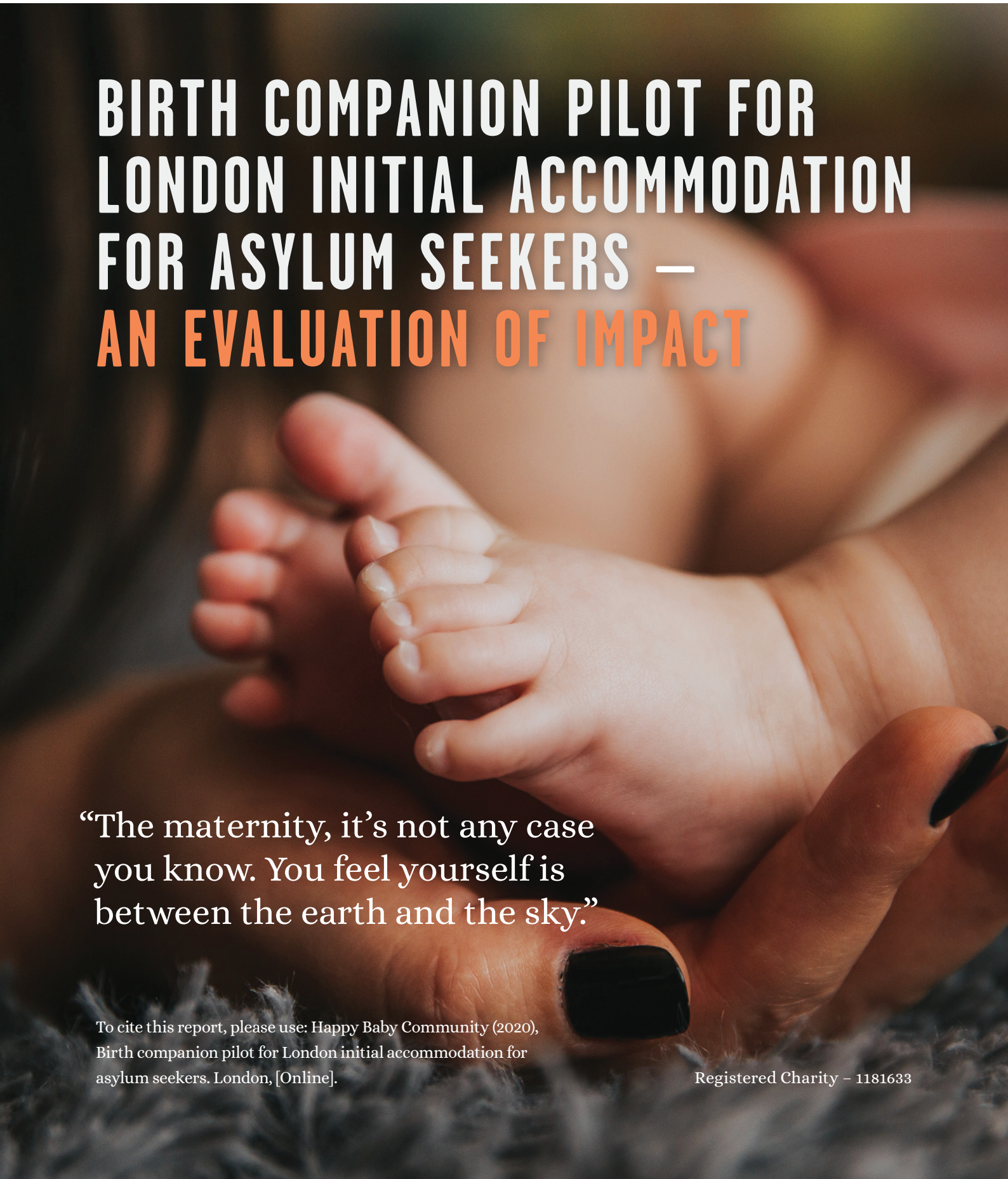
HAPPY BABY COMMUNITY

BIRTH COMPANION PILOT FOR LONDON INITIAL ACCOMMODATION FOR ASYLUM SEEKERS – AN EVALUATION OF IMPACT



"The maternity, it's not any case you know. You feel yourself is between the earth and the sky."

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ABOUT US

The Happy Baby Community (HBC) serves women across London who have experienced trauma, violence and/or abuse, who are seeking international protection in the UK and who are pregnant or have a new baby or young child.

Our two communities are safe and welcoming hubs where women can access multiple services and build the peer-to-peer relationships which will support them through the challenges of transitioning to motherhood whilst seeking asylum in the UK.

'The thing that I was most struck by was the first time I came to this project on Friday morning. Because I just walked in and I just felt like it was the most incredible atmosphere… I thought this is how good I know it can be and you rarely see that.'[Doula].

FOREWORD

People receiving maternity care in the UK have fundamental rights to dignified, safe and respectful care.

They are entitled to make choices about what happens to their bodies at this most significant of times. And they need to be cared for in an atmosphere of kindness and support. This is true whatever their background; whatever their circumstances.

Pregnant women who are seeking asylum are some of the most disadvantaged individuals in this country. New arrivals may be living in unstable and inadequate housing, dealing with trauma, and navigating new cultures and language, all without their friends and families' support. At the same time, they are preparing for birth and the transition to motherhood.

Individuals in this situation deserve the best care we can offer. Unfortunately, we know that this is not always what they experience. In 2019, Birthrights and Birth Companions published 'Holding it all together' which found that many women facing multiple disadvantage experience care that fails to respect their rights to choice and consent, to dignity and respect, and to equality of treatment. The research found that the experiences of women who were asylum seekers are often worse still.

The voices of women in this evaluation who did not receive doula support echo what we heard in researching Holding it all together. In both projects, women talk about being left alone at times that frightened them and being unable to access language support and interpretation. Women describe not even knowing that they were *able* to make choices in their care, let alone being supported to make the choices that were right for them. Their experiences make distressing reading.

It does not have to be this way. This excellent report shows that providing doula support hugely improves women's experience of care at a uniquely vulnerable time. I was particularly struck by the sense of safety that birth companions bring to women. Doulas support women to feel safe, but also to *be* safe, by empowering women to ask for help when they needed it. They provide much-needed practical and emotional support. They support women to understand their care and to make choices about what is right for their care and their bodies; something that is particularly important for women with a history of trauma.

This project offers a model for others to follow. It demonstrates the vital impact that doula support can have, and the benefits for everyone – woman and companion – when that is situated within a community of trust, support and safety.

As the report notes, the Covid-19 pandemic has highlighted how important it is that all women have access to a companion for emotional and practical support during and after birth. Yet women who are the most in need of support go without every day. This project shows that that need not be the case. The women in this pilot speak of being offered "hope and support" in "the most important moment of my life". Everyone should have access to that and this project shows how it can be achieved.

REBECCA BRIONE
Research & Partnerships Officer, BirthRights

EXECUTIVE SUMMARY

BIRTH COMPANION SUPPORT FOR WOMEN SEEKING ASYLUM

One of HBC's two communities primarily serves the 170-200 women a year who enter the asylum system in late pregnancy and give birth whilst housed in initial accommodation units for asylum seekers (IAUs). These new mothers face multiple disadvantage, have higher perinatal risks and experience numerous health inequalities.

In early 2020, HBC undertook a pilot project providing birth companion[1] support to this cohort, funded by NHS-England. This report evaluates the impact of this support on the labour and birth experiences of our community members and the effectiveness of our delivery model.

IMPACT OF BIRTH SUPPORT

Receiving continuous care from birth companions is generally accepted to be associated with improved perinatal outcomes for both mothers and babies[2]. We used a mixed-methods analysis to evaluate the impact of receiving professional birth companion (doula) support on the labour and birth experiences of women seeking asylum, when contrasted with a control group who gave birth without this support.

Women with doula support had significantly better labour and birth experiences overall than women who did not. Five primary themes emerged:

- **INCREASING EQUALITY FOR WOMEN FACING MULTIPLE DISADVANTAGE** Doula support increased equality, bringing the labour and birth experience for women seeking asylum closer to that of women living without disadvantage.
- **TRUSTING AND POSITIVE RELATIONSHIPS** Women seeking asylum saw doulas as compassionate and supportive and viewed them as 'standing in' for the families and communities they are cut off from.
- **SAFE AND APPROPRIATE CARE** Women with doula support felt significantly safer during labour and birth and found it significantly easier to ask for help than those who did not have doulas.
- **AUTONOMY, CHOICE AND CONSENT** Having the necessary information and understanding was key to women's ability to make choices and give informed consent. Without this, women were left feeling powerless. Women with doula support may have found it easier to understand their care and make informed choices.
- **RESPECTFUL AND DIGNIFIED TREATMENT** Women reported mixed experiences of maternity care and treatment regardless of the presence of a doula. Doulas felt they sometimes had to protect mothers from the discrimination that women facing multiple disadvantage can experience within the UK maternity system.

1 Birth companion' and 'doula' are used interchangeably throughout this report to describe women whose role it is to offer continuous, non-medical, social, emotional and practical support during labour and birth.

2 Bohren, M, Hofmeyr, G, Sakala, C, Fukuzawa, R, & Cuthbert, A (2017). Continuous support for women during childbirth. Cochrane Database of Systematic Reviews, (7).

EFFECTIVENESS OF DELIVERY MODEL

The delivery model (where birth companion support was offered via contact in established community groups) was an effective, accessible and sustainable model of birth companion support for women facing multiple disadvantage. Over the 2-month operational window:

- 96% of the target population enrolled in the pilot (n=23);
- 100% received antenatal and postnatal support;
- 100% of women who contacted us in labour (78% of those enrolled in project) received birth companion support (13 women received face-to-face support and 5 received virtual support due to the onset of Covid-19 and subsequent lockdown).

CONCLUSION

Women with doula support reported safer and more positive experiences of labour and birth. The pilot therefore met the goals of Better Births (2016)[3]to achieve maternity care that is "safer, more personalised, kinder, professional and more family friendly" for all families, and the NHS Long Term Plan (2019)[4] to drive down health inequalities.

The contrasts revealed in the evaluation (e.g. empowerment/disempowerment; control/loss of control; equality/inequality) demonstrate how imperative it is to hear the voices and experiences of those who are usually seldom heard and who face the greatest health inequalities. Situating birth companion provision within the Happy Baby Community, which is committed to a user-led operational model, put the voices of women facing multiple disadvantage at the very centre of their care.

Since this pilot was completed we have entered a global pandemic. Within the UK maternity world, there has been an emerging focus on the value of birth partners. Ensuring women go through labour and birth with a companion by their side has been rightly prioritised[5]. For most women, this companion is a family member or friend.

However some of the most disadvantaged in our society do not have the luxury of a social support network to supply a birth companion. Pandemic or no pandemic, the most disadvantaged women are expected as a matter of course to face long time-periods alone during labour (i.e. without a birth partner or a HCP present). As can be seen here in the experiences of the group that gave birth without doula support, this leaves them feeling unsafe and unable to ask for help. To quote the 'Holding it all together' report[6]: The time for change is now.

3 National Maternity Review (2016). Better Births: improving outcomes of maternity services in England.

4 NHS (2019). The NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan

5 Royal College of Midwives (2020). Birth Partners. Available at: https://www.rcm.org.uk/media/3887/birth-partners.pdf

6 Birthrights and Birth Companions (2019). Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care. London [online].

INTRODUCTION

Providing safe, personalised, kinder and more professional maternity care is widely accepted as a key aspiration in on-going transformation and improvement plans for UK maternity systems[7]. However, it is also widely acknowledged that some mothers face both additional barriers to receiving good quality maternity care and increased levels of perinatal risk. Black and minority ethnic (BAME) women face a substantially higher perinatal mortality risk[8]. Women facing multiple disadvantage are likely to have worse experiences of maternity care[9] and they and their babies are at a greater risk of dying[10]. It therefore follows that some mothers will need additional services and support in order that they are not left behind as our maternity care is transformed[11].

Women and babies who are seeking asylum, who are often both BAME and facing multiple disadvantage, are also at higher risk of adverse pregnancy outcomes[12]. BirthRights' and Birth Companions' 2019 report[13] explored the experiences of maternity care of women across London who were facing multiple disadvantage using a human rights perspective. They concluded that the experiences of women seeking asylum stood out as particularly poor even compared to those of other women facing multiple disadvantage.

It is possible that access to professional birth companion support could to some extent counteract asylum seeking women's poor experiences of maternity care. The concept of a 'birth companion' or 'doula' has re-emerged in the developed world over the last 45 years, as the issues inherent in a purely medicalised model of childbirth have become more apparent[14]. Doulas are women whose training is two-fold; first around a background understanding of maternity systems and childbirth (particularly the physiology of labour and childbirth), and second around supporting women socially, emotionally and practically during labour and birth. They provide a continuity of care that is lacking in UK maternity care today, but they do not fulfil any medical or clinical role during labour and birth and therefore always operate

7 National Maternity Review (2016). Better Births: improving outcomes of maternity services in England.

8 Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK (2018). Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16.

9 McLeish, J and Redshaw M (2019). 'Maternity Experiences of mothers with multiple disadvantages in England: A qualitative study'. Women and Birth, 32(2),178-184; Birth Companions and Revolving Doors Agency (2018) Making Better Births a reality for women with multiple disadvantages; Thomson, G and Balaam, M (2016). Birth Companions Research Project: Experiences and Birth Outcomes of Vulnerable Women. University of Central Lancashire.

10 Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK (2018). Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16; NHS London Clinical Networks (2016). London maternal deaths: A 2015 review.

11 NHS (2019). The NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

12 Heslehurst, N, Brown, H, Pemu, A, Coleman, H and Rankin, J (2018). 'Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews'. BMC Medicine, 16, 89.

13 Birthrights and Birth Companions (2019). Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care. London [online].

14 Steel, A, Frawley, J, Adams, J, & Diezel, H, (2015). Trained or professional doulas in the support and care of pregnant and birthing women: a critical integrative review. Health and Social Care in the Community, 23(3), 225-241.

alongside, ideally complementing, maternity service care. A recent Cochrane review exploring the effect of continuous support (from doulas/birth companions) during labour and birth suggests that it may improve both the experience of and the outcomes of labour and birth for women and babies[15].

Doula services in the UK to date have taken two forms: private services for those who can afford to pay for them, and a slowly increasing number of 'community' doula projects set up through the voluntary sector, focussed on supporting women facing disadvantage[16].

Reviews of voluntary sector projects across the UK providing doula support that is free at the point of delivery suggest that they can improve birth experience and psychosocial outcomes for disadvantaged women, particularly those who may not find it easy to engage with statutory services[17 18]. Most community doula projects follow the standard model whereby the doula builds a 1-1 relationship with the mother antenatally and then offers continuous support during labour and birth, plus time-limited postnatal support. Using this 1-1 matching model is resource-intensive in both human and financial terms, thus limiting the number of mothers that can be supported in any given geographical area/time-frame, and ideally requires referrals before the pregnancy is full-term, to give the doula-client relationship time to be established.

Reviews have also concluded that to be effective and sustainable, community doula projects need to be well-integrated (ideally formally-partnered) with other local organisations that can continue support after the early postnatal period and thus the doula support ends, or if possible embedded in organisations with a wider support remit[19].

Up to 200 women give birth each year whilst staying in IAUs for asylum seekers in London. Almost all have just entered the asylum system and access UK maternity care between 32-40 weeks of pregnancy. Bearing in mind previous work on how to ensure sustainability of community doula services in the UK, this pilot embedded doula support in an established project run by the Happy Baby Community (HBC) which supports expectant and new mothers seeking asylum with a wide range of services. Doulas both participated in the HBC South community and were then on-call to provide continuous 1-1 support to women during labour and birth.

This evaluation explores the impact of the intervention on women's experiences of labour and birth and the effectiveness and feasibility of the delivery model itself.

15 Bohren, M, Hofmeyr, G, Sakala, C, Fukuzawa, R, & Cuthbert, A (2017). Continuous support for women during childbirth. Cochrane Database of Systematic Reviews, (7).

16 Spiby, H, Green, J, Darwin, Z, Willmot, H, Knox, D, McLeish, J, & Smith, M (2015). Multisite implementation of trained volunteer doula support for disadvantaged childbearing women: a mixed-methods evaluation. Health Services and Delivery Research, 3(8), 1-332.

17 Spiby, H, Green, J, Darwin, Z, Willmot, H, Knox, D, McLeish, J, & Smith, M (2015). Multisite implementation of trained volunteer doula support for disadvantaged childbearing women: a mixed-methods evaluation. Health Services and Delivery Research, 3(8), 1-332.

18 McLeish, J., & Redshaw, M. (2018). A qualitative study of volunteer doulas working alongside midwives at births in England: Mothers' and doulas' experiences. Midwifery, 56, 53-60.

19 McLeish, J, Darwin, Z, Spiby, H et al. (2 more authors) (2016) The processes of implementing and sustaining an intensive volunteer one-to-one support (doula) service for disadvantaged pregnant women. Voluntary Sector Review: an international journal of third sector research, policy and practice, 7 (2). pp. 149-167.

DOULA SUPPORT IMPROVES THE LABOUR AND BIRTH EXPERIENCES OF WOMEN SEEKING ASYLUM AND FACING MULTIPLE DISADVANTAGE

A mixed-methods analysis (for a detailed methodology, see Appendix 1) was used to evaluate the impact of doula support on the labour and birth experiences of women seeking asylum and living in IAUs. Multiple choice and free comment questionnaires (n=20) (Appendix 2; Table 1A), plus qualitative interviews (n=3) were used to investigate the experiences of women giving birth with doulas (n=12) and without doulas (n=8). Multiple choice questionnaires (Appendix 2; Table 1B) were used to explore the experiences of midwives (n=23) working alongside doulas and focus groups were used to look at the perspectives of doula supervisors (n=3) and doulas (n=6) themselves.

Multiple choice answers from women with and without doulas were scored and used to create an ordinal dataset (Appendix 2, Table 1B). The non-parametric Mann-Whitney Test (with a Bonferoni-Holm post hoc adjustment) was used to compare responses between groups (with doula, n=11; no doula, n=8) and test for statistical significance. Comments, interviews and focus groups were recorded, transcribed and collated and explored qualitatively for emerging themes using an iterative process.

PROJECT FINDINGS

Overall, receiving professional birth companion support from women trained and experienced in supporting other women through birth in a non-medical capacity (i.e. doulas) significantly improved the labour and birth experience of mothers in IAUs when compared to a control group of mothers from the same IAUs who had not received this support.

The following themes emerged from the analysis: 'increasing equality for women facing multiple disadvantage', 'trusting and positive relationships', 'safe and appropriate care', 'autonomy, choice and consent' and 'respectful and dignified treatment'.

INCREASING EQUALITY FOR WOMEN FACING MULTIPLE DISADVANTAGE

Women seeking asylum and living in IAUs face multiple disadvantage, as demonstrated here. They are therefore less likely to receive good maternity care compared to other women in the UK and face higher perinatal risks. The goal of doula support in this pilot was to counteract the effect of the multiple disadvantages these mothers face by providing continuous support during labour and birth and thereby increasing the equality of their birth experience; their experience is otherwise likely to be both less positive and less safe than that of other women.

'Equality; that every life matters; that every woman has a right to feel supported and valued,' *[Doula]*

'STARTING BEHIND THE GATE'

These are women who, as one supervisor said, *'start behind the gate'*, when it comes to labour and birth. All the women in the evaluation (in both control and pilot groups) were experiencing one or more of the exemplar factors (i.e. recent migrant status) specifically identified in NICE guidelines (2010)[20], indicating that they require an enhanced model of service provision.

> *'She [the midwife] brought me milk [formula for her baby in hospital] but she said that next time you will have to pay for it. I didn't ask again because we don't have money.' [Mother; no doula]*

Everyone living in IAUs, as these women were when they gave birth, has no recourse to public funds and is living in extreme poverty. Most women room-share with non-family members up until birth. They are not always guaranteed sex-specific toilet and showering facilities.

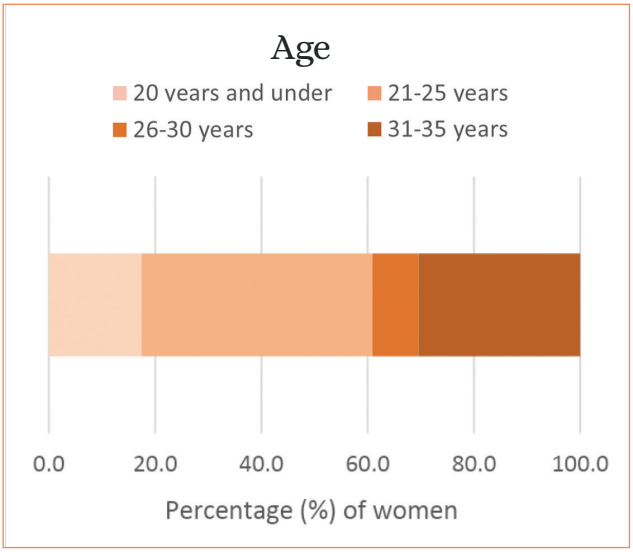
They receive 3 meals a day and basic toiletries but no cash subsistence allowance, *'They never have a choice about what they eat.' [Supervisor].* They are therefore dependent on receiving their £300 maternity grant to buy essential baby clothes and equipment, but the last survey showed that over half of women were not receiving this before birth and over a third still hadn't received it when their baby was 6 weeks old[21]. This delay leaves them completely dependent on charity to provide for their newborn baby.

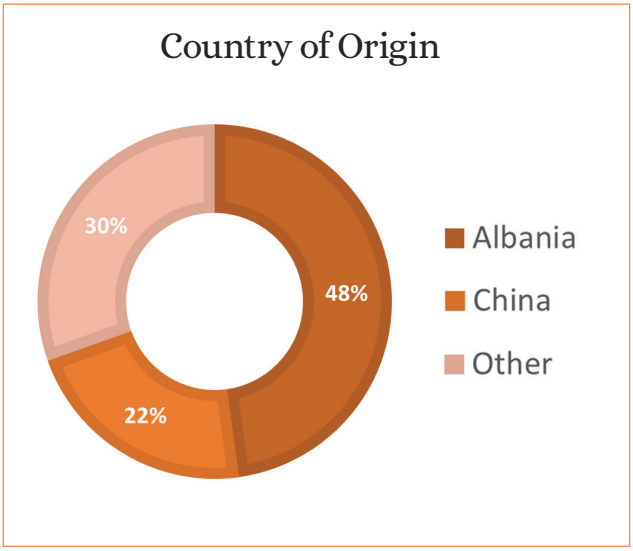
Women enrolled in the pilot group came from 7 different countries. Almost 50% (11/23) were Albanian and 20% (5/23) were Chinese, reflecting two of the source countries for trafficking to the UK. Others came from countries in Africa, South America, the Middle East and Asia. 100% said they had basic or no English and that they needed interpretation to understand what was happening during labour and birth.

[20] National Institute for Health and Care Excellence (2010). Clinical Guideline CG110 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors.

[21] Happy Baby Community, (September 2019). Internal survey.

Distribution of country of origin and age for all women enrolled in pilot





3/4 of women did not have a partner, or their partner was not with them in the UK. All were cut off from their wider network of family, friends and community. All women had just entered the asylum system. Three quarters were first-time mothers, and none had previously given birth in the UK. Some women had their older children living with them and others were separated from them. Women ranged between 19-34 in age, but almost 2/3 were 25 years and under.

Given their very recent entry into the asylum system, women living in IAUs when they give birth have not had the opportunity to develop any understanding of the UK in general or the maternity system in particular. It was clear that both lack of understanding of UK maternity services as well as women's cultural background and lived experiences meant that making and expressing choices, preferences and needs during labour and birth could be much more difficult for these women, *'They might not be as aware of the possibilities of the choices that they can make here in this setting or simply because in their own countries, such choices don't exist.' [Supervisor].*

'We are new here in the country... We don't know anything about this country.' [Mother, no doula].

39% of women in the pilot had known trauma histories, including domestic abuse, trafficking and FGM. For many this was very recent. Furthermore, given that it is well-established that many women will choose not to self-disclose trauma related to sexual abuse or assault, it is likely that 39% is a significant under-estimate.

Regardless however, all women living in IAUs are likely to have experiences of some form of recent trauma, for, as one mother said, *'No one left his country by... his [own] choice.' [Mother without doula; interview].*

The trauma they carry is likely to have a direct impact on their experience of labour and birth:

There was a sort of underlying sense that they thought they were going to have a battle on their hands,' [Doula; focus group].

'Often, the friends would give away to me more about the circumstances and they would say, 'Look, she's been through this awful time,' or 'This has happened to her, so she won't want that.' ...It's a difficult thing because some of them have so recently come from traumatic situations.' [Doula; focus group].

At the same time, their lived experiences may make it more difficult than it is for other women to speak about what support would help them, *'They were used to not trusting... They would say, 'If we say we don't want a man, then maybe no one will come.' I had to say, 'No, because that wouldn't happen in a hospital. Someone will come but we can wait.' Obviously, they've come out of situations where their trust has been betrayed.' [Doula; focus group].*

This is a group of pregnant women who not only 'start behind the gate', but for whom the gate isn't even in sight.

'BRINGING THE GATE INTO VIEW'

Doulas and supervisors agreed that the provision of doula support for this group of women has two primary strands: firstly, being present, providing companionship and support and ensuring that the mother does not have to go through labour and birth alone; secondly, providing information and supporting the woman to understand her choices, plus advocating for her needs and preferences when necessary.

Doulas and supervisors were both clear that the overall goal of providing labour and birth support is to increase the equality for these mothers, *'I thought that it gave the women an equality of experience with other women in the hospitals,' [Doula; focus group].*

Doula support can do this through practical means, *'I was there from 3 'til 10. It's so busy so I didn't actually have anything to eat - when the doula came she gave me chocolate. I think this was really important to give me energy,' [Mother with doula; interview],* and social/emotional means *'we could be relaxed because we were... just another family in a cubicle having a baby.' [Doula; focus group].*

TRUSTING AND POSITIVE RELATIONSHIPS

The theme running through the qualitative analysis is the high value that women seeking asylum placed on receiving doula support during labour and birth and the remarkable degree to which both doulas and mothers felt that they were able to build a trusting and supportive relationship. Our 360-degree feedback shows that doulas are eminently capable of building strong relationships with mothers from IAUs during labour and birth even in the absence of a pre-existing relationship and that mothers saw doulas as 'standing in' for the families and communities they are cut off from.

'When you come to a new country, you don't have your mother, your sister. The doula acts like a mother and a sister and they fill these gaps.' *[Mother with doula]*

MOTHERS' EXPERIENCES

100% of women chose the most positive multiple-choice answer for the two questions that asked directly about their experience of having a doula; all women said that their doula *'listened to them and what they wanted very well'* and was *'very kind and caring'*.

'...When I gave birth I was actually holding doula's hand, she gave me the strength and made me feel ease.' [Mother with doula; questionnaire].

50% of women likened the nature of the relationship between themselves and the doula to a familial relationship (questionnaires and interviews):

> *'Many times I have think is better to die than to feel all of that pain on my body but always have been a doula with me giving me hope and support that I can go on with all of that. When I feel to cry, doula has been there with me to hear me or cry with me like my mum or my sister will do.' [Mother with doula; questionnaire].*

'It's really, really important for me because the doula is like my family. It's really, really important, I'm so excited. So yeah, because it's like my family coming in.' [Mother with doula; interview].

'She was in the most important moment of my life when I become a mother for first time and she make me feel that I have everything I need as she was part of my family.' [Mother with doula; questionnaire].

PROFESSIONALS' EXPERIENCES

Midwives commented that the mothers they were caring for were more '*relaxed*', '*calmer*', more '*comfortable*' or more '*at ease*' because of the presence of a doula (6 midwives). Some doulas had felt trepidation before the pilot began about their ability to support mothers during labour and birth without building relationships beforehand, *'Now overwhelmed and surprised, for it worked perfectly...' [Doula; focus group].*

After the pilot, all doulas referenced moments which they felt showed that they had been able to build a trusting relationship with the mother they were supporting, even when meeting her for the first time in labour, *'As soon as her son was born she handed him to me and asked me to recite the Adhan [Islamic call to prayer] in his ear, which is usually something that's reserved for the father... that will stay with me forever.' [Doula; focus group].*

Doulas and supervisors hypothesised that this trust depended on two factors:

1. The mother is in control and invites the doula in.

   'My observation is that the strength of support that the doula can provide.... has nothing to do with whether they know each other beforehand. I think that flies in the face of everything that we think of as doulas [laughter] and probably as humans. We think trust is based on face time. I suspect that it's not. I think the trust in this situation comes from the fact that they invite us in... Sometimes they don't call us and so actually, they do exercise control.' [Supervisor; focus group].

2. The mother already trusts in the community (the Happy Baby Project) that the doula is associated with.

   'It doesn't matter who does come, they know that they're looked after because they've had that feeling of being looked after at the community anyway. So they've got that bit of trust there and it just builds on that.' [Doula; focus group].

Although this was beyond the remit of the present evaluation, both doulas and supervisors felt that providing support in this critical and transitional time can lead to long-term benefits and spoke of the transformational value it can have if someone feels they are *'worthy of the care, that they are valued by someone, particularly at this time but actually, just generally. It's about the fact that someone cares; someone stays with them; and someone keeps calling.' [Supervisor].*

SAFE AND APPROPRIATE CARE

Women who are living in IAUs and facing multiple disadvantage feel significantly safer during labour and birth when they have doula support; they are never left alone at times when they do not want to be, and they find it significantly easier to ask for help when they need it. Midwives felt that the presence of doulas made it easier for them to care for these mothers' overall wellbeing.

Women who were living in IAUs and facing multiple disadvantage who did not receive doula support felt substantially less safe and 87.5% were left alone during labour at a time they didn't want to be. This compares to only 0-21% of women from the UK population as a whole reporting that they were left alone during labour and birth at a time that they felt worried by this[22].

'The most difficult thing happened in my life and without any support.' *[Mother without doula]*

I am really happy and lucky, I had the chance to have 3 doulas with me to support me in this difficult time because I have been in the hospital for 6 days.'
[Mother with doula]

MOTHERS' EXPERIENCES

Quantitative Analysis

Women were asked the multiple-choice questions, 'How did you feel during labour and birth?' (Q1), 'Were you left alone at a time that you didn't want to be?'(Q2) and 'How easy was it to ask for help if you needed it?' (Q5) (Appendix 2; Table 1A). Comparing responses between women with and without doulas showed that women with doulas gave significantly more positive responses to all of these questions (Figure 1; Appendix 2, Table 1B; Mann-Whitney Test with post-hoc Bonferoni-Holm correction for multiple comparisons; Q1, $p < 0.009$; Q2, $p < 0.009$; Q5, $p < 0.032$). This level of statistical significance means that there is a very low likelihood that the more positive responses given by mothers with doulas were seen by chance (Q1 less than 1:100, Q2, less than 1:100, Q5 less than 1 in 20).

87.5% of mothers without a doula said that they felt 'not that safe' or 'very unsafe' during labour and birth and that they were left alone in hospital at a time when they didn't want to be, with 50% saying that they felt 'very unsafe' and 62.5% saying that they were left alone 'a lot' (Figure 1). By comparison, 91% of mothers who received doula support said that they felt 'safe' or 'very safe' during labour and birth and 100% said that they were not left alone at all at a time they did not want to be. When asked, 'Who (if anyone) helped you to feel safe?' 92% of women with doulas said that the doula helped them to feel safe (Figure 2). 25% of women without doulas said that there was no one present who helped them to feel safe (Figure 2).

[22] NHS England (2015). National Review of Maternity Services: Assessment of quality in maternity services.

100% of women with doulas also found it 'quite easy' or 'very easy' to ask for help when they needed it, compared to 50% of women without doulas found it 'quite difficult' or 'impossible' to ask for help when they needed it (Figure 1). When asked 'who did you feel you could ask help if you needed it?' 100% of women with doulas said they felt they could ask their doula for help and 18.2% also said they felt they could ask the midwife for help (Figure 2). Women without doulas said that they asked either a friend (37.5%) or a midwife/doctor (62.5%) for help (Figure 2). For women living in IAUs who are facing multiple disadvantage, the doula appears to hold a specific role that is different from and cannot be replaced by either a friend/family member or a midwife.

Figure 1 – Safe and appropriate care

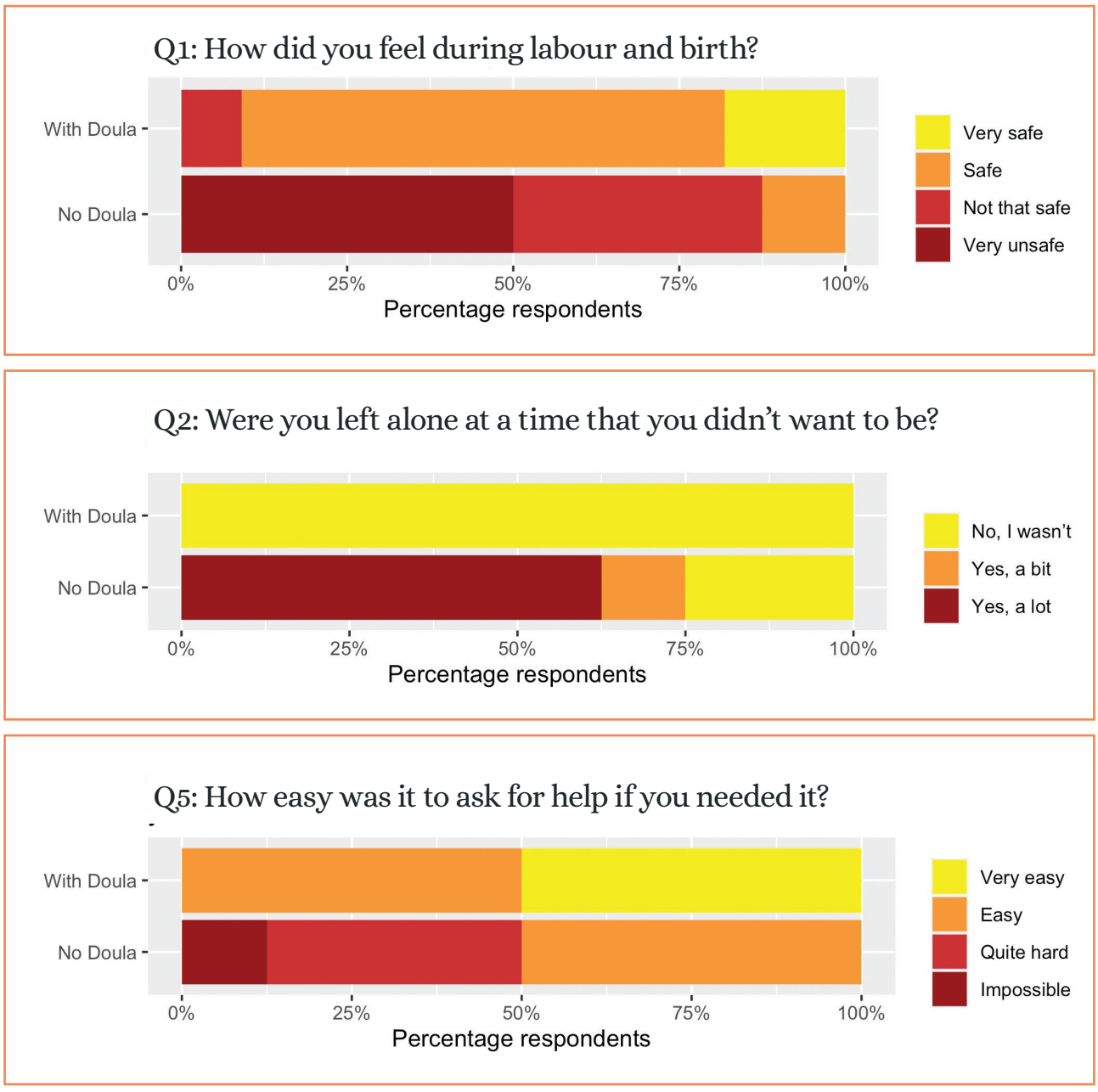
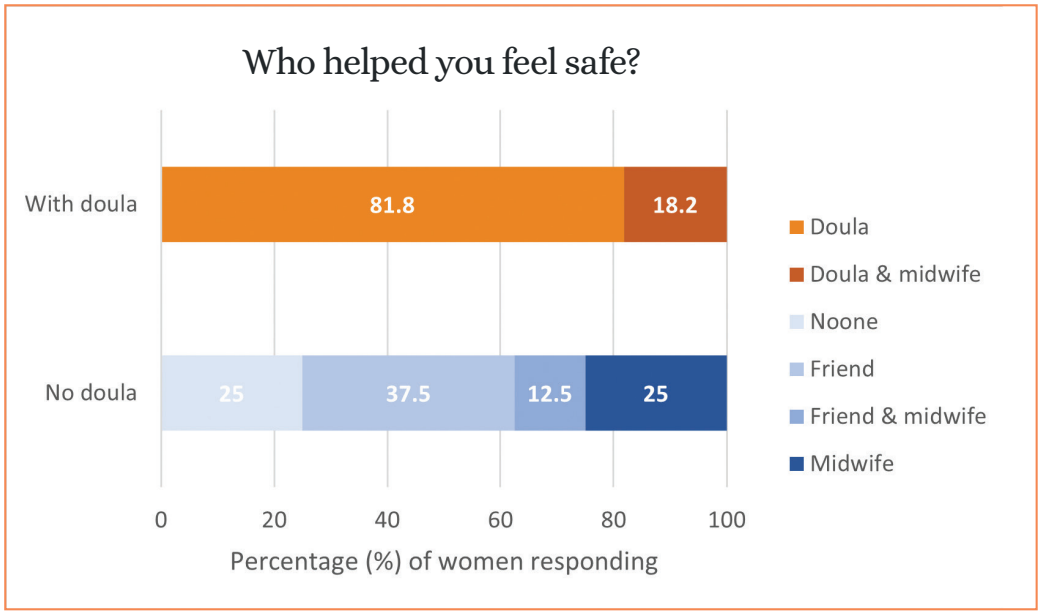
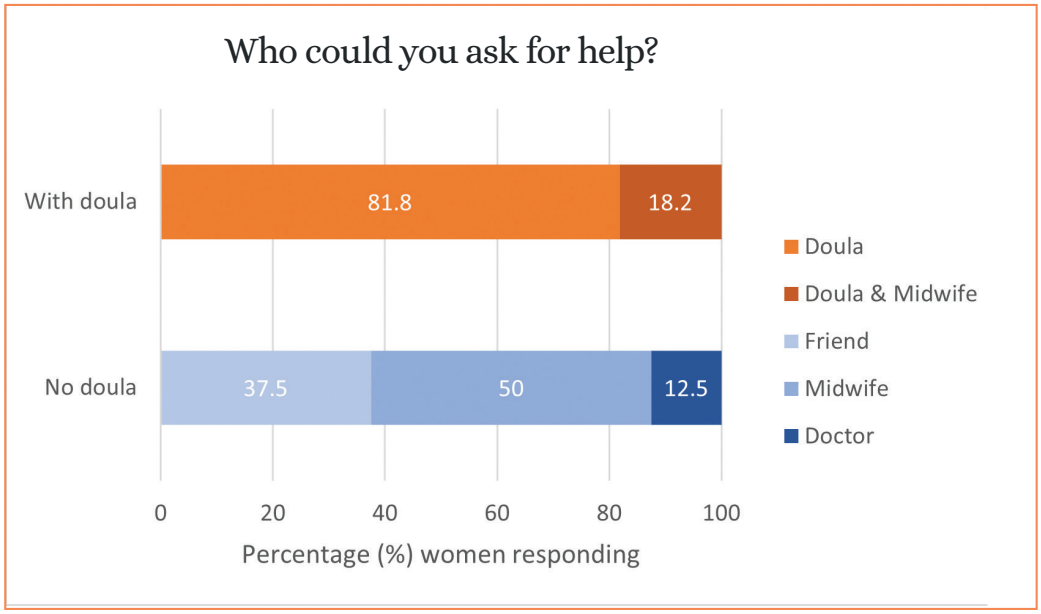
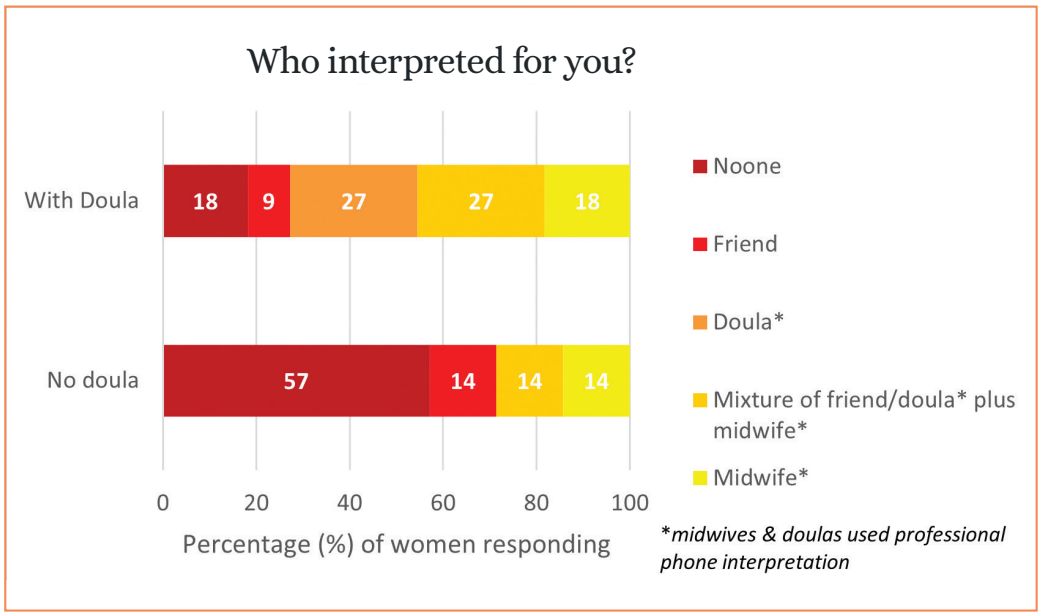


Figure 2 – Who supported you during labour and birth?







Quantitative Analysis

Some women both with and without doulas, referenced having friends or family with them at least part of the time during labour and birth, but their presence does not appear to have improved women's sense of safety in the same way that the presence of a doula did. In one case, the presence of the mother's partner appears to have made her feel less safe, because he had to bring their older children too, *'I told him, 'Don't come. Stay with the kids.' He said, 'No, I'm on the way'. So he came here.....My kids was in the room and, you know, I was shout. It was horrible.' [Mother without doula; interview].*

50% of women without doulas specifically commented when completing the questionnaire on how alone they had felt during labour and birth and how hard that had been. In one instance, the mother's description suggests that this led to unsafe care, as she says that she did not have a midwife present whilst her baby was actually being born, *'After I given birth, after head of baby come out, midwife come. The most difficult thing happened in my life and without any support.' [Mother without doula; questionnaire].*

A third of women with doulas spoke about feeling excitement or relief when their doula arrived at the hospital and 92% said that they felt safer, stronger or lucky because they had a doula (questionnaires and interviews):

1. feeling lucky, happy or thankful to have had a doula (5 women), *'She make me feel really happy and relaxed by giving me everything I need.' [Mother with doula; questionnaire].*
2. feeling safe or safer because they had a doula (4 women), *'My doula has arrived in the hospital just before me and this makes me feel really happy and safe.' [Mother with doula; questionnaire]*
3. feeling stronger, more confident, or more in control because of having a doula (5 women), *'I think if the doula wasn't with me it's difficult for me to carry on, to have the baby. I can't carry on with that confidence.' [Mother with doula; interview].*

75% of women with doulas referenced the doula helping them or being helpful in some form (questionnaires and interviews). Some women emphasised the feeling that they could ask the doula to help with anything or everything, *'If I need anything, I tell doula, anything to help me.' [Mother with doula; questionnaire].* By contrast, a woman without a doula said, *'I was begging her [the midwife] to help but she didn't. They didn't help me at all. They left me alone, you know? Alone.' [Mother without doula; interview].*

Women with doulas know that they won't be left alone unless they want to be and this, plus the fact that they know the sole purpose of the doula is to be a continuous presence and support them, may contribute to their feelings of safety, 'Midwife and doctor keep changing so I don't feel safe but doula is always there.' [Mother with doula; interview].

PROFESSIONALS' EXPERIENCES

During focus groups, 3 doulas gave specific examples of times when they felt that the labouring mothers they were caring for were left without support from healthcare professionals for an inappropriately long time. There was a feeling that the doula presence could be a *'double-edged sword'* if it meant that healthcare professionals were less present, *'I had to call them when the baby was crowning and coming out... If I wasn't there... Would she have given birth without a midwife there? I feel like it [our presence] kind of absolves some of the staff of the responsibility that I'm assuming and hoping they might give if we weren't there.' [Doula; focus group].*

However the similarities between the descriptions that women without doulas gave of times when they were left alone during labour and birth and the incidents described by doulas at other births suggests that doula presence is not a *'double-edged sword'*. One supervisor observed that she had noticed a correlation between a very busy maternity unit and a low level of hospital staff presence reported by doulas. The challenges of a busy maternity unit were also alluded to by one midwife who felt that the presence of the doula meant she could share her care more equally between the women she was responsible for. For women who are experiencing multiple disadvantage, who would otherwise be alone and who find it difficult to advocate for themselves, the presence of a doula who can support them to ask for help when they need it may enhance safety amidst the reality of a busy unit where midwives are of necessity caring for several women at once.

Midwives themselves were very clear that they appreciated the presence of the doulas. Over 93% said the presence of the doula made it 'easier' or 'much easier' to care for women's overall wellbeing during labour and birth and the immediate postnatal period (Appendix 2, Table 2). 11 midwives commented on the level of support doulas provided to mothers, *'The presence of a doula has been fantastic in providing support to the mother.' [Midwife working alongside doula; questionnaire],* often suggesting that this was greater than they would have expected, *'She went above and beyond to care for the woman.' [Midwife working alongside doula; questionnaire].*

AUTONOMY, CHOICE AND CONSENT

Mothers living in IAUs who received doula support had on average less questions about their care, understood more about their care and found it easier to make choices compared to mothers living in IAUs that did not receive doula support, although these differences did not quite reach statistical significance. Having the necessary information and understanding was key to women's ability to make choices and give informed consent and without this, women were left feeling powerless.

In the population as a whole, 26% of women say that they felt that they were not always involved in decisions about their care during labour and birth[23]. In comparison, 77% of women in this evaluation who did not receive doula support said that they did not everything about their care during labour and birth, 87.5% had outstanding questions about their care and 62.5% said they found it either quite hard or impossible to make choices during labour and birth. When the same cohort received doula support, only 25% said that they did not understand everything about their care, only 27% had outstanding questions about their care and only 33% said they found it quite hard to make choices about their care.

[23] NHS England (2015). National Review of Maternity Services: Assessment of quality in maternity services.

Doulas felt that they had not always managed to support mothers effectively to make informed choices and give informed consent, but 95% of midwives felt that doulas' presence made it easier for women to make choices and give informed consent.

Whilst using interpretation effectively in a medical situation can be challenging, given its key role in enabling women firstly to understand the care they are being offered, and then to make informed choices and give informed consent, it is also vital. Without interpretation, caregivers may on occasion be tempted to make decisions that they think are in the mother's best interest, regardless of whether she has actually consented. Women living in IAUs who received doula support appeared to be more likely to receive the interpretation they needed during labour and birth.

'How can I choose if you don't give me the choices to choose from?'
[Mother without doula]

MOTHERS' EXPERIENCES

Quantitative analysis

Women were asked, 'How much did you understand about the care you were offered during birth?' (Q6), 'Were there things you wanted to ask about but didn't?' (Q7), 'How easy was it to make choices about what happened during birth?' (Q8) and, 'How easy was it to say 'no' if you didn't want something to happen?' (Q9).

Overall, almost two thirds of women with doulas said that they had understood 'everything' about their care. By comparison, no women without doulas felt that they had understood 'everything' (Figure 3). Similarly, all women with doulas had understood at least some things about their care, whereas 25% of women without doulas said that they had understood 'nothing' about their care, (Figure 3).

72.7% of women with doulas also said that there was 'nothing' that they had wanted to ask about and hadn't during labour and birth, compared to only 12.5% of women without doulas who said that there was nothing that they had wanted to ask about and didn't ask (Figure 3).

27.5% of women with doulas found it 'very easy' to make choices; 45% found it 'quite easy' and 27.5% found it 'quite hard'. By contrast, over a third of women without doulas said that they found it 'impossible' to make choices (Figure 3).

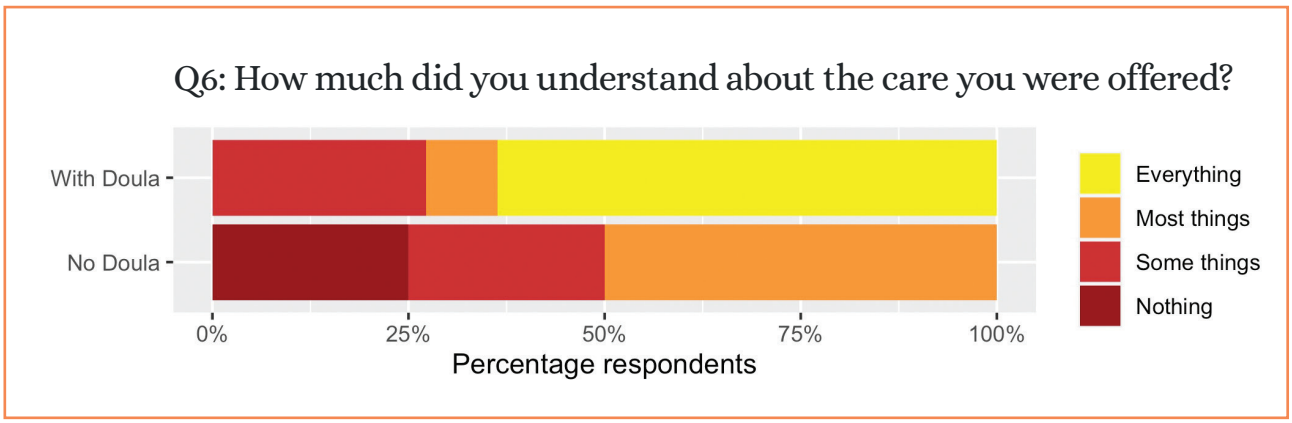
The responses to Q6, Q7 and Q8 were all more positive on average for women with doulas compared to women without doulas (Figure 3; Appendix 2, Table 1B). However, these differences did not reach statistical significance and we therefore could not rule out that they were seen by chance (Appendix 2, Table 1B; Mann-Whitney Test with post-hoc Bonferoni-Holm correction for multiple comparisons; Q6, $p < 0.111$; Q7, $p < 0.067$; Q8, $p < 0.148$). The confidence intervals (Appendix 2, Table 1B) for Q7 and Q8 suggest that the responses differed between women with and without doulas, although the p-value does not reveal this. Increasing the sample size in future evaluations will increase the power of the study and thus help us to distinguish between false and true negative results.

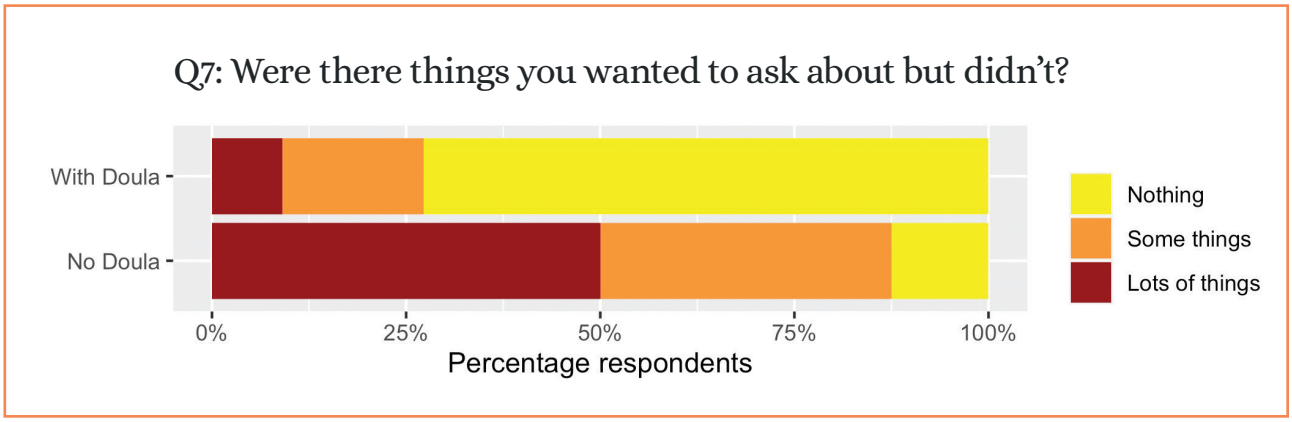
There was no significant difference in responses for mothers with and without doulas for Q9 (Q9, p=0.861). In both groups, two thirds or more of mothers said they felt able to say 'no' if they didn't want something to happen, suggesting that the presence of a doula did not affect women's ability to withhold consent.

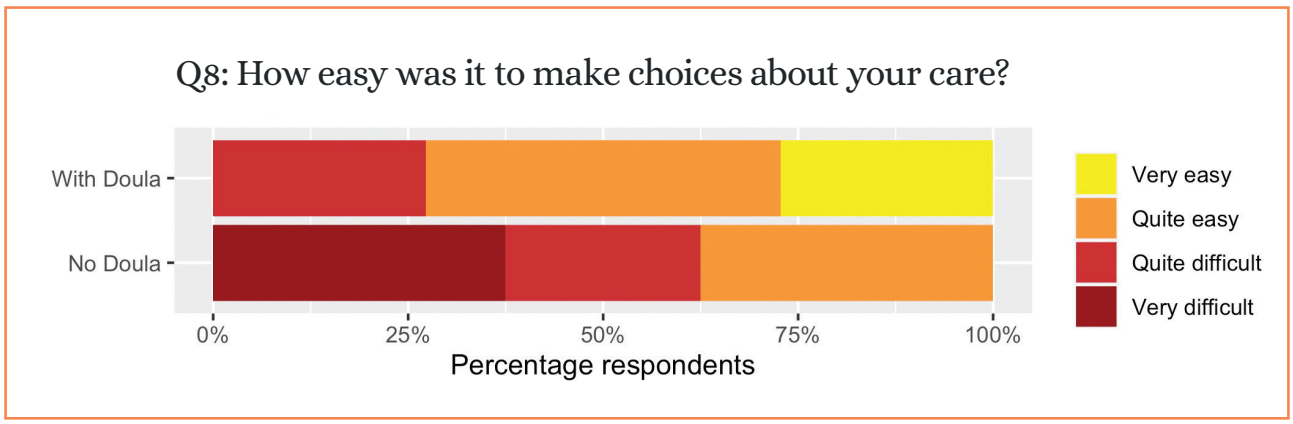
Finally, 7/8 women without doulas and all women with doulas felt that they needed interpretation during labour and birth, reporting their level of English as 'basic' or 'none'. 57% of women without doulas also reported that 'no one' interpreted for them during labour and birth (Figure 2). By comparison, only 17% of women with doulas reporting that 'no-one' interpreted for them.

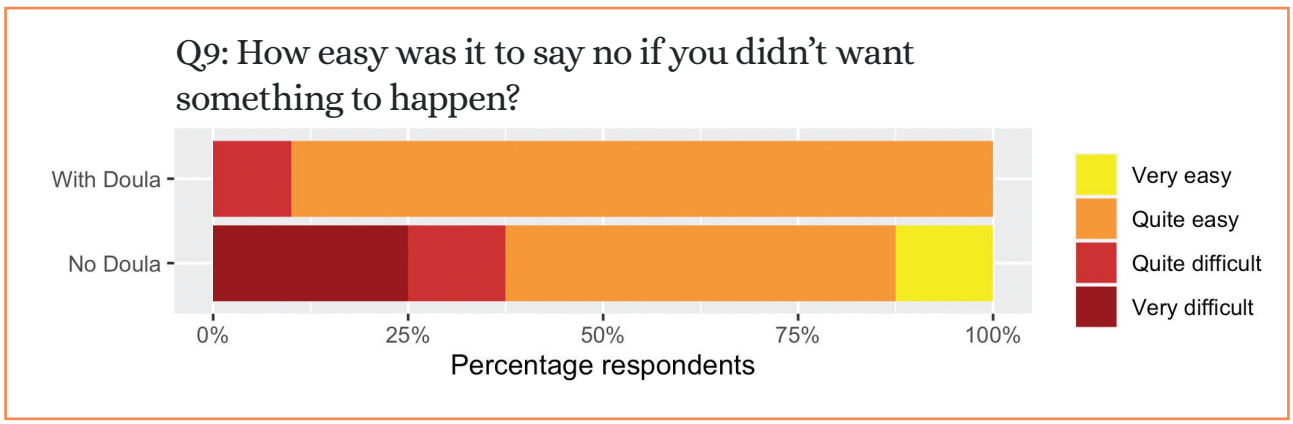
Whilst this was not explored statistically, women with doulas therefore appeared to be more likely to have their interpretation needs met than women without doulas, and this increase appeared to be based partly on increased used of phone-based interpretation by HCPs when doulas were present and partly on doulas themselves accessing professional phone-based interpretation to support women (presumably when this wasn't provided by HCPs). Interestingly, 92% of midwives assessed the level of English of women with doulas as 'none' or 'basic' (Appendix 2; Table 2), yet only 45% of women with doulas said that they were offered phone-based interpretation by midwives (Figure 2).

Figure 3 – Autonomy, choice and consent









Quantitative analysis

Women with doulas reported occasions when their doula had supported them to understand what was happening, *'Doula explain my care. I ask doula [anything that I don't understand].' [Mother with doula; questionnaire],* and other occasions when doulas had advocated for their choices, *'Midwife wanted to take baby away to weigh, but doula said, no, she wants to hold the baby first. Because doula checked with me first before birth and knew I wanted to hold the baby. [Mother with doula; interview].*

The link between being given information and support to understand one's care and subsequently being able to make choices about one's care was apparent throughout. A woman without a doula expressed the feeling of helplessness that not having the necessary information or understanding gave her, *'I could not make choices. How can I choose if you don't give me the choices to choose from?' [Mother without doula; interview].*

Even for women with doulas though, there were still times when they felt that there were things they had not understood or wanted to ask more about, *'I now understand I need to wait until, you know, how many centimetres before I can have baby but that moment I have no idea, I was just feeling really helpless.' "Who explained to you?" 'I stayed there five days, so, I realised! [laughs].' [Mother with doula; interview].* A quarter of women with doulas still found it 'quite hard' to make choices and the same woman describes wishing that more had been done to facilitate her understanding of the options to enable her to make choices, *'I wish they [the hospital] can actually tell me earlier and explain to me... why don't they tell me earlier? You know like in stage one I can have this, in stage two if not happened then I can have this, so, they let me know earlier so I can choose, I can decide, but they didn't.' [Mother with doula; interview].*

'When she was, do the stitches for me... I told her, 'I feel with everything you are doing. I feel the thread and the needle when you...' I was shouting also. 'Please don't shout. Put your bottom down'. This was all the time. 'No,' I told her, 'Please, I feel... the needle, the thread...' I felt everything, and not like that.' [Mother without doula; interview]

Two women without doulas gave descriptions of incidents where their human rights may not have been upheld [24]. One woman recounted an incident in which it appears that a procedure was performed throughout which she was trying to refuse consent. The other woman described expressing her choice to have a doula present, and this choice being denied, *'I asked the midwife to call the doula, she said that I was 36 weeks and the baby is coming earlier so we can't go through the birth plan, because the baby can't be delivered in the water when you're only 36 weeks, and you don't need the doula because of this.' [Mother without doula].* This could have infringed upon this mother's human right to a private and family life.

It is difficult for women who do not speak English to give true informed consent or make choices when their right to do so is not supported by the use of interpretation. Women made it clear how important interpretation was to their experience of labour and birth and their ability to understand their care, make choices and give informed consent.

In addition to the multiple choice questions, 3 women without doulas mentioned the difficulties of not speaking English:

'Not very easy if you don't speak English.' [Mother without doula; questionnaire].

On the other hand, a woman with a doula gave an example of how interpretation had helped her to understand her care:

'The hospital they did quite a good job, they have interpreter so, they can actually tell me now we give you injection so we can go to sleep first, have a good rest so, this is positive.... they let me understand.' [Mother with doula; interview].

One mother with a doula underlines how essential interpretation is even for mothers who might appear to have a grasp of English:

'There were so many things that I wanted to find out more but I couldn't because of the language. They thought that I understand English and didn't call an interpreter.' [Mother with doula; questionnaire].

PROFESSIONALS' EXPERIENCES

Doulas felt that it was part of their role to support, and in some cases, advocate for mothers' rights to make informed choices and give informed consent, but they did not always feel that they had been able to support women effectively in this manner. Doulas acknowledged that, when women don't speak English, midwives may be unsure whether doulas are truly conveying women's own preferences, or whether they are imposing their own. However, they felt that women with no understanding of English language or the maternity system may sometimes not even have been aware that choices are not being presented to them, *'They can say, "No, there is no Birth Centre. We're going to deliver on the ward." I felt like I didn't have the chance to say, "She has a birth plan here."' [Doula; focus group].*

Doulas also described incidents where they felt that they saw the mother's choice directly overruled, *'The mum was saying, 'I just want to*

[24] Birthrights and Birth Companions (2019). Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care. London [online].

wait. I want to see,' In the end, she said, 'I'm going to put you down anyway.' I said to her, 'Should we call LanguageLine so we can have a discussion about this properly?' ... I felt like maybe...my level of interpretation, she didn't feel like it was enough... but she said, 'Oh no, we spoke with LanguageLine before and I think this is best for her.' [Doula; focus group].

Finally, doulas described incidents that they thought the mothers may not have been aware of, but where they felt they were witnessing procedures carried out without informed consent, such as giving a mother a sweep during a vaginal examination. One doula described stepping in in a non-emergency situation to strongly request that a mother was not given an episiotomy without informed consent first being obtained via LanguageLine.

Contrasting with the doulas' impressions of how they performed this role, 95% of midwives felt that the doulas' presence made it 'easier' or 'much easier' to offer women choices and enable them to give informed consent during labour and birth (Appendix 2, Table 2), *'Wonderful in ensuring staff respect client's needs and preferences,' [Midwife working alongside doula; questionnaire].*

Midwives did not comment specifically on hospitals' use of interpretation with this group. Doula supervisors on the other hand found the lack of interpretation reported by doulas problematic, *'Compassion is not enough to cover for the idea of care that women all deserve and could have... I think language is a big problem.' [Supervisor; focus group],* suggesting that it hampered mothers' abilities to give informed consent, *'I have some concerns about them not using LanguageLine because I'm not sure that that's exactly informed consent [if they do not use it].' [Supervisor; focus group].*

Supervisors also related pre- and post-lockdown examples where they felt there had been conflict between doulas and hospital staff over the use of interpretation. Two post-lockdown examples (when doulas were not there in person but were speaking with the mother on the phone whilst she was in labour in hospital) were given where a hospital did not use LanguageLine. In one example, the doula set up a 3-way call to provide access to professional interpretation between a surgeon and a mother (between her phone, the mother's phone and an interpreter's phone).

Doulas used interpretation flexibly, employing a combination of a professional telephone interpretation service and google translate or, in one case, they shared a common language. One doula gave an example of a time she, the midwives and the doctors worked as a team to use interpretation to meet the given needs in a particular situation and also underlined the potential issues around using interpretation in a birth situation.

'I was holding my phone for the doctor. She was speaking and translating and the woman was just reading it. In the middle of that pushing stage, you don't really have the time to translate and so it worked really well. At some point, they were asking, 'Can you do it again? Can you hold your phone?... She was then giving her thumbs up and that's how we did it. We had two midwives and paediatric doctors and so the room was full. I don't think the Line was a possibility there, so speaking and translating was easy and a very good way, in my opinion.' [Doula; focus group].

RESPECTFUL AND DIGNIFIED TREATMENT

Women living in IAUs had mixed experiences of maternity care and treatment in terms of the respect and dignity with which they felt treated, regardless of whether or not a doula was present. Overall, 74% of women living in IAUs said that the hospital staff were kind and caring, and 63% said that they felt listened to. This compares with 85% across the population as a whole who felt that they were always treated with respect and dignity during labour and birth[25].

Doulas felt that in some circumstances it became part of their role to lessen the impact of poor treatment on mothers' overall experiences of labour and birth, helping to protect women living in IAUs from the discrimination that women facing multiple disadvantage can sometimes experience within the UK maternity system[26].

'I will say that please, be kind to others. All of us have had pressure. All of us. Just at the end you are dealing with a human being, and the maternity, it's not any case. You feel yourself is between the earth and the sky.'
[Mother without Doula]

MOTHERS' EXPERIENCES

Quantitative analysis

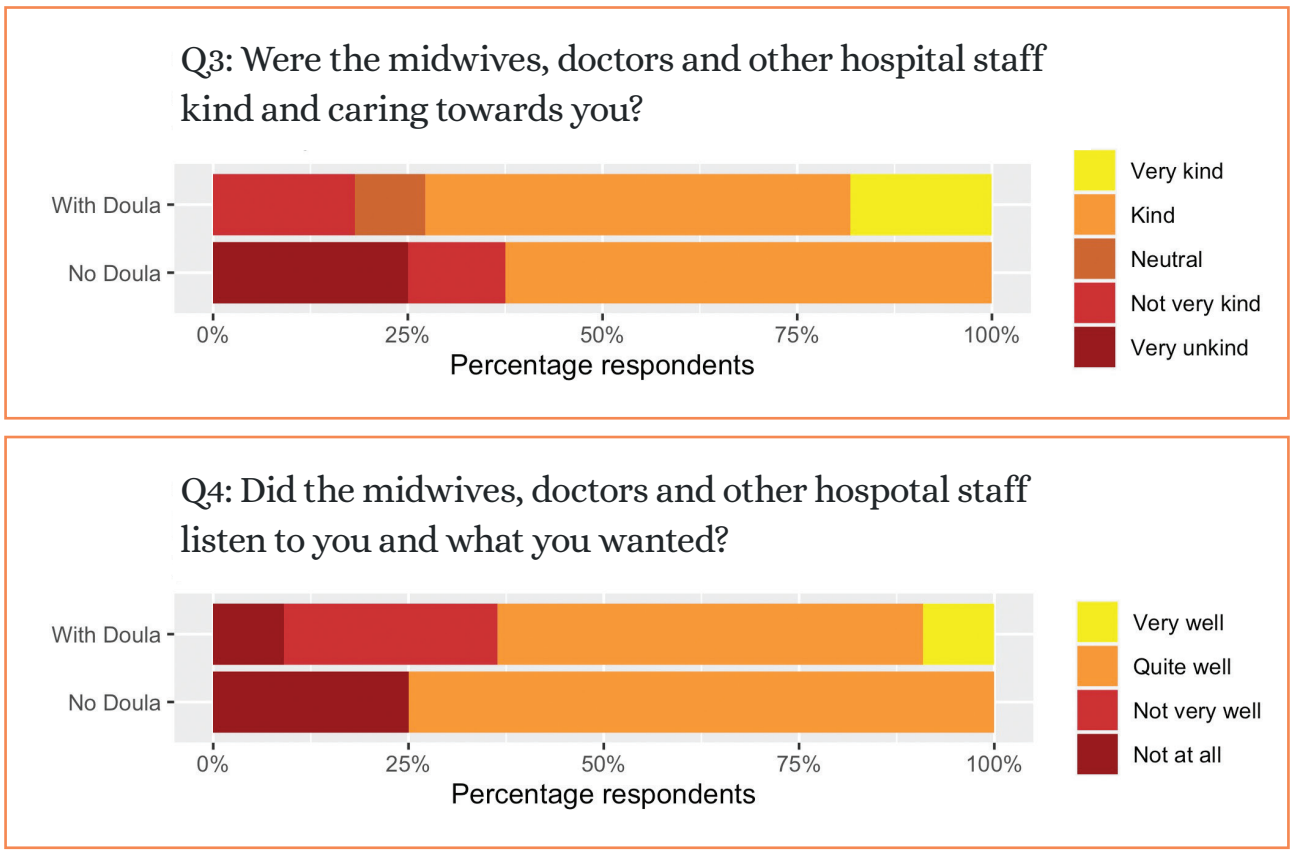
When asked, 'were hospital staff kind and caring towards you?' (Q3) and 'How well did hospital staff listen to you and what you wanted?' (Q4), over two thirds of women with and without doulas said that hospital staff were kind or very kind to them and listened to them quite well or very well (Figure 4). However, 37.5% and 18% of women with and without a doula respectively felt that they were treated 'not very kindly' or very unkindly' by hospital staff, and 25% and 34% of women with and without a doula respectively felt that hospital staff listened to them and what they wanted, 'not very well' or 'not at all' (Figure 4).

There were no significant differences between responses to Q3 and Q4 for women with or without doulas (Appendix 2, Table 1B; Mann-Whitney Test with post-hoc Bonferoni-Holm correction for multiple comparisons; Q3, $p < 0.748$; Q4, $p < 0.962$), suggesting that the presence of the doula does not alter women's perceptions of their treatment by hospital staff.

[25] NHS England (2015). National Review of Maternity Services: Assessment of quality in maternity services.

[26] McLeish, J and Redshaw M (2019). 'Maternity Experiences of mothers with multiple disadvantages in England: A qualitative study'. Women and Birth, 32(2), 178-184; Birth Companions and Revolving Doors Agency (2018) Making Better Births a reality for women with multiple disadvantages; Thomson, G and Balaam, M (2016). Birth Companions Research Project: Experiences and Birth Outcomes of Vulnerable Women. University of Central Lancashire.

Figure 4 – Respectful and dignified treatment



Quantitative analysis

Two women mentioned feeling afraid of hospital staff, one mentioned feeling ignored by hospital staff and one mentioned feeling like hospital staff didn't help her:

'Hospital, some people were good, some not very good. They frighten me.' [Mother with doula; questionnaire].

'They let me stand there and… she didn't explain to me what should I do, sit down, whatever, she just stayed beside me doing her own stuff with computer, concentrate, computer, ignore me, just ignored me… I was just feeling really helpless.' [Mother before doula's arrival; interview].

'Midwife just came and looked at me and that was it. No help me midwife.' [Mother with doula; questionnaire].

By contrast, one woman explained how important the caregiver who had been kind to her had been:

'Just the student midwife, you know, really she was, you know, kind. She was trying to calm me down.' [Mother without doula; interview]

The same woman specifically mentioned feeling that she was treated differently from other women on other occasions, *'There were 3 other women in my room. The staff treated them differently. Laughed and chatted. Helped them. It is because I wear a hijab.' [Mother without doula; interview].*

PROFESSIONALS' EXPERIENCES

Doulas described the care and respect from the hospital staff during 4 of the births in the pilot in glowing terms, *'One of them [a birth] was really outstanding. They were really good and they really cared; from the triage to the consultant.' [Doula; focus group].*

Doulas also spoke about other births when they felt there were occasions when women had not been treated with respect and/or dignity, *'She wasn't treated in a humane way.' [Doula; focus group].* Three doulas spoke of mothers being afraid of hospital staff, *'I turned off the lights ... and she was scared for me to do that because she thought she was going to get in trouble.' [Doula; focus group].*

Supervisors, with their broader overview, described witnessing a mixed pattern of care and treatment emerging, where they felt that the respect and dignity with which women were treated could change even within a birth, as staff changed shift.

Doulas felt that they saw examples of women living in the IAUs treated differently from the women they support as private clients (who are not facing the same level of disadvantage). They felt that there was sometimes an expectation that women from IAUs would be compliant, and that, on average, this group of women appear to wait longer for care or treatment than they see with women they support privately. They felt that this in turn had a knock-on effect on women's confidence and ability to make choices.

3 doulas described incidents where they felt like they had witnessed discrimination, *'The midwife said, 'Go and put those in the bin,' and I said, 'Oh, I'll put them in the bin. She's resting.' She said, 'She's no different from anyone else. She can pick them up and put them in the bin.' [Doula; focus group].* Doulas speculated that the difference in treatment that they felt they sometimes observed was primarily due to women's backgrounds and their status as asylum seekers, and perhaps, in some cases, their youth.

When care was less compassionate, doulas felt it became part of their role to lessen the impact of this, *'They kind of just treated her like she was a leper, to be honest, and she felt that. I had to cushion in there and just try and take on that burden of responsibility to human the experience again....' [Doula; focus group].*

CONCLUSION

This evaluation of the impact of doula support on the labour and birth experiences of women who are seeking asylum and facing multiple disadvantage provides clear quantitative and qualitative evidence that those receiving doula support felt that they were significantly safer and found it significantly easier to ask for help when they needed it compared to those who did not receive doula support. Doula support may also have improved women's understanding of their care and their ability to make informed choices and give informed consent. The reflections of women clearly demonstrate the overarching importance of the kind, compassionate care and continuous support during labour and birth that doulas offered here.

A DESCRIPTION AND EVALUATION OF A PILOT MODEL OF DOULA SUPPORT EMBEDDED IN THE FRAMEWORK OF A SUPPORTIVE COMMUNITY FOR WOMEN SEEKING ASYLUM

The pilot was set up, managed and evaluated by two part-time project leads and was overseen by an informal steering group composed of researchers, specialist midwives and community members with lived experience of birthing in the IAs, ensuring both quality and co-production. The numbers supported antenatally, during labour and birth and postnatally, in conjunction with the reported perceptions of the professionals involved in the project and the operational issues experienced by the project leads, have been used here as a basis for qualitatively evaluating the effectiveness of the delivery model.

SUFFICIENT RECRUITMENT OF DOULAS AND SUPERVISORS TO GUARANTEE BIRTH SUPPORT USING AN ON-CALL MODEL; ALL RECEIVED COMPREHENSIVE TRAINING AND SUPERVISION

Qualified doulas and supervisors (experienced doulas who are also trained as mentors) were recruited for the project as planned via adverts on both UK-wide and London-specific social media groups and platforms for doulas. The target number of 12 doulas was exceeded and 15 doulas (from 28 applicants) were selected for the project via phone interviews, with a particular emphasis on doulas who also had experience of working or volunteering with women seeking asylum and/or facing multiple disadvantage. 6 doulas went on to support women in hospital prior to covid-19 lockdown.

All doulas attended a comprehensive training programme including a full day's training focussing on the needs and background of the client group, trauma-informed care, safeguarding and language support, a half-day external training exploring human rights in childbirth and how these are protected (which included community members with lived experience of using the UK maternity system whilst living in IAUs) and a workshop run by the specialist midwives working with this client group (providing an introduction to hospital-specific working practices). Supervisors, whilst not receiving specific training (apart from the above) due to resources, were given additional guidance in their roles by the operational project coordinator.

During the operational phase (February-March 2020), labour and birth support was provided by a team made up of 1 supervisor and 2-3 doulas. A team was on-call for 2 weeks at a time. It was the responsibility of the on-call supervisor to hold the 24-hour support number and to coordinate and supervise each doula team, ensuring that all clients received appropriate and timely birth support and that doulas had access to 24-hour supervision. Supervisors reported to the project coordinator. Doulas attended the community group at least every Friday whilst they were on-call, building relationships across the community, and providing antenatal information and supporting with birth plans and preferences, and general postnatal support. Most doulas attended 1-2 births per 2-week period.

Challenges and Reflections

Doulas felt that this system provided them with the supervision and support needed to perform their role effectively, *'I think structurally nothing else could really be done [to support doulas],' [Doula; focus group].*

This is essential to retain highly skilled and compassionate support workers who otherwise over time can develop secondary trauma when working with clients with multiple disadvantage. Siting their work in a project with a wider support remit also helped to boundary their role, as they felt reassured that other support needs were being taken care of by other parts of the service. This meant that they didn't end up in the situation described by some specialist midwives where they find themselves 'holding it all together"[11].

On reflection, doulas also felt that they would benefit from ongoing peer-to-peer workshops to share learning around skills and practice as well as group supervision (in addition to the individual supervision already provided) and more training specifically around communicating across languages.

EFFECTIVE RECRUITMENT OF MOTHERS – 23 MOTHERS ENROLLED INTO THE PILOT BEFORE LOCKDOWN

Between 1/1/20 and 6/3/20, 23 women with due dates in February and March 2020 were enrolled into the pilot through being signposted or referred to the Happy Baby Community South Project as they entered the IAUs, by our referral partners (specialist midwife services and Migrant Help), our community ambassadors or word of mouth. Coordinators and peer volunteers then spoke individually with clients at the community (using interpretation as necessary) to explain the doula support on offer and enable women who wished to take it up to give informed consent.

Challenges and Reflections

The figure recruited is broadly in line with the numbers expected from the benchmarking period and represents 96% coverage of mothers in the London IAUs with February and March due dates in this period (1 woman chose not to be referred to either the pilot or the wider project it was embedded in[27]). Such a high take-up of the service indicates effective access routes, an element of service provision that is particularly important for women facing multiple disadvantage.

Due to covid-19, the HBC South Project (which was acting as the primary vehicle for delivering the antenatal and postnatal services wrapped around the actual birth support) closed its face-to-face services on 6/3/2020. This was slightly ahead of the UK government's instruction, due to an internal risk assessment taking into account both the particular vulnerability of our cohort (in 3rd trimester; higher than usual level of background health issues) and that a mother who had attended the project was being tested for covid-19. We estimate that the numbers enrolled would have been 20-25% higher without this unforeseen event.

The locations of IAUs in London mean that the cohort giving birth is split between two hospitals. The benchmarking period suggested that at any one time, 25-33% of the heavily pregnant women in London IAUs give birth at Hospital 1, whilst the remainder give birth at Hospital 2. However, only 3 women (13%) enrolled in the project actually gave birth at Hospital 1 over the pilot duration, due to a chicken pox outbreak in one IAU which meant that all pregnant women were routed to IAUs feeding into Hospital 2.

This highlights the logistical importance of considering the London IAUs as one intake unit. The pilot was embedded into the HBC South Project, which works across all the London IAUs and hence we were aware of the possibility of large fluctuations away from the average with regards to accommodation and birthplace. Doulas were selected who were prepared to go to either hospital at short notice and who could arrive at both within a reasonable timeframe. Providing the service through the voluntary sector affords an essential flexibility that is not available through borough-based local authority health care systems.

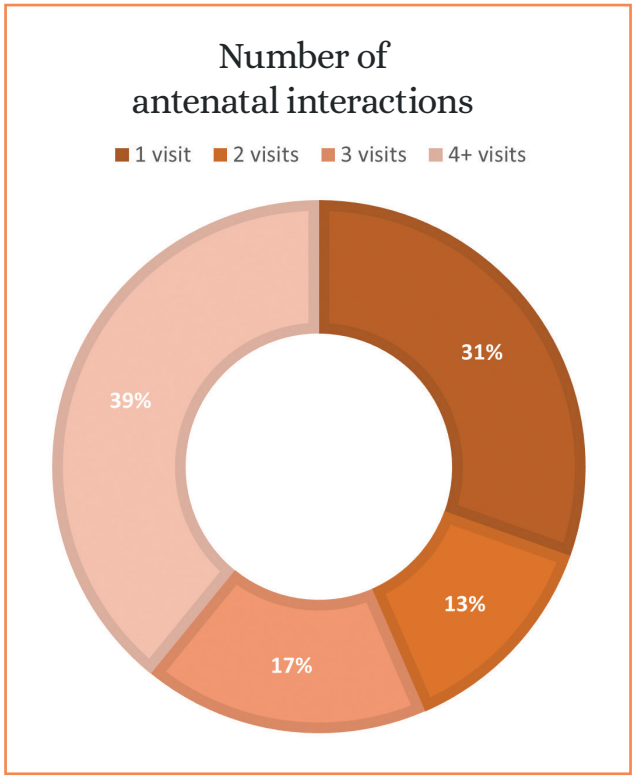
[27] The specialist midwife reflected that this mother felt that she did not need the support on offer.

ALL WOMEN ENROLLED IN THE PILOT RECEIVED ANTENATAL SUPPORT

Overall, a third of women entered the hostels so close to their due date that they were only able to make one visit to the project before birth; a third visited 2-3 times antenatally and a third visited four or more times.

Women received group-based antenatal education from qualified antenatal teachers at the HBC South Project, supported by community volunteer interpreters and phone interpreters as necessary. Doulas then built on the classes by having 1-1 conversations with mothers to discuss birth options, individual needs and preferences and birth plans.

'... I stayed at hostel in the first stage. Then when I had contractions every 5 minutes I went to the hospital. Was really great to have this information from the antenatal class in the Happy baby group.' [Mother with doula].



Challenges and Reflections

Doulas felt that situating the antenatal and postnatal support in the context of the group rather than using a 1-1 model throughout the perinatal period was better for both them and the mothers they supported. Doulas found it easier to maintain their boundaries, and mothers were embedded in a community (professionals, volunteers and peers) of support rather than just developing one close relationship.

'I imagine if you've been vulnerable and traumatised then it might be quite tempting to attach onto one person, one relationship. And we're sort of providing something a bit more stable than that really, broader.' [Doula; focus group].

'It's sort of supporting them to be independent in the world and continue their lives. Whereas the one to one sort of attachment wouldn't do that because it would have to end at some point. But I think the group is really supporting them as individuals in their community with the other women. [Doula; focus group].

'To have that continuity postnatally as well so it doesn't just stop when they've had the baby or with a postnatal visit.. It continues and they know that they can come back on a Friday and they'll be somebody there with that same kind of feeling of safety, community.. I think it's a hugely important part of the model.' [Doula; focus group].

With 30% of women only coming into the asylum system (a figure which chimes with our operational experience over time) in time to attend the group once before birth, there will be always be limits on what level of antenatal education is possible, and part of the ongoing challenge is to cater appropriately both for those that come in with ample time to prepare and those who we first meet at 40 weeks pregnant. Doulas reflected that group education sessions followed by 1-1 conversations around birth planning created a layered-learning environment that supported womens' ability to understand and retain antenatal information[28]. They also felt that this was reinforced by interactions within the peer group, 'They spread the word in terms of the planning and the birth plan.' [Doula; focus group]. This has added value for the women in the pilot due to language barriers, cultural needs, and multiple disadvantage, including history of trauma.

Contrary to our records, when asked postnatally, some women did not think they had made a birth plan and it was clear that not all women had understood their significance as a tool to help the midwife understand their preferences and needs during labour and birth. The project coordinator reported doulas reminding or encouraging women to show their birth plan to the midwife.

Doulas reflected that, with a better understanding of the needs of the mothers, they could continue to develop and enhance our set of communal pictorial antenatal materials to use in conversations about birth plans and preferences going forwards. These could also support women in understanding the significance of a birth plan and how it can be used to support informed choice and consent.

Doulas and supervisors reflected more generally on the increased level of difficulty they experienced with this group regarding discussions of choice and consent. They commented that women's overriding concern appeared not to be what they themselves wanted, but what course of action would please the person who held the authority in any given situation.

'When you talk about birth wishes and birth plans, no matter how the information, options and choices are presented to them in an informative way (as we would with anybody that we work with), this particular group of women appeared almost like they wanted to be obliging rather than questioning the information that was being given and making a choice…That is a challenge that needs to be overcome.' [Supervisor; focus group].

[28] Rogers, J (2007). Adult Learning. 5th edition. Open University Press: Maidenhead.

EFFECTIVE PROVISION OF BIRTH SUPPORT FOR MOTHERS – 13 MOTHERS SUPPORTED IN PERSON BY A DOULA DURING LABOUR AND BIRTH PRE-LOCKDOWN; 5 MOTHERS SUPPORTED VIRTUALLY POST-LOCKDOWN; ALL MOTHERS WHO MADE CONTACT DURING LABOUR RECEIVED BIRTH SUPPORT.

18 of the women enrolled in the pilot went into labour between 26/1 and 23/3. 13 women contacted us to ask for birth support when they were in labour, either before they left for hospital or by asking the midwives to call us when they arrived at hospital. 100% of these women received doula support and were supported for significant periods, ranging from 4 hours to 6 days total. Time-periods between a mother enrolling into the pilot and going into labour varied from 10 hours to two months.

Of the remaining 5 mothers, 2 contacted the 24-hour number when they went into hospital for induction/c-sections but ultimately decided that they didn't want doula support. Both of these mothers were supported by partners. 1 mother who experienced premature labour chose not to contact us. 1 mother said she wasn't able to ask hospital staff to contact us because she was in too much pain and 1 mother said that she asked hospital staff to contact us and they refused.

Challenges and Reflections

As many women don't have access to phone credit (or in some cases, phones), one of the key challenges they faced was contacting the 24 hour number when they went into labour. In recognition of this, three suggested contact routes were set up (the mother contacts us herself in early labour before leaving for hospital, the mother asks staff at the IAU reception to contact us when she requests transport to hospital because she is in labour, or the mother asks the midwife to call us/ points at the sticker on her notes when she arrives in triage at the hospital).

Some mothers contacted us themselves as they left for hospital and the remainder asked the hospital staff to call us when they arrived in triage. In spite of agreement from IAU management and posters at receptions explaining that staff may be asked to contact us when mothers were in labour, no mothers used this contact method; it is unclear if any tried to use this route and were refused.

Appropriate and user-friendly access routes to services underpins effective provision of support for people facing disadvantage. In spite of the 3 different access routes set up for the pilot, 1 mother who tried to contact us during labour was not supported to do so.

Even for women who did manage to get in touch with us, the emotional cost of being dependent upon the 'good-will' of others was evident to supervisors:

'The other observation is that, I have to say, without exception, all of the labours that I've been the mentor for were harder mentally for the woman at the beginning.' [Supervisor; focus group].

'I wonder whether some of the more practical issues are around the beginning of labour. So when the women greet labour, they're actually so concerned and they may not have articulated this to anybody... who do they go and say to, 'I think I'm in labour and I don't know what to do'?' [Supervisor; focus group].

Building the cost of phoned and phone credit into the project so that women can contact us themselves early in labour would be beneficial both for women (by decreasing anxiety) and supervisors (by ensuring they receive calls early enough to get doula support in place).

Finally, it was clear from the feedback from both women and supervisors that some women were not sure exactly when they were 'allowed' to call us in early labour. Supervisors speculated that it could help avoid this confusion if we were to emphasise to women that we hope and expect to hear from them in early labour, and they do not have to wait until they are ready to go to hospital.

HBC withdrew its face-to-face doula services on 24/3/20 following lockdown due to a high number of doulas self-isolating because of symptoms or underlying health conditions which meant that we could no longer guarantee face-to-face birth support for mothers, and the extra element of risk of covid-19 infection that is created for all when a mother is accompanied by a birth companion that she does not already live with.

The remaining 5 antenatal mothers who were already enrolled in the project were offered and accepted phone support in lieu of face-to-face support. They were assigned to a doula on a 1-1 basis who spoke with them several times over the perinatal period using interpretation to provide antenatal education and information and create birth plans and postnatal support. 4/5 mothers also called in early or established labour or before elective caesarean sections. Mothers therefore received a significant amount of support over multiple phone sessions, including for long periods during labour.

ALL MOTHERS ENROLLED IN THE PILOT RECEIVED SOME FORM OF POSTNATAL SUPPORT

Regardless of whether they had called for birth support, all mothers enrolled in the pilot received some form of postnatal support. Half the mothers who gave birth before covid-19 lockdown received a postnatal visit in hospital; other mothers received postnatal support at the HBC South community group. A third of mothers received specialist breastfeeding support. Following lockdown, mothers received postnatal support on the phone. However, as it was planned that postnatal support would mainly be held by the community group from March - May 2020, (which had to close on 6/3/20 due to covid-19), it has not been possible to fully evaluate this stage.

Challenges and Reflections

Some mothers called the 24-hour number in distress whilst they were still in hospital following birth. On the basis of this, the option of one postnatal visit whilst the mother was in hospital was introduced mid-pilot and 6/13 women received a postnatal visit either from the same, or a different doula.

Both mothers and doulas found the ending of the 1-1 relationship directly after birth difficult, although doulas suggested that it may have been healthier that the locus of support moved straight back to the community project, rather than the mother becoming dependent on a single relationship with a doula. Research from other community doula projects suggests that the ending can be difficult at any point[29]. In this pilot, one mother in particular found it very hard that her doula hadn't contacted her again after the intensity of the relationship during induction, labour and birth, *'I just don't understand why she didn't contact me again.' [Mother with doula].* The HBC South Community project had to close abruptly due to covid-19. It had originally been anticipated that mothers would see their doulas again postnatally in the community group, and this may have created a gentler ending and lessened the feelings of abandonment on the part of the mother.

[29] McLeish, J, & Redshaw, M (2019). "Being the best person that they can be and the best mum": a qualitative study of community volunteer doula support for disadvantaged mothers before and after birth in England. BMC pregnancy and childbirth, 19(1), 1-11.

WORKING ALONGSIDE NHS SERVICES

Partnership working is a key element of addressing the complex needs of vulnerable groups and research has shown that community doula programmes are most successful when they build good working relationships with local maternity services based on respect for and appreciation of each other's specific roles[30]. The specialist midwives for both boroughs were actively involved in the design and planning of the original HBC South Project (in which the birth companion pilot was embedded) and both their individual support and the wider relationships they built on our behalf have continued to be a key part of our success at all stages of the pilot.

In the set-up phase, specialist midwives both contributed to the training and orientation provided for doulas (e.g. by running a workshop and providing a hospital tour) and raised awareness of the pilot with the hospitals (e.g. by disseminating information about the project on mailing lists and by hard copy). Project co-ordinators also attended meetings with both hospitals and doulas carried information sheets to give to hospital staff when they attended births.

During the operational phase, specialist midwives helped to ensure smooth running of the pilot and maintain good lines of communication with the NHS services. The quick response and commitment of the maternity unit to supporting the project is exemplified by the one occasion on which we were not contacted when the mother requested it. Following this incident, the specialist midwife sent reminders out to staff across the unit about the project, explaining both the project rationale and the processes, including to contact doulas when requested. Doulas were clear that they appreciated having a good working relationship with midwives, *'They were really onboard as soon as I came in and they knew who we were. They were really attentive.' [Doula; focus group].*

23 midwives filled in questionnaires to explore their experience of working alongside doulas. Over 95% of midwives said it was 'very easy' or 'easy' to work in partnership with the doula to support the mother (Appendix 2; Table 2). In many cases, midwives felt that the doula supported not only the women, but also themselves, *'She was a great help to the midwives,' [Midwife working alongside doula; questionnaire]. 'Invaluable to have in the room.' [Midwife working alongside doula; questionnaire].* Some midwives also referenced the ability of the doula to work within the team in maternity services, *'Blends and works so well within the care, with the midwives and birthing partner.' [Midwife working alongside doula; questionnaire].*

One midwife referenced *'feeling watched'* and it will be important, going forwards, to continue to facilitate learning opportunities for both doulas and midwives to explore the needs of the most vulnerable women in their care, and how they can work in partnership together and make effective use of their different roles to provide the best care for these women. Maintaining and developing our ways of working together will be essential to the project's success as we move forward.

[30] McLeish, J, Darwin, Z, Spiby, H et al. (2 more authors) (2016) The processes of implementing and sustaining an intensive volunteer one-to-one support (doula) service for disadvantaged pregnant women. Voluntary Sector Review: an international journal of third sector research, policy and practice, 7 (2). pp. 149-167.

CONCLUSION

This pilot model effectively delivered doula support during labour and birth for some of the most vulnerable women in our society, on occasion within hours of self-referral. 96% of the target population enrolled in the pilot. All women enrolled received antenatal support, including 1-1 support. All women also received some form of postnatal support (including postnatal hospital visits and breastfeeding support and general postnatal support either at the group pre-lockdown or by phone post-lockdown). All women who called during labour before covid-19 lockdown received face-to-face support in hospital (13 women). The project adapted rapidly post-lockdown and provided phone support (including during labour) for the remaining mothers (5 women). 78% of the target number of women (24) received support during labour and birth. It is anticipated that numbers enrolled in the pilot and therefore supported during labour and birth would have been 20-25% higher in the absence of the covid-19 pandemic.

The pilot has demonstrated the feasibility of using the voluntary sector, with the additional flexibility this brings, to provide a universal offer of birth companion support to women living in IAUs in London across boroughs, who face multiple disadvantage and sometimes do not access maternity care until they are full-term. The model has also developed the concept of embedding doula support in wider support services by delivering the antenatal and postnatal elements of the care through the medium of the group, whilst still retaining continuous 1-1 support during labour and birth. By centralising interactions within a wider service before and after birth in this way it used resources efficiently and effectively to deliver doula support to the maximum number of women and thus improved sustainability.

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WITH MANY THANKS TO:

Our informal steering group and advisors, including both specialist midwives attached to the hospitals, community member volunteer E. Sadria, statistician Dr I. Oren (affiliated to Datakind), midwifery researcher Dr L. Abbott (University of Hertfordshire) and researcher Dr. E. Brooks (University College London).

The doulas and supervisors who supported women during the pilot.

The numerous healthcare professionals who worked alongside our doulas.

The community members who shared their experiences with us for the evaluation.

APPENDIX 1 – METHODOLOGY

Recruitment

The impact of doula support on women's experiences of labour and birth was evaluated through the comparison of a pilot group of women living in IAUs and attending the HBC South project who enrolled into the pilot and gave birth with a doula and a control group of women living in IAUs and attending the HBC South project who had previously given birth without a doula.

The pilot group was formed by inviting all women enrolled in the pilot to participate in the evaluation. The control group was formed by inviting (on two successive weeks) all women present at the HBC South project who had given birth without a doula whilst living in IAUs in the preceding 8 months to participate in the evaluation. All women who were interested were given an information sheet explaining the purpose of the pilot and the evaluation (available in English, Albanian and Mandarin or read to the mother either via a telephone interpreter if she spoke a different language or by a community volunteer if she was not confident in her literacy).

All literature was reviewed and shaped by community member volunteers at the draft stage to check for clarity and understanding, as well as by other steering group members. It was made clear both verbally and through the information sheet that none of the support offered by HBC, including that provided through the pilot, was contingent on agreeing to take part in the evaluation and that community members could change their mind about participation at any point up until report completion. Community member volunteers (who have more credibility and find it easier to build trust with women) underlined this where necessary in informal conversations. Informed written consent was obtained for all women who took part.

The original targets of 20 for both the control and pilot groups had to be adjusted following covid-19 lockdown. The results of this analysis are therefore based on 12 of the 13 women that gave birth before lockdown with doula support (1 woman was lost to follow up) plus a control group of 8 women who gave birth without doula support between June 2019 – February 2020. 2 of the pilot group gave birth in Hospital 1 and 10 in Hospital 2. All of the control group gave birth at Hospital 2. One mother was moved from the pilot group to the control group after birth because she asked the hospital to contact us and they did not, so she gave birth without doula support.

Data collection

Both quantitative and qualitative data collection focussed on women's experiences of choice and consent (including information provision and language support) and their perceptions of how they were treated during labour and birth. These were chosen for particular exploration following previous research that highlights them as areas where UK maternity services struggle to offer an acceptable level of quality for women seeking asylum and facing multiple disadvantage[31], and as areas on which doula support might reasonably be expected to have an impact.

A multiple-choice questionnaire with free-text comment boxes was used to collect quantitative and qualitative data exploring women's labour and birth experiences, interventions and outcomes.

[31] Birthrights and Birth Companions (2019). Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care. London [online].

This was available in English and Albanian (to cater for our main language group) or was filled in via an interpreter. Prior to covid-19 lockdown, women were offered the choice of filling in the questionnaire at the project or in the hostel. Following lockdown, women were supported over the phone by a community member volunteer and/or the project co-ordinator to fill out the questionnaire. Birth interventions and outcomes questionnaires were also completed by doulas after every birth.

All women who filled out questionnaires were invited to take part in 1-1 semi-structured interviews (using topic guides focussing on the areas described above) to collect more in-depth qualitative data on their experiences. It was noticeable that some women in the control group who agreed to fill in the questionnaire did not want to be interviewed (because they did not want to go back over their experience in detail). Information was provided as previously and informed written consent was obtained before interviews. Interviews were conducted by the HBC Evaluation Project Lead who was not involved in direct delivery of the birth support but who worked in the community group and hence had had the opportunity to build trusted relationships with the women being interviewed.

Interviews were originally planned to continue until saturation was reached (i.e. when no new themes are emerging from the data); however, only 3 interviews were completed before covid-19 lockdown (1 control and 2 pilot). 2 were conducted via an interpreter and 1 was conducted in English (which was the mother's second language). In recognition of the practical and ethical issues faced when conducting sensitive interviews over the phone via an interpreter, this facet of the evaluation was suspended.

Demographic data was collected for all 23 women who enrolled in the pilot, including age, country of origin, level of English, first language, parity, presence of partner and trauma indicators (by self-disclosure only). Demographic data was not collected systematically for women in the control group as it became clear they were much more reticent about providing information and that these questions were discouraging participation. The control group was drawn from the same wider pool of women and therefore their demographic data is not likely to be significantly different, but this should nevertheless be addressed in future evaluations.

Midwives working alongside doulas were invited by the doula to fill in multiple choice questionnaires with free text boxes for comments about their experience (Appendix 2, Table 2). Questionnaires were agreed beforehand with specialist midwives and maternity care management in both hospitals. After filling in the questionnaire, midwives were asked to place it in the sealed envelope provided and hand it back to the doula to give to the project co-ordinators. The email of the project coordinator was also provided as an alternative. 23 midwives (1-2 per birth on average) completed this form.

2 semi-structured focus groups (using topic guides) were run via zoom with doulas (n=6) and doula supervisors (n=3) to explore their perspectives.

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Quantitative analysis

The answers to the 9 multiple choice questions that could be scored (Appendix 2, Table 1) were used to create an ordinal data set that could be analysed statistically to compare response distributions for women with and without doulas. Answers were scored either from 1-4 or 1-3 (where 1 = most positive and 3 or 4 = most negative). One woman with an incomplete dataset (3/9 questions) was removed before the analysis was performed. Two women with one missing response each were left in. The non-parametric Mann-Whitney Test was used to compare responses between groups (with doula, n=11; no doula, n=8). Non-parametric testing was used to account for non-normal, ordinal data. A Bonferoni-Holm post hoc adjustment was applied to correct for multiple comparisons. Statistical analysis was designed and run by an independent statistician affiliated with 'Datakind'. The statistician was blinded to group and question.

Although birth outcomes and interventions at each stage of labour were collected from women in both the control and pilot groups, as well as from the doulas for the pilot group, this data was not analysed due to the smaller than expected sample sizes and the lack of agreement between doula's answers and women's answers for several questions, suggesting that women either did not know the answer or did not understand the question. Longer-term patient outcome measures (such as breastfeeding rates at 6 weeks and interaction with health care services postnatally) were not collected due to the potential confounding effect of covid-19 lockdown.

Qualitative analysis

Focus groups and interviews were audio-recorded and professionally transcribed. All comments were extracted from questionnaires and collated. Transcripts and comments were subject to analysis by the project evaluation lead to explore emerging themes. The interpretation of emerging themes was assisted by 2 independent researchers from the field.

Methodological limitations

Sample sizes in both groups were smaller than planned due to covid-19 lockdown. The control group sample in particular may not represent the true diversity of the group because it is restricted to those women present at the community group on two weeks in succession when project information was distributed (it had originally been intended that this information would be distributed over a much longer time-frame but this was cut short due to covid-19 lockdown). Due to ethical reasons, the control group was taken from women who had given birth prior to the start of the pilot, and so assignment to control or pilot group was not random.

The evaluation was completed by the project evaluation lead who was also involved in the design of the project. To ensure objectivity, external support was accessed in the design of the evaluation, and three independent advisors (see acknowledgements) assisted with and checked qualitative and quantitative data analysis.

APPENDIX 2 – TABLES

Table 1 – Mothers' experiences of labour and birth

1A Multiple choice questions used for statistical analysis

Q1. How did you feel during labour and birth? Very safe / safe / not very safe / very unsafe
Q2. Were you left alone at a time that you didn't want to be? Yes a lot / yes a bit / no I wasn't
Q3. Were the midwives, doctors and other hospital staff kind and caring towards you? Very kind / kind / not very kind / very unkind
Q4. Did the midwives, doctors and other hospital staff listen to you and what you wanted? Yes, very well / Yes, quite well / No, not very well / No, not at all
Q5. Did you feel you could ask for help if you needed it? Very easy / easy / quite hard / impossible
Q6. How much did you understand about the care you were offered/what was happening/ what midwives and doctors were doing? Everything / most things / some things / nothing
Q7. Were there things you wanted to ask about but didn't? Lots of things / some things / nothing
Q8. Were you able to make choices about what happened (e.g. what pain relief you had) during birth? Making choices was: very easy / easy / difficult / very difficult
Q9. Were you able to say 'no' if you didn't want something to happen? Saying no was: very easy / easy / difficult / very difficult

1B Summary statistics of multiple-choice questions

Summary

	Mode		Mean			Effect size[a]	Conf. Interval[b]	
Question	No Doula	With Doula	No Doula	With Doula	p	A	Lower	Upper
Q1	4	2	3.375	1.909	0.009	0.926	0.681	1.000
Q2	3	1	2.375	1.000	0.009	0.875	0.613	1.000
Q3	2	2	2.625	2.045	0.747	0.648	0.281	0.945
Q4	2	2	2.500	2.364	0.962	0.511	0.189	0.863
Q5	2	1	2.625	1.500	0.032	0.795	0.528	1.000
Q6	2	1	2.750	1.636	0.111	0.807	0.473	1.000
Q7	3	1	2.375	1.364	0.067	0.830	0.567	1.000
Q8	2	2	3.000	2.000	0.148	0.778	0.534	0.958
Q9	2	2	2.500	2.100	0.861	0.540	0.304	0.786

[a] Vargha Delaney's A with Bonferoni-Holm correction. A = 0.5 indicates that the groups are stochastically equal. A approaching 1 indicates a strong effect of 'No Doula' > 'With Doula'

[b] Confidence interval for Vargha Delaney's A. A range excluding 0.5 suggests a significant difference between the groups. Note that the confidence interval suggests that the response to Question 7 differed significantly between the groups, although the p value did not reveal this.

Table 2 – Midwife responses to multiple-choice questionnaire

Midwife Experience Questions	Percentage (%) of midwives answering:			
What was the mother's level of English?	**Fluent**	**Medium**	**Basic**	**No English**
	4	4	22	70
How did the presence and support of a Happy Baby Community doula affect your ability:	**Much easier**	**Easier**	**More difficult**	**Much more difficult**
1. to communicate with the mother?	26	70	4	0
2. to care for the mother's overall wellbeing during labour and birth?	70	26	4	0
3. to care for the mother's overall wellbeing during the immediate postnatal period?	79	14	7	0
4. to offer the mother choices during labour and birth?	50	45	5	0
5. to enable the mother to give informed consent during labour and birth?	48	48	4	0
Was it possible to work in partnership with the doula to support the mother?	**Very easy**	**Easy**	**Difficult**	**Very difficult**
	83	13	4	0

HAPPY BABY COMMUNITY

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