



A qualitative study of volunteer doulas working alongside midwives at births in England: Mothers' and doulas' experiences



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ABSTRACT

Objective: to explore trained volunteer doulas' and mothers' experiences of doula support at birth and their perceptions of how this related to the midwife's role.

Design: a qualitative descriptive study, informed by phenomenological social psychology.

Methods: semi-structured interviews were carried out between June 2015 and March 2016. Interview transcripts were analysed using inductive thematic analysis.

Setting: three community volunteer doula projects run by third sector organisations in England.

Participants: 19 volunteer doulas and 16 mothers who had received doula support during labour.

Findings: three overarching themes emerged: (1) 'the doula as complementary to midwives', containing subthemes 'skilled physical and emotional support', 'continuous presence', 'woman-centred support', 'ensuring mothers understand and are understood' and 'creating a team for the mother'; (2) 'the doula as a colleague to midwives', containing subthemes 'welcomed as a partner', 'co-opted to help the midwives', and 'doulas identify with the midwives'; and (3) 'the doula as challenge to midwives', containing subthemes 'confusion about the doula's role', 'defending informed choice', and 'counterbalancing disempowering treatment'.

Key conclusions & implications for practice: volunteer doulas can play an important role in improving women's birth experiences by offering continuous, empowering, woman-focused support that complements the role of midwives, particularly where the mothers are disadvantaged. Greater clarity is needed about the scope of legitimate volunteer doula advocacy on behalf of their clients, to maximise effective working relationships between midwives and doulas.

Introduction

Midwives are normally the lead professional in the care of women with uncomplicated pregnancies in England, and for more than two decades the concept of 'continuity of care' has been at the heart of maternity policy (Department of Health, 1993, 2004, 2007; National Maternity Review, 2016). In the light of evidence that continuous support in labour reduces intervention and improves outcomes (Hodnett et al., 2013), guidelines for intrapartum care recommend one to one continuous care during labour and birth (National Collaborating Centre for Women's and Children's Health, 2014). The 'caseload midwifery' model, where a mother is cared for in labour by a midwife who has cared for her throughout pregnancy, can improve birth outcomes for socially disadvantaged mothers (Homer et al., 2017; Rayment-Jones et al., 2015). Labour care from a known midwife can also improve mothers' experience of birth (McLachlan et al., 2016).

In practice, 85% of mothers report not having previously met any of the midwives caring for them during labour and birth (Redshaw and Henderson, 2015). A total of 21% of mothers report that they were left alone at a time when it worried them during labour or straight after birth; and single women are particularly likely to have been left alone and worried (Redshaw and Henderson, 2015). These figures reflect understaffing in some maternity services and the current organisation of maternity care which is not necessarily based on continuity models (Care Quality Commission, 2014; National Maternity Review, 2016).

'Doulas' are trained or experienced lay women who provide social, emotional and practical support to other women during pregnancy and birth, but do not provide any clinical care (Steel et al., 2015). International evidence links support from a trained or professional doula with reduced interventions, increased breastfeeding, increased satisfaction with the birth experience and increased maternal emotional wellbeing (Hodnett et al., 2013; Spiby et al., 2015; Steel et al., 2015).

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Building on the traditional practice of women assisting one another at birth (Hodnett et al., 2013), the modern doula movement originated in North America in the 1970s, in a birth culture with little midwifery involvement (Steel et al., 2015). The concept of the private doula (hired by the individual mother) has since spread to other countries where midwives are an integral part of the maternity services, including Australia, Sweden, the Netherlands and the United Kingdom (Steel et al., 2015). Hospital and community doula models have also been developed, primarily to serve disadvantaged women (Ballen and Fulcher, 2006; Gentry et al., 2010; Holland, 2009; Kane Low et al., 2006), who are disproportionately likely to access maternity care late and to experience poor outcomes (Centre for Maternal and Child Enquiries, 2011; Downe et al., 2009; Hodnett et al., 2010; Manktelow et al., 2016). In these models, the doula may be a paid community worker or a volunteer, and the service is free for the mother (Ballen and Fulcher, 2006; Deitrick and Draves, 2008; Dundek, 2006; Kane Low et al., 2006). In England, the first volunteer community doula project began in 2005, and by 2011 there were five volunteer doula projects running (Spiby et al., 2015), as well as a third (voluntary) sector organisation providing birth support from small teams of volunteer doulas to extremely vulnerable women in prison or in the community (Kerr, 2015).

Doulas are unregulated in England and practice may vary. The evidence from North America and Australia is that doulas may position themselves as guardians of 'normal' birth, encouraging the mother and advocating for her to clinicians who are perceived to have a medicalised agenda (Gentry et al., 2010; Meadow, 2015; Stevens et al., 2011; Stockton, 2010). Alternatively doulas may see their role as 'protecting' the mother's emotional wellbeing (Gilliland, 2011) and 'holding the space' for birth through emotional and physical intimacy (Hunter, 2012). Other doulas stress their role in empowering the mother to make and articulate her own choices (Campbell-Voytal et al., 2011; Gilliland, 2011; Holland, 2009; Meadow, 2015).

Some health professionals in North America and Australia have expressed antagonistic attitudes towards private doulas, believing that they disrupt the relationship between health professional and mother and may inappropriately attempt to influence the mother (Ballen and Fulcher, 2006; Campbell-Voytal et al., 2011; Papagni and Buckner, 2006; Steel et al., 2015; Stevens et al., 2011). By contrast, Swedish midwives have welcomed community doula-interpreters as 'facilitators' for their care of migrant mothers (Akhavan and Lundgren, 2012). The limited evidence from England is that midwives appreciate the contribution of community doulas providing they respect professional boundaries, and that mothers and doulas feel that doulas work well with midwives some but not all of the time (Kerr, 2015; Spiby et al., 2015; Spiby et al., 2016).

This paper arises from a qualitative study, and focuses on volunteer doulas' and disadvantaged mothers' understanding and experience of the community doula role during labour and birth in England, and how that interrelates with their understanding and experience of the midwife's role. A subsequent paper will explore the community doulas' antenatal and postnatal role.

Methods

Study design

This was a qualitative descriptive study (Sandelowski, 2000), based on semi-structured, in-depth interviews, theoretically informed by phenomenological social psychology (Landridge, 2008). This 'low-inference' (Sandelowski, 2000) study design was chosen because the purpose was to explore participants' own perceptions and thus to stay close to their accounts (Landridge, 2008), while acknowledging the role of both participants' understandings and the researchers' interpretations in the production of knowledge (Pidgeon and Henwood, 1997).

Setting

The research took place at three community doula projects in England in Bradford, Hull and Essex, chosen because they were operating broadly the same model of doula support but in ethnically and geographically diverse areas. At each site a third sector organisation ran a project which offered free doula support from unpaid volunteers during pregnancy, at birth, and for 6–12 weeks postnatally. The volunteers were women from the local community who received up to 90 hours initial training, leading to an accredited qualification. They received ongoing regular support and supervision from the project co-ordinator. The supported mothers were either women with no partner, women whose partner was unable to be present at birth, women with additional vulnerabilities (such as recent migration or domestic abuse), or women who were involved with children's social care services. When a mother was referred, the project co-ordinator visited her to gain an understanding of her needs and matched her with an available volunteer. The volunteer provided one-to-one support, usually through weekly visits. The volunteer was 'on call' to attend birth, 24 hours a day from two weeks before the expected date of birth. Each mother was also assigned a 'back-up' doula in case her own doula was unable to attend the birth or needed respite during a long labour.

Recruitment

The doula project coordinators were contacted to introduce the research. They then explained the research to the volunteers and recently supported mothers using the study information leaflets, and invited them to participate. Where a volunteer or mother chose to participate, the co-ordinator asked her permission for the researcher to contact her, or arranged an interview. The sampling was thus purposive insofar as all participants had experience of giving or receiving volunteer doula support (there was no specific attempt to interview mothers who had been supported by the participating doulas or vice versa). The researcher did not have any prior contact with participants.

Data collection

Semi-structured qualitative interviews were conducted between June 2015 and March 2016. Each participant was interviewed once, and each interview took place at a time and place of the participant's choice, after explaining the reasons for the study and obtaining written informed consent. Most chose the project base or their home, but four volunteers and one mother chose to be interviewed by telephone (oral informed consent was given and recorded in writing). Three mothers chose to have their partners present during part or all of their interviews. Although professional interpreting was offered, none of the mothers took this up; however, one mother used informal interpreting support from the project co-ordinator (this mother is not quoted in this paper), and a second mother had partial informal interpreting support from her partner.

The mothers' interviews lasted 25–75 minutes (median 41 minutes). Topics included their experience of using the maternity services; the support received from the doula antenatally, at birth and postnatally; and the impact of the doula support. The volunteers' interviews lasted 37–99 minutes (median 55 minutes). Topics included their motivation for volunteering; training; activities as a doula; support received from the project; and experience working alongside professionals. All interviews were audio-recorded and fully professionally transcribed. Data collection continued until saturation was reached in the themes identified in the analysis.

Data analysis

The volunteers' and mothers' transcripts were analysed as separate data sets using inductive thematic analysis (Braun and Clarke, 2006).

After checking against the audio recording, each transcript was read and reread, and codes were identified inductively and recorded using NVIVO software. Codes were refined, combined and disaggregated as data collection continued, and emergent themes identified; the technique of constant comparison (Glaser and Strauss, 1967) was used to reconsider earlier codes and emergent themes in the light of subsequent interviews. Themes emerging from each data set were compared with the themes identified from the other data set and integrated into an overall thematic analysis. To ensure the validity of the analysis, each researcher analysed the transcripts independently; codes and emerging themes were discussed and agreed. Both researchers approached the analysis reflexively, putting aside their existing knowledge as experienced researchers in this field so that the analysis remained close to participants' accounts, and acknowledging the potential impact of their own perspectives as White, UK-born women with children.

Participants

Sixteen mothers and nineteen doulas took part in the study. The mothers were from a diverse range of backgrounds. Nine had a husband or partner and seven were single parents. They ranged in age from 20 years old to mid-forties, with the majority being in their thirties. Three were first time mothers and the remaining thirteen had between one and five older children (mode one). Six were White British, two were British Asian, and eight were born abroad in Asia, Africa, and the Middle East. The primary reasons for wanting doula support during birth were: their partner would be looking after an older child with disabilities (four mothers), their partner would be working away or was unwilling to be at the birth (two mothers), the mother had fled domestic violence and was isolated after being rehoused in a new town (four mothers), a distressing previous birth experience (two mothers), recent arrival in the UK (two mothers, both refugees), and maternal mental health concerns (two mothers). Thirteen of the mothers gave birth in a hospital obstetric unit and three in a midwifery-led birth centre. Seven had their partner or a female relative present for at least some of their labour, as well as the doula. Fifteen mothers gave birth vaginally and one had a caesarean section.

The doulas were less ethnically diverse: fourteen were White British and five were Asian or British Asian. They ranged in age from early twenties to mid-sixties, with the majority being in their thirties. All but one had children of their own, and three were grandmothers. Besides volunteering, fourteen were in paid work, three were full time mothers, one was a student, and one was retired. They had volunteered as doulas for between 4 months and 6 years (mean 3.2 years). One had not yet attended a birth, six had attended 1–2 births, three had attended 3–4 births, five had attended 6–8 births and four had attended over 10 births.

Findings

Three overarching themes emerged from the analysis of participants' accounts of how the doulas worked alongside and interacted with midwives during labour and birth: 'the doula as complementary to midwives', 'the doula as a colleague to midwives', and 'the doula as challenge to midwives'. These themes and the related subthemes are shown in Table 1. Subthemes present in both mothers' and doulas' accounts are identified 'M+D'; subthemes present only in doulas' accounts are identified 'D'.

The doula as complementary to midwives

Both doulas and the mothers they supported described their role as distinct from, but complementary to, current midwifery support. This theme contains five subthemes: 'skilled physical and emotional support', 'continuous presence', 'woman-centred support', 'ensuring

mothers understand and are understood' and 'creating a team for the mother'.

Skilled physical and emotional support

The strongest representation of the doula role during labour and birth was that doulas provided physical and emotional support throughout: '*She was helping me to stand up because it was better, talking to me to forget the pain, she did everything*' (M15). Participants described a range of physical support activities including arranging the birth room according to the mother's wishes, walking around the hospital with her during early labour, supporting her to use active birth techniques, breathing with her, massaging her, holding her hand, or '*just some physical presence*' (M05). The emotional support from the doulas encompassed '*telling them that they can do it*' (D17), '*reassurance... that you'll help them get through whatever it is they have to get through*' (D02), and '*calm[ing] her down*' (D10). Doulas also supported mothers during caesarean sections: '*reassuring her, talking her through what's happening*' (D14). Mothers reflected the same aspects of emotional support, with an emphasis on overcoming fear and pain, and building up their confidence in their bodies: '*Someone to encourage you...like a mother's role*' (M12). M14 said that she had felt '*Well I can't do it anymore, ...and [the doula] was like, 'No, you can do it.' And I think having that push actually pushed me in thinking, 'Right, I can do this.'*' Doulas had enabled mothers to '*get my peace back*' (M10) and '*to forget the pain*' (M15), and the doula's presence helped M08 face an emergency caesarean: '*I really wasn't panicking anymore because I knew that even if I go into the theatre she's going to be there*'.

The doulas also supported partners who were present, noting that '*sometimes the partners need more support than the mum*' (D07). They reassured partners, explained what was happening, and guided them in how to support the labouring mother:

[The doula] explained to my partner what was going on 'cause I could have not, and [the midwives] would have not explained to him, they would only explain to me...She was telling my partner, 'Yeah, do this for her'... He was like, 'If [the doula] wasn't there I probably would have [run] out of the room'(M07).

It was also important to recognise when the partner did not need much support, with one doula describing how she '*stepped back a little bit and just kind of let them bond and go through it together*' (D13). One admitted that because of the challenge of getting this right, '*I'm slightly more comfortable when there isn't a dad*' (D04). However, another talked of her '*immense sense of wellbeing...to support those two people*' (D09). Mothers whose partner was present greatly appreciated the additional support of a knowledgeable and experienced woman: '*It's a different support, what she gives and what he gives... he gives his presence and his love, but he don't really know how to touch my back to release the pain*' (M10).

Continuous presence

Unlike midwives who were said to '*go, come in and go out*' (M07), doulas provided continuous support throughout labour: '*She stayed all though and everything was easier really because she was there*' (M08). Some doulas had to leave a labour (handing over to their back-up) because they had a job or young children: '*I was there with her for 10 hours, and then I had to go back to work... I missed [the birth] by an hour*' (M06). However, individual doulas developed a strong commitment to their clients and frequently chose to remain with a labouring mother through multiple changes of midwifery shift (in some cases, remaining at the hospital with a mother for two or three days): '*I'd struck up a bond with this lady and I wanted to be there for her the whole time*' (D13). As well as the emotional and physical benefit of being continuously supported through labour, some mothers experi-

Table 1
Overarching themes and sub-themes arising from women's and doulas' experience of labour and birth.

Over-arching themes	The doula as complementary to midwives'	The doula as a colleague to midwives	The doula as challenge to midwives
Sub-themes	<p>Skilled physical and emotional support (M+D) 'You'll help them get through whatever it is they have to get through'</p> <p>Continuous presence (M+D) 'She stayed all though and everything was easier really because she was there'</p> <p>Woman-centred support (M+D) 'Our role is to make the mum feel she's like the VIP'</p> <p>Ensuring mothers understand and are understood (M+D) 'My voice'</p> <p>Creating a team for the mother (M+D) 'We're doing this together'</p>	<p>Welcomed as a partner (D) 'Midwifery teams [are now] being champions for what the [doula] project is about'</p> <p>Co-opted to help the midwives (D) 'An extra pair of hands'</p> <p>Identifying with the midwives (D) 'There's me and a midwife ...and you think, 'Ah, come on, we can do it'</p>	<p>Confusion about the doula's role (D) 'A bit of threat'</p> <p>Defending informed choice (D) 'We stick up for them...[when] one of the midwives [says] 'Oh you have to do this''</p> <p>Counterbalancing disempowering treatment (M+D) 'I had [the midwife] having a go at me, [the doula] trying to reassure me'</p>

enced prolonged companionship from an unpaid volunteer as intrinsically supportive. M07, whose doula stayed with her during a complex 24 hour labour, said that *'It made it more beautiful and more meaningful, because there was someone there that I literally had known for a very limited amount of time that was willing to be there...by my side.'*

Most participants believed that midwives might want to offer more continuous care, but were unable to do so as on a busy labour ward they would typically support several labouring mothers at the same time: *'Midwifery carers, I'm not saying that they don't care as much, but I think they're just so under stress now'* (M04). Both doulas and mothers explicitly acknowledged that the doulas' supportive role might fill this gap, believing that having doulas *'takes the pressure off'* (M01) overstretched midwives and could be *'a great support to them'* (D04). Some participants thought that midwives might adjust their practice if a doula was present: *'They don't visit quite as often...they know that... if we think there's a problem we'd call them'* (D04). On the other hand, one doula described how in the less pressured environment of a midwife-led birth centre, there could be potential for duplication: *'[The doula and midwife may be] looking at each other going, 'Do you want to do that, or shall I do that?' ... One of us is kind of sat twiddling our thumbs.'* (D14).

Woman-centred support

Although they felt they were relieving pressure on the midwives, the doulas also believed that their support was fundamentally different from that of midwives who *'see lots of people in this situation, we don't. That lady is special to us at that time'* (D04). The support offered by doulas was completely personalised and woman-centred, or *'lady-led'* (D04), because *'our role is to make the mum feel she's like the VIP'* (D06). Mothers agreed, for example M05 felt that her doula *'was there for me. And there was nobody else in the room that was just there for me'*. They strongly contrasted the *'personal touch'* (M04) of the doula role with that of the midwives, who in most cases were said to be focused on *'clinical'* (M04), even *'mechanical'* (M08) care. For some, another essential difference was that doula support took place in the context of a relationship established during pregnancy: *'You need to build the relationship up first'*(M06). None of the mothers was cared for in labour by a midwife who had provided any of their antenatal care.

Mothers appreciated the doulas' needs-led, non-directive approach, describing how the doula *'asked how do I want, what do I want... supporting [my] way to achieve that'* (M10). This was very different from the midwives who *'try to enforce their own knowledge on you'*

(M08). Doulas also articulated this distinction between support (doulas) and advice (midwives): *'We don't advise, we just support and encourage...a midwife always gives the advice for something pro, so she'd say 'I think an epidural's really the best thing''* (D18). They felt that where these boundaries were understood, their complementary role was appreciated by midwives: *'A really good working relationship... Midwifery teams [are] being champions for what the [doula] project is about, because it got to a point where there was clarity around 'This is what doulas do''* (D12).

Ensuring mothers understand and are understood

Part of the doulas' role was ensuring that there was effective communication between midwives and mothers. Doulas frequently needed to explain what the midwife was saying in terms that the mother could understand, and they supported the mother to communicate her needs to the midwife. Mothers whose first language was English commented that *'you do not understand half the things [midwives are] trying to explain to you'* (M08), whereas the doula would *'explain it in... normal terms, all what the midwife was trying to say'* (M09). Mothers for whom English was not their first language also reported that the doula would *'explain something to us if we don't understand very well'* (M14). One doula took a different approach: checking the mother's understanding and asking the midwives to *'explain that again to mum so she understands'* (D13).

Equally important from the mother's point of view was that it could be difficult to communicate her wishes to a midwife during labour, especially (but not only) if she did not speak much English: *'Talking is hard for that time'* (M02). The doula had in most cases worked with the mother beforehand to prepare a birth plan, so she was aware of the mother's wishes and could communicate them on her behalf, at the mother's request: *'I knew she was going to [say what I wanted]... because we had discussed it over and over and over and over again'* (M08). In this situation mothers described their doulas as *'my voice'* (M04, M05), or *'talking for me'* (M02, M07). Several mothers said that they would find it difficult to talk directly to a midwife because of previous bad experiences: *'they say the wrongest things'* (M08), or because they were *'intimidating because they are a professional'* (M06).

Doulas agreed that some women could be a *'little bit hesitant to ask [the midwife] questions'* (D13) because the imbalance of power made them *'feel a little bit vulnerable and they're not very confident'* (D02). Some echoed the language of 'voice': *'you need somebody to be that voice for you'* (D15); *'I could speak up for her'* (D18). Several described this role of 'speaking up for' as being an *'advocate'* (D02, D10), but one

doula had a different, empowerment-oriented understanding of doula advocacy and ‘voice’:

It's very much being an advocate for women, or giving women a voice...We're giving them the strength to say things for themselves and it's not coming from us...I would talk to the woman and say, 'Do you remember what we talked about? How do you feel about this now?' And it's very much giving her the tools to say it herself in the situation. We'd never talk for them. (D14)

Other doulas described how they reinforced the midwives' authority in the birth room by urging parents to ‘listen to the midwives’ cause they're the experts’ (D16). They gently reminded mothers that the doula could support them in communicating, but was not taking the place of the knowledgeable midwife: ‘[The mother]’ll ask me the questions, then I’ll say, ‘I can’t give you the answer... we’ll ask those questions’ (D13). They were clear that midwives were in charge: ‘[Midwives] are the lead people there and we have to respect their space’ (D04).

Creating a team for the mother

A fifth subtheme identified how doulas deliberately created a team for the mother to be part of, particularly if she was vulnerable: ‘I wouldn’t want the mum to think, ‘I was on my own, I didn’t have anyone with me’ (D11). For example, D07 worked to give a frightened mother a sense that ‘We’re doing this together’...I was there as part of it, and that’s what she needed.’ She described how a vulnerable young mother reflected this language back to her when facing a safeguarding assessment after birth: ‘She patted me on the shoulder and said ‘We know this room well, don’t we?’ And I said, ‘We do, don’t we?... We can tell them all about what a wonderful birth it was’ (D07). Other doulas likewise used the language of ‘we’ when speaking to mothers (for example, ‘We’ll ask those questions’ (D13), ‘I told her we needed to keep calm’ (D03)), creating the sense that the doula was completely ‘on their side’ (D02). This approach could be meaningful even for mothers whose partner was also present: ‘All three of us went through it, although they didn’t go through it physically, but mentally they did with me’ (M07). This was not something that mothers experienced from their midwives.

The doula as a colleague to midwives

This second overarching theme describes situations or relationships which suggested that some midwives did not simply see the doulas as complementary, but as valued colleagues in the shared endeavour of supporting mothers and their partners during labour. It contains three sub-themes: ‘welcomed as a partner’, ‘co-opted to help the midwives’, and ‘doulas identify with the midwives’.

Welcomed as a partner

Some doulas described being welcomed and included by midwives, particularly once the midwives got to know them: ‘If you’ve worked with them and helped them in some ways, they’re very supportive of you being there’ (D05). Working together could lead to the development of warm collegiate relationships: ‘[The midwife] give me a hug and a kiss, ‘Oh it’s so lovely to see you again’ (D07). One doula had been made to feel part of the team by a midwife after a long labour: ‘This woman had her baby...I hadn’t been home for three days, and I said, ‘I’ve got to go home now.’ The midwife went, ‘No, come and have tea’ (D06). Another doula had experienced a striking variation in midwives’ attitudes in the course of one labour, from grudging tolerance to full partnership:

There was a changeover of staff and the midwife was so different... very embracing of my presence ...‘We’re in this together with the

mum.’ As opposed to, ‘Okay, well now somebody else that is going to ask me questions (D15).

Co-opted to help the midwives

Several doulas recounted how they were co-opted to help the midwives carry out their professional role. Sometimes this involved the midwife actively asking for the doula’s help in communicating with a mother who did not speak much English: ‘They was like, ‘Can you ask mum?’ (D02). At other times it might be physical assistance: ‘They were saying to me, ‘You’ve got to try and keep [the mother] still’ (D08). Another doula described how a midwife asked her to stay and help manage the situation as ‘an extra pair of hands’ (D07) when two birth partners unexpectedly arrived:

I’d said, ‘Lovely, your sister’s here, your partner’s here, I’ll be just outside for a little while,’ and the midwife went, ‘No, you’re going to be here in the room with me. So please be here in the room with me.’ ...They all stank of smoke, they were all very phones stuck to their ears and...they needed someone to be a bit more, ‘And this is what happens in the delivery room,’ with them. You know, and the midwife had other things to do... And the midwife said [to me], ‘Can you pass me this, can you pass me that?’ So she was making my role slightly different as well. Normally you’re hanging onto the mum or the mum’s hanging onto you... but this time I was standing right next to the midwife the whole time. (D07)

Identifying with the midwives

Two doulas identified to some extent with their role as a supporter for the midwife, using ‘we’ to describe themselves and the midwives, rather than themselves and the mother: ‘So there’s me and a midwife ...and you think, ‘Ah, come on, we can do it’ (D06). One also said that she had turned to the midwives for advice about how to support the mother. Neither of these doulas had met the mothers they were supporting at these births until shortly before the labour, and they had different levels of experience (one was at her first birth and the other had been at six births).

The doula as a challenge to midwives

This third overarching theme describes how some mothers and doulas perceived the doula role as potentially challenging or in conflict with midwives. It contains three subthemes: ‘confusion about the doula’s role’, ‘defending informed choice’, and ‘counterbalancing disempowering treatment’.

Confusion about the doula’s role

None of the mothers had noticed any direct conflict between their doulas and their midwives. Many of the doulas had, however, experienced difficulties of some kind: ‘I’ve been ignored’ (D05); ‘they kind of looked at you like you’re nothing...it were like we were in the way’ (D17). Some doulas attributed hostility from midwives to lack of confidence: ‘they’re worried that you’re going to judge them’ (D15), or midwives’ mistaken preconceptions about doulas having an agenda to oppose pain relief: ‘They had the perception that’s what we planned’ (D05). Generally they said that difficulties belonged to the early days of their doula project when midwives were ‘not quite sure what you’re there for’ (D15) or saw doulas as ‘a bit of threat’ (D14). Some illustrated the difficulty of defining the boundaries of doula advocacy, describing how some midwives rejected their attempt to ‘speak for’ mothers who did not speak much English: ‘I started to talk because I knew what she wanted. And then they says, ‘We don’t need to hear it from you, we need to hear it from the mum.’ [It] felt like I was getting my wrist slapped’ (D02).

Defending informed choice

The fact that the doula's advocacy role encompassed supporting mothers to 'make their own informed decisions' (D18) was described as being sometimes a source of irritation to busy midwives: 'You can see there's a lot of shaky heads and tuts' (D14). Doulas ensured that mothers were aware that they had the right to choose whether or not to have interventions: 'We stick up for them ... [when] one of the midwives [says] 'Oh, you have to do this'" (D09). The issue of defending informed choice frequently related to internal (vaginal) examinations during labour, as described by D10 when she was supporting a mother who did not understand English well:

The midwife just said, 'Oh I'll examine you internally'... She wasn't asking her...[The mother's] face were just full of fear and I said to the midwife, 'Can I just explain to her what you're going to do before you actually do it?' So there I was getting my phone out again and got Google Images up, and I said to [the mother], 'This is what they will do' ...I said, 'Look, you have got the choice. You don't have to do it if you don't want to, but it does help.' And she was like, 'I don't want it'...[The midwives] weren't too happy because it's easier to get it done and then... you can put it down in the notes. (D10)

Several doulas saw their advocacy role as an implicit challenge to the midwives if they were 'failing to listen' (D15) to the mother's expressed needs. One described how careful she was to prevent this challenge becoming explicit: 'I did it very subtly. I wouldn't say I was in anybody's face' (D15). She was very conscious of not alienating staff while advocating, politely but persistently, for what the mother requested: 'You need them on your side, you need them on mum's side' (D15).

Counterbalancing disempowering treatment

One mother, who described her midwife as 'horrible...harsh' (M08), believed that having a doula might protect her against poor treatment by maternity professionals:

I could hear [the midwife] telling [another woman], 'Stop being a baby' ... She just marched into my room, like, 'Oh I can't stand that woman,' and she left the woman by herself. And I'm thinking, 'If I was by myself and [my doula] wasn't there... is this how they're going to treat me as well' (M08)

Another mother positioned her doula support as a counterbalance to a midwife who was undermining her confidence: 'So I had [the midwife] having a go at me, [the doula] trying to reassure me' (M09). Several doulas also described how they tried to reframe negative comments from midwives while also trying to avoid conflict:

Trying to use positive language, so trying to counteract some of the not so positive language from the midwife sometimes. [The midwife says,] 'Oh the pain's going to get worse,'...I generally say things like, 'That's one less contraction to go through.' ... I said to a mum once, 'You're doing really well,' and the midwife said, 'Well I hope she is.' And I just continued saying what I say because I don't like confrontation. (D05)

Several mothers described how midwives 'didn't believe me' (M04) when the mothers said they were in labour. One doula was the only attendant at a rapid home birth after the midwife had left, telling the mother she was not in labour. This doula said that she 'absolutely terrified inside' at the prospect of assisting at a birth without a midwife, but she focused on making it an empowering experience for the mother:

'[The mother] said 'Have you done this before?' And I said, 'Yes, it's fine. I was at home when I had my baby'... You could see her just

go, 'Okay, somebody else is in control of this.' And I was saying, 'You are in control of this. I am just helping you do this. It's absolutely fine' (D14).

Discussion

The three overarching themes of 'doulas as complementary', 'as colleagues' and as 'a challenge to midwives' echo findings in the international literature about doulas working with health professionals (Akhavan and Lundgren, 2012; Deitrick and Draves, 2008; Middlemiss, 2015; Papagni and Buckner, 2006; Stevens et al., 2011), but this is the first study where all three themes have been identified together. None of the mothers in this study had experienced caseload midwifery. They frequently referred to their anxiety about birth and in many cases did not have the confidence or language skills to communicate readily with the midwives they met in labour and who were with them intermittently. The mothers and doulas positioned doulas' emotional and physical support as complementary to that of the midwives in that it was provided continuously and often in the context of a pre-existing relationship. This resonates with Australian doulas and Swedish midwives who felt that doulas were filling gaps in midwifery care (Akhavan and Lundgren, 2012; Stevens et al., 2011).

Doula support was also complementary because it was experienced as having a different purpose from midwifery care, being entirely focused on supporting the individual labouring mother or couple and her or their needs, and without any clinical or advisory role. This fits with Meadow's concept of the doula role as 'fostering relational autonomy' (Meadow, 2015). As identified in studies of doulas working with mothers who were very young or in prison (Holland, 2009; Schroeder and Bell, 2005), it was especially significant for vulnerable and unsupported mothers to feel they had someone 'there for me'. Higher childbirth self-efficacy is associated with lower perception of labour pain and increased ability to cope with pain (Lowe, 2002; Tilden et al., 2016). Consistent with earlier research on doulas (Akhavan and Lundgren, 2012; Berg and Terstad, 2006; Gilliland, 2011; Hunter, 2012; Koumoutzes-Douvia and Carr, 2006), the calming, motivational support from the doula enabled mothers to master their fear and anxiety and to have confidence in their bodies during labour and birth. Some partners may be ill-equipped to support the mother and their distress may be a source of stress to her (Bäckström and Hertfelt Wahn, 2011; Hanson et al., 2009; Maher, 2004). The doulas both supported the mothers' partners, and guided the partners to support the mothers, improving the birth experience for both parents. This aspect of doula support has previously been highlighted by mothers in Sweden and the USA (Berg and Terstad, 2006; Koumoutzes-Douvia and Carr, 2006).

Some doulas had experienced truly collaborative relationships with midwives, where they were welcomed as colleagues - 'we're in this together'- or effectively co-opted onto the midwifery team to help with specific tasks including interpreting (although the doulas were not trained as interpreters and this was not meant to be part of their role). This reflects the dynamic reported by some Swedish midwives regarding doula-interpreters for migrant women (Akhavan and Lundgren, 2012). Two volunteer doulas had reciprocated by identifying themselves as a 'we' in a shared endeavour with the midwives. In the context of peer support, Dennis (2003) raises the possibility that receiving too much training risks transferring peer supporters' allegiance from the client to the healthcare system. Although the volunteer doulas received extensive training, it seems unlikely that the training was the cause of this identification as only two of the nineteen doulas identified themselves in this way. An alternative explanation is that these two doulas had not had time to make a meaningful relationship with the mothers they were supporting, as these were both very late referrals.

The doulas who had experienced conflict with midwives attributed this to midwives' lack of confidence or to their misunderstanding of the volunteer doula role, as previously reported in England by Spiby et al.

(2016). Doulas inferred that some midwives felt, like Australian midwives, that doulas were encroaching on their role (Stevens et al., 2011). Alternatively they suggested that, like health professionals in Canada and the USA, midwives believed that doulas were encouraging women to take a negative attitude to interventions (Ballen and Fulcher, 2006; Eftekhary et al., 2010). Experienced doulas were generally positive about how relations improved over time as midwives had experienced the restrained reality of volunteer doula practice. None of the mothers had noticed any direct conflict, in contrast to some of the English mothers surveyed by Spiby and colleagues, who had observed midwives being dismissive of their volunteer doulas (Spiby et al., 2015). However, some mothers and doulas had experienced disempowering comments from midwives that undermined the labouring mother's self-confidence. They described how the doula role could include counteracting negative treatment where necessary by affirming the mother's competence.

It was apparent that the concept of 'advocacy' had differing meanings for the doulas in this study, although they had all trained in the same model. Advocacy was a key element in each of the three overarching themes: supporting effective communication at the request of the mother (complementary), assisting communication at the request of the midwife (collegial) and ensuring that the midwife had gained informed consent for interventions (challenge). A range of definitions of doula advocacy appear in the literature (Meadow, 2015). One approach emphasises the doula's role in supporting the client to be more involved in decisions and to communicate on her own behalf, and another places the doula as an intermediary between client and clinician, communicating on her behalf and giving advice (Amram et al., 2014; Ballen and Fulcher, 2006; Berg and Terstad, 2006; Deitrick and Draves, 2008; Gentry et al., 2010; Meadow, 2015; Papagni and Buckner, 2006; Stockton, 2010). With the exception of giving advice, these different versions of advocacy were adopted by different doulas in this study. While one doula was adamant that '*we'd never talk for them*', for others '*being a voice*' was a normal part of their role if that was what the mother requested (as many in this study did). The significance of this type of advocacy is reflected in the findings of the National Maternity Survey, where 16% of mothers said doctors did not always talk to them in ways they could understand, 10% had this problem with midwives, 18% said that midwives and doctors did not always listen to them, and poor communication was most likely to affect women from lower socio-economic groups or from Black and Minority Ethnic communities (Henderson et al., 2013; Lindquist et al., 2015; Redshaw and Henderson, 2015).

All the doulas were committed to ensuring that the mother's legal and ethical right to make informed choices and to be asked for consent to any intervention was respected by health professionals (National Collaborating Centre for Women's and Children's Health, 2014; Nursing and Midwifery Council, 2009, 2015). This is similar to the advocacy practised by caseload midwives who were found to be 'rooting for' mothers and 'fighting their corner' against obstetric colleagues who were attempting to impose interventions on mothers (Finlay and Sandall, 2009). The Nursing and Midwifery Council requires midwives to 'be an advocate for women' (Nursing and Midwifery Council, 2009). However, in the National Maternity Survey, a third of mothers said they were not always involved enough in decisions about their care during labour and birth, and 5% said they were not involved at all; single mothers and mothers from Black and Minority Ethnic communities were particularly likely to have been insufficiently involved (Henderson et al., 2013; Redshaw and Henderson, 2015). In the current study as in others (Bulman and McCourt, 2002; Higginbottom et al., 2016; McLeish, 2002), there were instances of midwives not fully respecting mothers' rights to make informed choices and to give consent, and it was the doula who had to advocate for the mother to the midwife.

It was a strength of this study that it was based on in-depth

interviews with both volunteer doulas and mothers, enabling the two perspectives to be analysed in parallel. There were also some limitations. The mothers interviewed were a diverse and predominantly disadvantaged group, but they did not reflect the full range of mothers supported by the doula projects, because none of those referred by children's social services were willing to be interviewed. Two mothers who would have benefited from professional interpreting did not take up the offer, preferring to use informal interpreting support from the project co-ordinator or partial support from a partner. Finally, midwives were not participants in the study.

Conclusions

Volunteer doulas can play an important role in improving women's birth experiences in England by offering continuous, empowering, woman-focused, physical and emotional support in a way that complements the more clinical role of midwives, particularly where there is no midwifery caseload care and the mothers are disadvantaged. While doulas were generally very clear about the boundaries of their role, some blurring of these boundaries may be initiated by midwives as well as doulas. There is a need for greater clarity about the scope of legitimate volunteer doula advocacy on behalf of their clients, to maximise effective working relationships between midwives and doulas.

Ethics approval and consent to participate

The University of Oxford Medical Sciences Ethics Committee (reference MSD-IDREC-C1-2013-111) approved the study. An information leaflet was provided and written informed consent to participate was obtained. Women consented to data collection and for their experiences to be used in reports or publications with no details or other information being published that could identify them.

Availability of data and materials

Following the consent process the individual qualitative interview transcripts will not be made publicly available.

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Author contributions

This study is part of a programme of work, the research questions for which were developed by MR and JM. MR and JM conceived and developed the outline for this study. JM undertook the data collection and JM and MR both took part in data analysis. JM drafted the manuscript with input from MR. Both authors were involved in interpretation, review and revision of the draft manuscript and approval of the final version. Conflict of interest

The authors declare they have no conflict of interest. Clinical trial registry and registration number

Not applicable.

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