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**The processes of implementing and sustaining an intensive volunteer one-to-one support (doula) service for disadvantaged pregnant women.**

**Jenny McLeish, Helen Spiby, Zoe Darwin, Helen Wilmot, Josephine Green**

### **Abstract**

'Doulas' (lay women who are trained to support other women during pregnancy, birth and postnatally) can improve outcomes for disadvantaged mothers and babies. This Realist Evaluation study uses qualitative interviews to explore the views of staff, commissioners and local champions about the processes of establishing and sustaining five volunteer doula support projects in England. The six key factors in their successful implementation are: fitting with local commissioning priorities; staff commitment and skills; networking with other agencies; defining and marketing the role; providing strong support for volunteers; and having some costs absorbed by others. The four key factors in sustaining the projects are: finding ways to balance the numbers of referrals and volunteers; shaping the service to local service drivers; constant networking; and creative responses to funding shortages. It is a constant challenge to balance the rate of referrals and the number of trained volunteers within tight budgets and timescales.

Pregnant women in disadvantaged circumstances (including poverty, recent migration, teenage pregnancy and domestic abuse) are less likely than other women to access maternity services (Downe et al, 2009) and more likely to experience poor birth and child health outcomes (Confidential Enquiry into Maternal and Child Health, 2009) and poor mental health (O'Hara and McCabe, 2013). 'Doulas' are trained or experienced lay women who support other women during pregnancy and birth, but do not provide any clinical care. There is international evidence linking support from a doula with improved physical and

emotional outcomes for mothers and their babies (Nommsen-Rivers et al, 2009; Hofmeyr et al, 1991; Campbell et al, 2006; Kennell et al, 1991; Wolman et al, 1993).

Although the practice of experienced women assisting other woman at birth is ancient and widespread across cultures, the modern doula role has developed since the 1970s, primarily in North America but spreading to Australia and the United Kingdom and with small numbers of doulas active in most European countries (European Doula Network, undated; Steel et al, 2015). Doulas are unregulated but national associations provide training and/or accreditation in some countries (Steel et al, 2015). In the United Kingdom, the national association has over 600 members, the majority of whom are self-employed private doulas who charge fees of £600-£2000 per birth (Doula UK, undated). The setting-up and sustaining of volunteer doula projects in England is the subject of this paper.

National Health Service (NHS) maternity care in England is free at the point of delivery, and midwives provide clinical care and support for most women during pregnancy, birth and the immediate post-birth period. However, midwifery staffing levels are low, and midwives do not normally have the capacity to provide meaningful social support to vulnerable women (Care Quality Commission, 2014). Recognising that vulnerable women may be 'hard-to-reach' for maternity services, in 2010 the National Institute for Health and Care Excellence (NICE) recommended research into the effectiveness of third sector family support on improving outcomes for mothers and babies (National Institute for Health and Care Excellence, 2010). Although volunteer breastfeeding peer support schemes (Dykes, 2005; Muller et al, 2009) and schemes that provide volunteer social and mentoring support to new mothers (Barnes, 2006; Suppiah, 2008) are well established in England, volunteer support for pregnant women is underdeveloped. There has been recent interest from funders in testing volunteer support for disadvantaged pregnant women, with pilot schemes including peer supporters for pregnancy and early parenthood (Bhavani et al, 2015), and volunteer support to improve mothers' mental health (Barlow and Coe, 2012).

An issue that has been raised in a number of studies involving laypeople in maternal and child health is that professionals may feel threatened by the potential erosion of boundaries

between their roles and the roles of non-professional supporters (Glenton et al, 2013; McInnes and Stone, 2001; Murphy, 2008; Thomson, 2015), including where doulas were hired by mothers in North America and Australia (Steel, 2015; Stevens et al, 2011). This echoes the substantial concerns about volunteers being used to substitute for professionals which have been voiced across other public sector fields (Strickland and Ockenden, 2011; Naylor et al, 2013), and which are expected to intensify with funding cuts driven by UK government 'austerity' policies (Naylor et al, 2013). It differs, however, in that maternity health professionals who oppose volunteer roles tend to see them as superfluous, amateur, and interfering with their own relationship with the mother, rather than directly threatening their jobs (McInnes and Stone, 2001; Thomson, 2015; Murphy, 2008).

The limited evidence on the actual processes of setting up and maintaining one-to-one volunteer schemes in the maternal and child health field (Barlow and Coe, 2012; Dykes, 2005; Suppiah, 2008; Watt et al, 2006) emphasises the key role of the volunteer co-ordinator, the importance of networking with health professionals to gain referrals, and the challenges of recruiting, training and retaining volunteers, resonating with the wider volunteering literature (Naylor et al, 2013; Ockenden and Stuart, 2009; Volunteering England, 2009). There is no previous research on the process of establishing and running volunteer doula schemes. This paper reports independent qualitative research on the processes of setting up and sustaining five schemes in England that provided free one-to-one volunteer doula support to disadvantaged women during pregnancy, birth and for 6-12 weeks after birth. The research was carried out between 2011 and 2013.

### **Setting**

One of the five schemes considered by this research was England's first volunteer doula project for disadvantaged women, established in 2005 as part of a social enterprise. The other four were replication sites established in 2011 with funding from the Department of Health to support set-up, but not running costs. One was hosted by a NHS organisation and the others were all based at independent community organisations. All served economically and socially disadvantaged communities.

At each site the project recruited unpaid volunteers from the community and prepared them for the doula role with a training programme of 12-20 weeks (depending on the site) that included portfolio completion and an oral assessment to achieve an accredited qualification. Pregnant women in disadvantaged circumstances were referred to the projects by health and social care professionals or could self-refer. Following an initial interview, project staff would 'match' the woman to a doula, and the doula and client would arrange how often and where to meet (on average, two hours a week). Support continued until the baby was six weeks old at four sites, and until the baby was three months old at one site. Support varied according to the client's needs and the doula's availability, but could include: emotional support through non-judgemental active listening; giving information about pregnancy, birth and parenting; preparing for birth; support during labour; breastfeeding support; signposting and introducing the client to local services; practical help (for example with finding free baby equipment); and accompanying the client to health and other appointments. The project staff aimed to give doulas regular supervision.

### **Methods**

This paper arises from a larger study (reference removed for blinding) and focuses on the question "What are the processes of implementing and sustaining a volunteer doula service for disadvantaged childbearing women?" The study took a Realistic Evaluation perspective (Pawson and Tilley, 1997), in recognition of the complexity of the intervention being investigated in five real-life settings (McCourt, 2005). This means that the focus was on "how the intervention works, and for whom and in which circumstances" (Pawson and Tilley, 1997). The aim was to understand the contexts (C) in which hypothesised mechanisms (M) lead to particular outcomes (O) and particularly to understanding the contexts and individuals for whom the intervention is more or less effective. The first stage of data collection therefore included interviews with key informants to explore their beliefs about how, when, and for whom the intervention was and was not effective, including the enablers of, and barriers to, establishing a volunteer doula service. Ethics approval was obtained from the University of York's Department of Health Sciences Research Ethics Committee for preliminary data collection and from the West Midlands Multicentre Research Ethics Committee for remaining components of the research.

We initially interviewed eleven members of staff, who were the project managers and the project workers responsible for matching women with doulas at each site. The majority were re-interviewed a year later to identify changes and factors related to sustaining their services. We also interviewed the former manager of the original site, four local commissioners (one site had not been commissioned) and four 'local champions', identified to us by project staff (at the fifth site a local champion had already been interviewed in another role).

Potential participants were provided with written information explaining the research and inviting them to take part in a telephone or face to face interview at a time of their choice. Individual and group semi-structured interviews were digitally-recorded, following written informed consent. The topic guide for project staff covered: how the service worked in practice; underlying beliefs about how it worked; the contexts in which it had more or less impact; and the enablers and barriers to establishing a doula service. That for commissioners covered: local commissioning arrangements; relationship with the doula service; influences on the decision to commission; challenges encountered; and their perceptions of the service's future. The topic guide for local champions covered: relationship with the service; perceptions of impact; and barriers to establishing and continuing the service.

The recordings were fully transcribed and the transcripts were analysed using inductive thematic analysis (Braun and Clarke, 2006): each transcript was read and reread, codes were identified and recorded manually, and emergent themes were identified. These emergent themes contributed to the development of theories about the Mechanisms that might result in particular Outcomes in particular Contexts (Pawson and Manzano-Santaella, 2012), using Jackson and Kolla's technique of coding data extracts for each element of the CMO configuration (Jackson and Kolla, 2012). In the presentation of Findings, the letters (C), (M), (O) are used to highlight Contexts, Mechanisms and Outcomes. Any given circumstance (e.g. volunteer drop-out) can potentially be seen as more than one of these, depending on the focus.

## Findings

Different themes emerged for implementing and sustaining doula projects, as shown in Table 1.

### Implementation

#### ***Meeting local commissioning priorities***

Commissioners said that they had chosen to fund the doula services for three reasons, each of which is an Outcome (O) in Realist Evaluation terms: because the service could reach vulnerable families who were least likely to access maternity services; because they were a pathway for volunteers (often women with limited education and aspirations) to access training and ultimately paid work; and because they met some public health priorities in the context (C) of overstretched maternity services.

*When the project first started it was for the pregnant women, and then it was found that it was having a really positive effect on the volunteers...Some hadn't even finished formal education...hadn't worked, had babies straight away and just felt that that was their lot in life. And then they would go into a doula project and... one of the things we found was a really high number going into the medical and nursing services...and it enabled them to suddenly have this opportunity to realise that educationally they could achieve way more. (Commissioner, original site)*

*The volunteers...are from that community and are known in that community... it actually got over some of the barriers that professionals have traditionally had in terms of those harder to reach communities... it's an area that's a challenge for me in terms of hitting some of the key targets around maternity booking [timing of accessing care] and breastfeeding, but it was about filling a gap, because maternity capacity locally, in terms of midwives, were not able to fulfil a lot of the extended role, and the more holistic approach that is required for some of these communities. (Commissioner, replication site)*

#### ***Staff commitment, expertise and skills***

The project managers were highly committed, working long hours and adopting flexible roles to avoid having to turn a vulnerable woman away.

*At points where we didn't have enough volunteers ...I used to do the volunteering, the doula-ing myself. (Staff member, original site)*

This may be considered as Context (C) because it can be conjectured that without this in place the desired outcomes would not be achieved. The wide experience and different professional backgrounds of staff (C) contributed to the establishment of the project and their existing links with health and other agencies facilitated communication.

### ***Networking***

All the projects understood the importance of establishing a visible and credible presence within their local health and social care economy and the voluntary sector (C/M), so that professionals would make appropriate referrals (M/O), and potential volunteers would hear about the project. This also facilitated effective signposting by the doulas to other agencies (O). Networking methods included attending local multi-agency and midwives' meetings, inviting other agencies to attend the project's meetings, involving local midwives in the doula training, and representation of a wide range of agencies on the doula project's steering group. Some projects benefited from being part of a larger organisation with an established local reputation.

### ***Defining and marketing the doula role***

As doulas were a relatively new concept in the UK, the projects had to explain their role: neither to replace a midwife nor to displace a woman's own partner, family or friends, but to complement what they offered with mother-focused support. Some services replaced the term 'doula' with more easily understood words. Clarifying the 'offer' was an important aspect of promoting the service (C/M) both to women, many of whom already had several agencies involved in their lives, and to professionals, who could feel threatened by the scope of the new service. The projects used various promotional strategies (C/M) including local media, leaflets in health and community venues, and volunteers running promotional stalls in the town centre or hospital and advertising at parent and toddler groups.



*We do a lot of promotional work in the city, letting everybody and anybody know about the service...we get referrals in both from the women... [and] from the statutory agencies, like midwives and children's centres and Social Services and other voluntary organisations. (Staff member, original site)*

*We train the doulas not to advise .....it's all about making the mum feel a bit in control of her own situation. Because they feel so bombarded by all the different organisations ...that makes a lot of difference to make the mum feel as if they're her decisions, about her baby, about her pregnancy, and the doula's there to support the mum. (Staff member, original site)*

At three of the sites, there was initial tension between the doula service and the local midwifery service (C). This included: midwives' concern about overlapping roles; doulas overstepping some of the boundaries set out in their training; and some midwives' previous poor experiences of working alongside paid doulas which had given them a negative impression of the doula role.

*[T]he question that I get asked most when I go [to speak to midwives] is...what are the boundaries, first off?... What are the volunteer doulas going to be doing actually in here? Are they going to be taking the jobs of maternity assistants? (Staff member, original site)*

These initial tensions were resolved through a combination of reinforcing and clearly marketing the boundaries of the doula service, and midwives' positive experiences of working alongside volunteer doulas.

*We've really tried to highlight exactly what the role is, what the boundaries are, the little sections of the bottom of the leaflet saying that we don't provide medical or clinical advice. So very much pointing out exactly what we do and what we're here for. (Staff member, replication site)*

*It took [the midwives] a bit of a time to get used to it, thinking 'Are these private doulas?' but... as they have worked with [the doulas] on delivery suite, things are changing, positive working relationships....We have always highlighted that [the doulas] have responsibilities, their role is a non-clinical role and the midwives are there clinically, so knowing that they are not going to step on each other's toes really.*  
(Staff member, replication site)

### **Supporting the volunteers**

Like other volunteer-based projects, the doula projects faced the challenge of maintaining the volunteers' motivation (C) so that the projects could reap their substantial investment in the training (O). While they saw volunteers' progression into education or employment as a positive outcome from a community development perspective, they also stipulated a minimum number of women to be supported by each volunteer before leaving the project (M) (some projects did this from the outset and others based on experience).

Recognising the emotional demands of doula work, projects worked hard to develop ways to support volunteers. These included responding to the doulas' self-identified training needs with on-going group training which also brought doulas together for social support; regular supervision sessions; debriefing after births; access to counselling services after a traumatic event (such as stillbirth); linking new doulas with a more experienced mentor; and an open-door policy at the project office. In addition, some replication sites adapted the training (M) to better equip their doulas to meet local needs (O).

*I have never in my life seen a project that manages to get such value out of volunteers but also gives so much back...it has crystallized the whole issue around social capital really. Which wouldn't have meant anything to me before - I was of the view that managing volunteers was challenging and 8 out of 10 times disappointing for both the volunteer and the organisation.* (Staff member, original site)

### **Costs absorbed by others**

None of the doula projects was freestanding: each was hosted by a third sector organisation or (in one case) NHS organisation (C). Three of the projects had benefited from 'in kind' support from their host organisation or another organisation, for example providing free premises, or workers from different services at the host organisation helping each other out. Members of staff and others had also donated their time, for example staff worked unpaid hours and local champions contributed time to the doula training.

## **Sustaining the doula services**

### ***Balancing numbers of referrals and volunteers***

All the projects faced the challenge of balancing the numbers of trained doulas with the numbers of referrals received. Recruiting and training a group of doulas was a lengthy process, and funding was not always available for the planned number of training cohorts. Too many referrals meant making unwelcome choices about who could be supported or risking overburdening volunteers, and too few referrals meant that doulas became demotivated when they were unable to put their training into practice, as happened at one site.

### ***Increasing referrals***

Each project had criteria for who would receive the service, for example, women from a defined geographical area or with specific needs. Where referrals were slow (C), the doula services proactively targeted new sources of referrals (for example, promoting the service at GP surgeries, or making links with a mental health agency) and became more flexible about eligibility criteria (M). Three sites had adjusted the period during which they offered support to meet changing needs, and two had adapted to accommodate early referrals from social services. One project had extended the postnatal visiting period from six weeks to three months, which had enabled them to work constructively with late referrals. This had proved particularly effective for women who did not attend antenatal care, those who had just moved into the area, and those in homeless hostels. Another service extended the postnatal period of support if the baby had been taken into care or the mother had health needs.

*Now our support continues three months postnatally so a late referral we no longer see as, 'Oh well, this will be impossible to be of any use here or to make any*

*difference' ... We thought [it] would be very easy to just tell partner [services] we don't accept referrals after thirty-four weeks and, actually, we were wrong. We've done some very good work with late referrals. (Staff member, replication site)*

### *Retaining volunteers*

Four of the projects had continued to reflect on and improve the support and opportunities they offered to their volunteers, to maintain motivation and increase retention (M/O). At one site staff strived to ensure that volunteers felt valued and kept them up to date on plans and service developments; at two sites experienced volunteers were offered the chance to mentor newer ones or take part in the support aspects of supervisions; at another supervisions were refashioned with new ideas and a new group format (requested by the volunteers). None of the sites mentioned volunteers leaving the project to become private doulas, although some had gone on to train as midwives.

*[A]ll new doulas are mentored on their first match. And what it's done for the experienced doulas is give them so much confidence that we trust them to actually explain the procedures correctly...So it's not only going to make good doulas from the new intake but I also think it is going to strengthen and reinforce the existing doulas that we are a team and we trust them. (Staff member, original site)*

Two of the sites had experienced problems with volunteers discontinuing training, or not supporting any women once trained (C/O). One site had responded by adjusting the content of their taster course so that volunteers had more realistic expectations of the training and doula role. The second site had incorporated a requirement to support some women into the training itself, making this a prerequisite of the training qualification being awarded. That site also noted that a supportive relationship between the volunteers and their project worker (M) was very important for retention of volunteers (O), and there had been difficulties with retention during the project worker's absence.

*We have learned as we have gone along. We didn't initially make the stipulation, but now we say until [the doulas] have done two mums and two backups they won't get their certificate. So this is part of the training. (Staff member, replication site)*

One site had encountered a serious problem with volunteers' availability: 50% of women referred wanted a doula with them for the birth, but 70% of the volunteers were for personal or cultural reasons unavailable to work at night. As a birth supporter would need to be on call 24 hours a day for a period around the baby's due date, the project had decided to be even more explicit about this at the recruitment stage:

*The mums who need labour support means you can be called any time 24 hours but only a few volunteers are available to support during night time...In the induction day we are making them sign an agreement that they have to be available and when I make the presentation on the open day I will make it all clearer...When I do the interviews I will ask the question specifically about availability and who will look after their kids. (Staff member, replication site)*

### **Shaping the service to local service drivers**

The research reported in this paper was carried out at a time of major changes to the commissioning processes for health and social care under the Health and Social Care Act 2012, which brought in new Clinical Commissioning Groups. The uncertainties associated with these new structures (C) had implications for the stability of funding of the doula services (O), and the projects had responded flexibly to the new commissioning priorities (M).

At the original site the project had had to evolve from an initial focus on birth support to include wider public health priorities around healthy lifestyles (C), and this had meant a subtle change in the doula-woman relationship as the volunteers were now expected to challenge women about their health behaviour, such as smoking in pregnancy (O).

*It has been a culture change for the organisation, the volunteers were reluctant to take on that side of work ... and the managers weren't that keen either because when the volunteer doula project started, it was really focusing on a natural childbirth and the impact of a natural and enjoyable birth had on parent and baby opportunity to bond... And I think that then became a bit tricky because they suddenly had to start*

*challenging women about behaviour and that is kind of changing the relationship a bit. (Staff member, original site)*

At the same site there was a new commissioning emphasis on early intervention for troubled families, and the doula service responded to this with additional relationship training for all their volunteers. Several sites had found that they were increasingly receiving referrals from social services (C), for example to support women whose child might be removed, and that these referrals were pushing the volunteers into new territory (O) - there was more paperwork and attendance at many more meetings, including Multi Agency Risk Assessment Conferences (MARACs).

*When you look at the referrals, before it was either self-referrals or referrals from the hospital or children's centres. When you look now, Social Services are recommending us at MARACs....because we do make a difference for that woman engaging with others, in a multi-agency approach. So it's very different from what it [was]. (Staff member, original site)*

These safeguarding situations were very resource-intensive for the projects, because the doulas needed extra supervision, debriefing, and training, and project workers also had to write reports and give the women and doulas additional telephone support.

*I think sometimes that's where we struggle if we are looking at how many doulas we've got because what you are doing is saying when you've got eight or nine safeguarding cases, the time that you take to support them, you could quite easily have supported twelve cases that were not safeguarding. (Staff member, original site)*

### **Ongoing networking**

As funding challenges and commissioning changes affected the local voluntary sector and health and social care organisations (C), small non-governmental organisations came and went and there was significant staff turnover among health professionals (O/C). This meant that the task of networking to build up a local profile was never-ending. Project staff had to

constantly invest time in building links with new colleagues in other organisations (C/M), and limited staff time meant that at some sites it was difficult to maintain a range of networking activities.

*Always networking, always having the service absolutely there, responsive, reflective, you know, making sure that we are one hundred percent on the ball. (Staff member, original site)*

### **Addressing funding shortfalls**

A volunteer doula project is an intensive intervention and the service takes time to become established, as it needs to simultaneously build a local reputation to gain referrals from other services, and to recruit, train and support the volunteers who may work with an individual woman for up to six months. However, only two of the projects had received the amount of funding they had initially requested from commissioners and for the time period required. One site had only received transformational seed funding, and another had sought one year's funding, but only received eight months' worth.

Detailed information on the costs of running these five doula services can be found in (reference removed for blinding). Some costs had been impossible to anticipate accurately – for example, the costs of interpreting, childcare while volunteers were training, external accreditation of training, and security for the doulas.

*I think the cost that is the one that fluctuates the most is translation costs... ...I mean I say 'fluctuates', it tends to go up rather than down. (Staff member, original site)*

The projects used three mechanisms (M) to cope with ongoing funding shortfalls (C) – economising, pursuing multiple funding streams, and staff 'going the extra mile'. The projects made great efforts to economise in the face of funding challenges. Several of the sites had postponed training more volunteers, one planned to reduce volunteers' supervisions, one was involving volunteers in the support of other volunteers to reduce the supervision burden, and one had stopped using the original site's database because of cost.

*At the moment [staff member] is doing [supervision] using some of the more experienced volunteers...to be not necessarily providing direct supervision but providing the support side of the supervision. She has set up little teams which I think is a very creative way of doing it without having that additional person in post. (Staff member, replication site)*

As well as making their funding stretch as far as possible, project staff creatively pursued multiple funding streams. For example, two sites were exploring a funding route that would involve paid doula work helping to sustain the unpaid doula service. It was important for future funding that the sites could demonstrate effectiveness by recording data on their activities and impact. Three of the replication sites had chosen to create their own database which they felt met their local needs more effectively than the database created at the original site.

To some extent, staff buffered the funding shortfalls by taking on more tasks themselves, coping without proper administrative support, and at one site accepting a pay freeze that saw inflation erode the real value of their salaries. In one project, staff were rather overwhelmed to discover that there was far more skilled work involved in recruiting and supporting volunteer doulas than they had anticipated, even though the host organisation had extensive experience of working with volunteers in other contexts.

*[We are] embedded in a big organisation that is consistently having to spend less and provide more... we are all having to do more than we first were employed to do. (Staff member, replication site)*

*We were really running to keep up, to start with, because there was so much to do, and we didn't have the staff that [the original site] have. (Staff member, replication site)*

There was, however, a limit to how much even the most dedicated staff could do. At one site, the pressure of personally managing the safety of volunteers when going into family



homes had become unsustainable, so an additional cost had to be incurred with the hiring of a security company to do this monitoring.

*In the early days it was quite a lot of a burden where doulas would ring me to say 'This is where I am, this is my location.' I would have to call them back after an hour later and literally throughout the day and night. ....in the last year we've had [security company] who've taken over that, and they've been...really good. (Staff member, replication site)*

### **Discussion**

An intervention such as a volunteer doula project is set up with the intention of achieving certain outcomes, some of which are ultimate goals (helping disadvantaged childbearing women), while others may be stepping stones along the way (maintaining a motivated group of trained volunteers). Some outcomes may potentially conflict with each other, for example, the needs of the supported women versus those of the volunteers. Using Realist Evaluation as an analysis tool allowed us to focus on the different outcomes, both intended and unintended, that were identified by research participants, and to explore the many and varied contexts that shaped the actions leading to these outcomes. The comment from one participant that *"I have never in my life seen a project that manages to get such value out of volunteers but also gives so much back"* was a useful starting point for examining what it was about the Contexts of this scheme that led to these dual Outcomes: 'value from volunteers' and 'giving so much back'.

It is recognised that recruiting the right volunteers and retaining them is inherently challenging for any organisation, and high turnover is normal (Ockenden and Stuart, 2009; Volunteering England, 2009). The fact that volunteers are unpaid does not mean that they are 'free', because there may be significant training and support costs (Institute of Public Care, 2015; Taylor et al, 2011), and without a proper support infrastructure volunteers may become demotivated and leave (Institute of Public Care, 2015; Marden et al, 2013; Volunteering England, 2009). However, projects that provide volunteer support to new parents have been bedevilled by low funding and an underestimation of the complexity of

“the multifaceted role of the Project Coordinator with its array of constantly competing tasks” (Barlow and Coe, 2012), which leads to unrealistic assumptions by funders about what can be achieved with the limited funding available (Suppiah, 2008).

These challenges were particularly acute for the volunteer doula services, which trained volunteers to an accredited standard over a substantial period of time, and then expected the volunteers to offer intensive one-to-one support to women for up to six months around the time of birth. The volunteers needed to be prepared for and supported through the challenging emotional circumstances that could arise in the course of their long term engagement with clients, who often had more complex needs than the services had originally envisaged. They needed to have the skills to deliver a high quality personalised service to vulnerable women, and to pass the scrutiny of health professionals when their volunteering was highly visible (for example, at a birth). The projects had to organise both professional supervision and, unusually for a volunteer project, safety procedures for night working at births as well as home visiting. Staff at one site observed that there was much more work involved in running the doula project than in running their other volunteer-based services.

It was also apparent that when the projects began, volunteers were not always aware of the full extent of the doula role, which included being constantly on-call around the expected date of birth, supervisions and training, as well as weekly visits. Some volunteers were unable to cope with these demanding requirements and found it difficult to balance family responsibilities with their volunteering, which had led some to leave the projects and others to restrict their availability. Because we interviewed staff at two time periods, we were able to see their expertise in managing this issue developing: they felt that with experience they had themselves gained a better understanding of the necessary time commitment from volunteers. They had improved the robustness of their recruitment process, avoiding disappointment on both sides by ensuring that all volunteers who were accepted for training had realistic expectations. They also enabled volunteers who needed a temporary break for personal reasons to remain part of the projects (reference removed for blinding).

In parallel with this process of engaging, training and supporting doulas, the volunteer doula service needed time to establish its credibility within the local health and social care economy and win over professional groups who could at first feel worried by the support activities of the volunteer doulas. This reflects the concerns of health professionals in other contexts who have feared that their authority would be undermined by volunteers and have sometimes been obstructive 'gatekeepers' to volunteers' services (McInnes and Stone, 2001; Curtis et al, 2007; Dykes, 2005; Murphy, 2008). It was encouraging that the experience of these doula projects was that over time, these concerns were overcome by midwives' positive experiences of working alongside volunteer doulas and in particular their confidence that the doulas understood the boundaries of their role; this process was assisted by the doula projects inviting midwives to have input into the doula training (Akhavan and Lundgren, 2012). This suggests that conflicts between health professionals and volunteers are not inevitable where there is absolute role clarity and trust, and that contrary to some studies in other countries' maternity contexts (Stevens 2011; Steel et al 2015), doulas from outside the healthcare system can be accepted by maternity professionals when they are confident the doulas will not challenge their clinical authority.

Even with local credibility established, because of staff turnover in other organisations, it was essential for the doula services to continually network with health and social care professionals to maintain awareness of their service, and also to publicise their service to women by other means. This requirement for ongoing networking may be particularly important in the maternal and child health field, as reflected in the experience of breastfeeding peer support projects (Dykes, 2005), infant feeding (Watt et al, 2006) and support for maternal mental health (Barlow and Coe, 2012). Whereas one-to-one volunteer projects in the fields of chronic illness (such as HIV) may be able to make links with and gain referrals from small, specialised healthcare teams (Positively UK, 2014), the healthcare 'team' for most pregnant women is drawn from a large pool of midwives and other health professionals working across multiple community and hospital settings, with substantial variation in referral practice unless the referral option has been incorporated into an established care pathway (Redshaw and Henderson, 2015).

Prolonged and intensive engagement between doulas and the woman they support is a key feature of volunteer doula services. This differs from some of the other peer support schemes in the maternity context where support may be less intensive, of shorter duration and not necessarily include face-to-face meeting, and where the volunteers may have less training (Dennis et al, 2009; Dykes, 2005; Jolly et al, 2012; Muller, 2009). Doula services may therefore need even more time and resources in order to establish and optimise the balance between a steady rate of professional referrals to the service, and the number of trained volunteers. The doula services worked to achieve this by carefully defining and publicising the service, ongoing networking with professionals and voluntary sector workers, and giving support to the volunteers to motivate and retain them in the project. This balance was, however, particularly difficult to achieve when short-term funding made it difficult to plan ahead, as training a new cohort of volunteers was a substantial investment, and some of the services had had to suspend plans for training more volunteers. Likewise the project staff, who were key to the effective support of volunteers, had to spend substantial amounts of time away from the core activities of the project because of the continuous need to fundraise. Short term funding of a year or less was not sufficient to enable a doula project to build up the essential local profile and networks, yet annual funding with the grant confirmed or withdrawn at the end of every financial year is now normal for local authority funding of third sector organisations (Lindsey, 2013), and the National Council for Voluntary Organisations estimates that between 2010 and 2018 funding for the third sector will have fallen by £1.7 billion across the UK (Bhati and Heywood, 2013).

There could be a tension between what commissioners saw as two key strengths (Outcomes) of the doula projects, firstly the ability of volunteers to reach and connect with 'hard to reach' communities and thus to help deliver local public health priorities, and secondly the transformation of volunteers' own life chances through the re-connection with education provided by the accredited training and their subsequent increase in self-confidence. Where newly-empowered volunteer doulas quickly left volunteering to take up further education or employment, this was a 'win' from a community development perspective, but also represented a 'loss' in terms of the substantial wasted investment in training (Volunteering England, 2009). This was brought out clearly through the Realist

Evaluation lens, as different Outcomes are likely to need different Contexts and Mechanisms to bring them about. In line with South et al's (2014) analysis of the complex issues surrounding payments for 'volunteers' in public health initiatives and the varied approaches to providing financial and non-financial incentives, it appeared that some of the doula projects saw that supporting a specified minimum number of women was a way for volunteers to 'pay back' the cost of their training.

It was a strength of this research that it included the views of staff from all of the first five doula projects established in England, with some staff re-interviewed a year later to reflect on developments and challenges as projects became more established, and with their views about 'what works, for who and in what circumstances' to set up and run volunteer doula services triangulated with the views of commissioners and local champions involved in establishing the services. It was a limitation that the findings drawn from replication sites reflect services still very much in development, in comparison with the established original service. However, commonalities in the services' experiences rendered it reasonable to combine the findings from all services.

### **Conclusion**

Volunteer doula projects can make a positive contribution to physical and psychological outcomes for new mothers and their babies (reference removed for blinding). The doula role has some specific challenges from a volunteering perspective, including the substantial training and lengthy commitment required; the need for regular supervision, support and safety procedures to enable intensive and skilled lone working with vulnerable women; and the visibility of the role at a birth when the doula works alongside (and can be judged by) maternity professionals. However, tensions between health professionals and volunteer doulas can be overcome where role boundaries are clear and respected.

This research suggests a number of important requisites for setting up and sustaining a new one-to-one volunteer service for disadvantaged pregnant women. The service needs a committed manager and team with a flexible approach, experience of supporting volunteers, and adequate administrative support. It should be hosted by a larger organisation that is linked in to maternity, early years or community services and that will

be prepared to either accommodate some of the doula service's overheads or provide support in kind. It needs to establish systems to maintain its profile in the local area and with others agencies, to support referrals and networking, and to maintain these even when the service is established. It needs to clearly define the purpose and boundaries of the service, but also be prepared to flex these as local commissioning priorities change. It needs funding for a realistic timeframe that will enable it to recruit and train volunteers and to gain the trust of local health professionals. Finally it needs to be able to demonstrate effectiveness and impact by establishing systems that capture process and outcome data. Realist Evaluation proved a useful tool for focusing on the many different contexts that shape outcomes and we would recommend it as a heuristic device for other researchers.

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