their clients on a number of topics including pregnancy and birth, infant care, family planning, and the like. The third level of Schaefer, Coyne and Lazarus's model, *instrumental or tangible support*, is provided by the doula via the direct assistance she provided to the client during labor and delivery. Thus, based on our findings, the CHHS doulas did provide the kind of supportive care Schaefer, Coyne and Lazarus (1981) outline. The components of support identified in this research seem to take the form of *mothering*, which is identified by Klaus, Kennel, and Klaus (1993:30) as being a quiet, calming, and nurturing presence. This present study supports this behavior as one of the most critical functions of a doula's role.

Female Knowledge and Support

Findings from this research also suggest that having a knowledgeable and supportive woman to consult during pregnancy and labor, as well as during the initial postpartum period, was a key component of the CHHS doula program. This mimics the traditional female support pattern that was the norm prior to the medicalization of birth in the United States in the early 20th century. As an example, one doula client said, "I had my partner there too, but there is just a difference when there is a female there. She [the doula] is reassuring when she talks to you; she answers all your questions; it is just different." Another client said, "She [the doula] was there the whole time. She didn't leave me 'til I finished my whole labor. It was real important that I could turn to somebody." A third client said,"She [the doula] called me afterwards. She has been out to see me; she gives me advice." A different respondent said her doula was "professional and almost like a mom.... She knew how to react and what to say and what to bring me." During labor, the doulas were attentive to the desires of the clients with regard to the kind of birth experience their clients hoped for, and empowered the laboring mothers to be partners in decisions made by the care team during the labor and delivery period. All of these comments reinforce the importance of help from a knowledgeable female during the peri-natal period.

The CHHS doulas encouraged their clients to attend their pre-natal medical visits and made sure the women knew what to expect during labor and delivery. The prenatal teaching was reinforced during the six-week postpartum period, when doulas visited their clients and made sure that the women were comfortable with the care and feeding of their newborns. It appears that this prenatal support and teaching function of the doula was an important component of doula support that was particularly helpful with high-risk women such as those served by the CHHS project both before and after delivery.

The prenatal component of the project, which provided doula support during the crucial third trimester of pregnancy re-creates the traditional cultural role of knowledgeable women teaching and supporting pregnant women. This reaffirms the importance of experienced, knowledgeable women supporting new mothers during pregnancy and validates the importance of female authoritative knowledge (Jordan 1993; Raphael 1973; Raphael and Davis 1985), an important theoretical underpinning of the doula model of pregnancy support.

As an example of the scope of pregnancy support by CHHS doulas, one woman who knew she was having a baby with a deformity appreciated having a doula. The client said

she had been in the hospital often during her pregnancy due to her diabetes, and her doula came and saw her each time she was in the hospital. During the interview at home after her postpartum visits ceased, this client told the interviewer that she felt confident as a mother and able to help her disabled infant have a good life. These feelings of confidence were instilled by her doula during the pregnancy and afterwards, and illustrate the value of doula support as provided in the CHHS model.

Doula Empowerment

The sense of personal empowerment experienced by the doulas themselves was also an important outcome of the CHHS program. The jobs provided the doulas with not only employment and income, but also an increased sense of personal worth. One doula said,"Being a doula has given me my self-confidence back. I was at a point where my self-esteem was very low.... I am feeling better about myself than I have in a long time, I feel like I am worth something now." One doula said that being a doula has "built strength in my inner part. It has made me want to further my education and become a midwife...this is just me." Another commented, "Actually, I have been a doula all of my life, I just didn't know it." Some of the doulas said that they became better people as well as better parents by becoming doulas. These personal benefits were passed on to the doulas' own families. One doula summed up her experience as a doula by saying, "I think my becoming a doula has been a stepping stone for things I am about to do in my life. It's really rewarding; it's like instant gratification...so it's really wonderful."

Limitations

This study had several limitations. These included a small sample size due to the limited time period of the study (eight months). The sample is also non-random. The ethics of excluding pregnant women from a program such as the CHHS doula program made it necessary to include every woman who both qualified for and desired services. This limits the ability to generalize about the results. Also, as noted earlier, researchers were not permitted to conduct any observations in either hospital's labor and delivery suites. Thus, we are unable to comment on the conduct of the doulas while at work with clients during the hospital part of the program.

Conclusions

Our study adds to the literature on doula support by identifying specific techniques (Tables 2 and 3) doulas were using and which of these techniques clients found most supportive and helpful. CHHS clients were very satisfied with their doula experience. We also looked at the role of the doula from the perspective of the doulas themselves and identified multiple benefits for the neighborhood women who worked as CHHS doulas. Additionally, findings from the CHHS doula program support the importance of having a knowledgeable woman present during labor to help women through labor, and re-create the traditional model of knowledgeable female pregnancy support identified by anthropologists in traditional cultures.

Thus, the importance of the theoretical role of female authoritative knowledge is foundational to the entire doula concept. The understanding of the role of doula from our research suggests that women, no matter their status in society, want something more from their pregnancy than a healthy baby. Women want to be supported and mothered in the ways that women in the past had been supported. We see such attitudes in the media daily.

Anthropological studies of pregnancy and childbirth can contribute to the understanding of the role of female support in pregnancy and the benefits of this support for women who may not have the resources for private doulas to help them during labor, even if they would know of such. Today the CHHS program continues to provide doula services to at-risk pregnant women in 17 census tracts in urban Tampa that record over 1,000 deliveries per year. The community-based program provides prenatal support as well as postpartum home visits, along with doula labor support. The community has been extremely receptive to the program, and the Community Council has been instrumental in service planning and program operations. In addition, community women continue to be recruited and trained as doulas, providing much needed economic and employment opportunities for these women.

It is clear from our research that the CHHS doula model re-creates the traditional cultural pattern of women helping and supporting each other during pregnancy and childbirth, and may represent an effective strategy for improving the birth experience and outcomes for at-risk inner city as well as other pregnant women in the Tampa area and elsewhere.

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