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Factors affecting the implementation and sustainability of an Australian community-based doula service: A qualitative study

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ABSTRACT

Background: Community-based doula support for women and gender-diverse birthing people has a range of benefits in improving maternal outcomes and experiences. However, there is limited research on how doula services operate in Australia. Birth for Humankind is an Australian community-based volunteer doula service, which provides free doula support for women and gender diverse birthing people experiencing social discrimination and financial disadvantage. The aim of this study was to understand facilitators and barriers to implementation and sustainability of a community-based doula service delivered to clients concurrently receiving care at a major maternity hospital in Melbourne, Australia.

Methods: We conducted a qualitative study consisting of 30 in-depth interviews with doulas and managers of the community-based doula service Birth for Humankind, and midwives, doctors and social workers from a maternity hospital. Data were inductively thematically analysed, and themes were then deductively categorised using the Capability, Opportunity, and Motivation (COM-B) model and Theoretical Domains Framework (TDF) to understand behavioural influences and facilitators and barriers to implementing and sustaining the doula service within a hospital setting.

Results: Facilitators to implementation of the doula service included: collaborative relationships; having sound knowledge of referral processes; and being a valued professional doula service with dedicated volunteers. Barriers to implementation included: limited knowledge of the doula service from hospital staff; difficulty in retaining volunteer doulas; being a small non-profit doula service; and limited capacity of hospitals to financially support the doula service. Advocacy for renumerating doulas may be one means to strengthen and sustain existing doula-provider service relationships.

Conclusion: Consideration of establishing strategic partnerships between the doula service and hospitals may create financially-sustainable pathways to enable provision of high-quality, community-based doula support for women and gender diverse birthing people to continue.

1. Introduction

The benefits of continuous support from doulas during labour and birth are well-documented and include lower rates of caesarean section, more positive birthing experiences, and prolonged breastfeeding rates (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Caughey, Cahill, Guise, & Rouse, 2014; Gruber, Cupito, & Dobson, 2013). Doulas are non-medical birth support people trained in providing continuous emotional, practical and social support (Bohren et al., 2017, 2019; Meadow, 2015; Steel, Frawley, Adams, & Diezel, 2015; Waller-Wise,

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2018). Doulas can provide continuous support throughout the pregnancy, perinatal, and postnatal periods (Bohren et al., 2019). Private practice doulas charge an estimated $800AUD to $2,000AUD for their services in Australia, that may include support throughout the entire perinatal journey or a specific timeframe such as postnatal support only (O'Connor, 2021). Private practice doulas may also be seen as involved in decision-making and limited regulation which may contribute to mixed acceptance and understanding of doula roles among providers, particularly during labour and birth (O'Connor, 2021; Stevens, 2011). In practice, doula support in high-income countries (HICs) is often limited to women of higher socioeconomic status, who can afford private practice doulas (Bohren et al., 2017; Steel, Frawley, Sibbritt, & Adams, 2013; Stevens, 2011). For lower-income individuals earning less than $500AUD a week in Victoria, Australia these doula support services are often financial inaccessible (Australian Bureau of Statistics, 2021).

In contrast, community-based doula support for women and gender diverse birthing people from socially disadvantaged backgrounds (e.g. lower socioeconomic and limited social supports), has emerged in response to inequities in childbirth outcomes and negative experiences within maternity settings (Akhavan & Edge, 2012; Dundek, 2006; Mottl-Santiago et al., 2008; Spiby et al., 2015). Community-based doulas share the same cultural, language and/or racial backgrounds with those who they support, and/or support communities on a needs-based approach (e.g. financial hardship) (Akhavan & Edge, 2012; Khaw et al., 2022; Spiby et al., 2015). Community-based doula services typically operate externally to maternity hospitals, are often non-profit, and provide free or low-cost services (Akhavan & Edge, 2012; Khaw et al., 2022; Spiby et al., 2015). Typically, the community-based doula workforce is comprised of volunteers or staff who are only partially reimbursed for services rendered (Khaw et al., 2022). Community-based doula services have historically served socially disadvantaged women in HICs including: Black and minority ethnic groups in the United States (LaMancuso, Goldman, & Nothnagle, 2016; Reed et al., 2023); migrant and refugee women in Sweden (Akhavan & Edge, 2012; Schytt et al., 2021, 2022); and women and gender diverse birthing people from socially disadvantaged backgrounds in the United Kingdom (Spiby et al., 2015) and more recently in Australia (Khaw, Homer, Dearnley, O'Rourke et al., 2023; O'Rourke, Yelland, Newton, & Shafiei, 2022).

Australia has a universal health care system, where public health maternity services are accessible to most women and birthing people via Medicare, a public health insurance scheme, and government taxation policies (The Commonwealth Fund, 2016; Willis et al., 2012). Public hospital maternity care ('standard care') is the most common model of care, received by 41 per cent of women and birthing people in Australia (Australian Institute of Health and Welfare, 2023). Standard care is provided by various midwives and obstetricians for all-risk pregnancies, with midwives as the primary maternity care provider for 46 per cent of clients (Australian Institute of Health and Welfare, 2023; Tracy et al., 2014). However, there are limited options for continuity of care within the standard care model, as clients see different providers in the public system (Tracy et al., 2014).

Midwifery Group Practices (MGP) are one care model that promotes continuity of care, and currently accounts for 14 per cent of pregnancy care in Australia (Australian Institute of Health and Welfare, 2023). In public hospitals, low-risk women are supported by a known primary midwife throughout pregnancy and birth, which has been associated with better birth outcomes (i.e. spontaneous births, lower rates of caesareans) and birth satisfaction (Tracy et al., 2014). Although the benefits of continuity of care through MGP are well-established, there are limited dedicated maternity care programs for specific population groups such as young women, Aboriginal and Torres Strait Islander women, and migrant and refugee women. In Australia, community-based doula support may help to address these gaps (Australian Institute of Health and Welfare, 2023).

A recent evaluation of Birth for Humankind, an Australian community-based doula service, demonstrated positive short- and long-term outcomes in terms of client confidence and lasting improved psychological wellbeing (O'Rourke et al., 2022). A qualitative study in Australia likewise demonstrated how doulas provided culturally-responsive care for migrant women through respectful care, enhanced maternity care experiences, and supportive relationships with individual maternity care providers (Khaw, Homer, Dearnley, O'Rourke et al., 2023). Moreover, when both doulas and health workers understood each other's roles, positive working relationships could ensue, which appeared to sustain relationships, and thus professional maternity care providers' acceptance and appreciation of the doula service (Khaw, Homer, Dearnley, O'Rourke, et al., 2023). However, aside from these potential relational approaches in sustaining the doula service which are supported by Swedish (Akhavan & Edge, 2012; Schytt et al., 2021, 2022), English (Spiby et al., 2015) and American (Reed et al., 2023) community-based doula program evaluations there has been limited exploration of other institutional or systemic factors influencing organisations (Marshall et al., 2022; Spiby et al., 2015), such as Birth for Humankind.

A recent systematic review focusing on community-based doula support for migrant women from low- and middle-income countries (LMICs) resettling in HICs showed that doulas complemented mainstream maternity care systems by providing culturally-responsive care (Khaw et al., 2022). The doula services described in that review varied substantially in terms of client eligibility criteria, doula reimbursement, and doula backgrounds (e.g. culturally-matched or needs-based) (Khaw et al., 2022). However, despite these differences, the review found common implementation and sustainability issues faced by services. These included the need for doula role clarity, difficulties faced in relation to a volunteer workforce (e.g. attrition), the demanding nature of doula work, and precarious funding of doula services (Khaw et al., 2022). The variation of community-based doula programs in HICs and results from this review provided limited exploration into the implementation and sustainability of these doula services in the Australian context (Khaw et al., 2022).

Therefore, the aim of this study was to explore factors affecting the implementation and sustainability of a community-based doula service providing support to Australian clients concurrently in the care of mainstream maternity services.

2. Material and methods

2.1. Qualitative approach and paradigm

We used interpretive phenomenology and social constructivism as theoretical frameworks to explore the phenomenon of interest: community-based doulas (Gray, 2021; Liamputtong, 2013). These theoretical approaches acknowledge the existence of multiple realities when understanding a phenomenon, such as possible factors impacting the implementation and sustainability of community-based doula programs (Gray, 2021; Liamputtong, 2013). An interpretive

phenomenological approach posits the human experience as valuable in understanding the lived experiences of participants lives which inherently are not fixed and impacted by their interactions in the sociocultural contexts they live within (Gray, 2021; Liamputtong, 2013). Seeking multiple perspectives aligns with the social constructivist paradigm and interpretive phenomenological lens to understand possible similarities or divergences of the same phenomenon (Baxter & Jack, 2010; Charlick, Pincombe, McKellar, & Gordon, 2016; Yin, 2014). Standards for reporting qualitative research (SRQR) guidelines (Tong, Sainsbury, & Craig, 2007) were used for reporting (Appendix A).

2.2. Birth for Humankind

Birth for Humankind is the only community-based volunteer doula organisation supporting women and gender diverse birthing people with free doula support in Melbourne, Victoria, Australia. Birth for Humankind provides doula care throughout pregnancy, labour and birth, postpartum periods, and during late-term abortions for women and gender diverse people experiencing social and financial hardship [18]. In the 2022–2023 financial year, Birth for Humankind doulas supported 116 clients, including: labour and birth support for 79 clients; extended postnatal support for 28 clients; and abortion support for 9 clients (Birth for Humankind, 2023a). Most of these clients had no other birth support person available (81%), and were at risk of perinatal mental health challenges (76%) and/or family violence or trauma (73%) (Birth for Humankind, 2023a). In 2021–2022, refugee and newly-arrived migrants comprised 55% of clients respectively, with 32% of clients using interpreters and over half (56%) having a primary language other than English (Birth for Humankind, 2022). Public maternity hospitals were the main referrers to Birth for Humankind, comprising 69% of all referrals (Birth for Humankind, 2023a).

Birth for Humankind requires doulas to have training prior to volunteering, such as being a midwifery student, practising or retired midwife, private practice doula, or a graduate of Birth for Humankind's Foundational Doula Training course, which provides full scholarships to those from bicultural backgrounds (Khaw et al., 2022). However, doulas volunteering for Birth for Humankind only function in a non-clinical community-based doula support function. All volunteers are required to attend Birth for Humankind's Doula Induction Training course and have Doula Code of Practice governing their roles and responsibilities [19]. This includes acknowledging their roles as a doula and not making decisions for clients nor performing clinical tasks, and when something is out of their scope of practice to refer to their doula managers or to the appropriate support services (Birth for Humankind, 2023b).

2.3. Study context and sites

This study was part of a larger doctoral study of the experiences of migrant women with community-based doula services (Khaw, Homer, Dearnley, O'Rourke et al., 2023; Khaw, Homer, Dearnley, O'Rourke, et al., 2023). The two study settings in this study were both located in Melbourne: Birth for Humankind and a tertiary public maternity hospital, which provides higher acuity of specialist maternal and newborn care. Both organisations service diverse clients, including migrant women. The research team involved key stakeholders from the hospital and Birth for Humankind throughout the study design, from initial study conceptualisation, participant recruitment, implementation and data collection, through data analysis, synthesis of findings and dissemination.

2.4. Study sampling, recruitment and consent

Inclusion criteria required participants to have experience supporting migrant and refugee women clients of Birth for Humankind (the population group of interest for the SMK's doctoral research) or be employed by the doula service and hospital at the supervisory or managerial level. We elected to recruit participants from Birth for Humankind and a maternity hospital to gain rich insights from multiple perspectives on possible factors influencing the implementation and sustainability of community-based doula services (Gray, 2021; Liamputtong, 2013).

A variety of purposive, snowball and random recruitment strategies were used across both study sites, commencing 22 June 2021. Recruitment of Birth for Humankind doulas involved: direct email invitations from study personnel to Birth for Humankind managers; four rounds of email invitations from Birth for Humankind's Programs Manager and Programs Support Officer to volunteer doulas and in-person recruitment of doulas in the hospital setting. Recruitment of tertiary maternity public hospital staff included: flyers in hospital common areas (e.g. tea rooms); two rounds of hospital-wide email invitations to midwives and doctors; in-person recruitment; and snowball sampling. We purposively recruited social workers and maternity managers through direct email invitations.

Consent was provided as written or verbal (audio-recorded) before participant interviews. All but one participant accepted reimbursement for their time (an AUD$40 gift card). Recruitment concluded once participant interview data sufficiency was achieved (Braun & Clarke, 2021b). Participants could withdraw their consent to participate, and their unprocessed interview data, until the data analysis stage. There were no participant withdrawals from the study.

2.5. Data collection and management

Qualitative in-depth, semi-structured interviews guides for each profession (doula, doula managers, hospital providers (i.e. midwives and doctors) and hospital manager) were informed by a socio-ecological model of health approach (Golden, 2012), to examine possible personal, interpersonal, organisational and systemic influences on a community-based doula service (Appendix B).

Questions were pilot tested with a doula and two midwives. The audio recordings, transcripts and SMK's post-interview notes from these pilot interviews were checked with the research team, and the interview guide was refined with an introduction of SMK's positionalities included for transparency.

SMK audio recorded and transcribed reflective post-interview notes, and transcribed all interviews using Otter. ai transcription software, with transcripts checked for accuracy against the audio recordings Otter. ai, Inc. (2022). This process involved the first phase of Braun and Clarke's (2022) thematic analysis of familiarisation (Braun & Clarke, 2021a). SMK engaged in familiarisation through: re-reading transcripts; reviewing reflective post-interview notes; and engaged critically with the transcripts before starting data analysis (Braun & Clarke, 2021a). All participants were given the opportunity to member-check their transcripts (e.g. include more detail, ensure clarity, make corrections) (Mero-Jaffe, 2011), with 13/30 doing so.

All written data and digital audio records were password-protected in a secure cloud storage system, with access only for SMK. Transcripts for imported and managed in NVivo software (QSR International Pty Ltd, 2020). Confidentiality was maintained by redacting personal information in transcripts and assigning pseudonyms; only SMK had access to the identification key.

2.6. Data analysis

Data collection and analysis occurred simultaneously. Firstly, data inductively underwent the remaining phases of thematic analysis to ensure rigour which involved: 2) line-by-line coding of transcript; 3) developing themes by grouping into initial codes; 4) editing and revising themes; 5) defining final themes; and 6) writing the final analysis (Braun & Clarke, 2021a). Data then underwent deductive analysis guided by two models of behaviour change – the COM-B (Capability, Opportunity, and Motivation) (Michie, van Stralen, & West, 2011) and TDF (Theoretical Domains Framework) (Atkins et al., 2017). We introduced these

frameworks to understand what intrinsic behavioural and psychological factors may be required to positively enact a targeted behaviour (Atkins et al., 2017; De Leo, Bayes, Bloxsome, & Butt, 2021). The targeted behaviour analysed was implementing and sustaining a community-based doula service in a hospital setting.

All participant groups were analysed separately to understand their own realities and explore similar themes with other participant groups (Braun & Clarke, 2021a). The major themes derived from the thematic analysis were then deductively mapped to a COM-B model (i.e. Behaviour Change Wheel) as it is theorised that individuals require Capability, Opportunity, and Motivation to influence behavioural change (Michie et al., 2011). The COM-B model highlights six individual determinants which are required for overall organisational change which include: an individual's physical and psychological Capability to engage in the behavioural change; their behaviours and processes related to their Motivation to adopt change; and lastly the environmental and socio-cultural Opportunities that impact an individual's own abilities to change (De Leo et al., 2021). From these findings, the COM-B model was integrated into a TDF to investigate the nuances of the COM-B model's categories of Capability, Opportunity and Motivation (Atkins et al., 2017). The TDF comprises of 14 determinants which are 'cognitive, affective, social and environmental influences on behaviour' (Figure B) (Atkins et al., 2017, p. 2).

Therefore, by identifying the key determinants for behaviour change from both the COM-B and TDF models, there will be evidence for practical application and identified areas that may need to change for the targeted behaviour to be enacted (Atkins et al., 2017). Stakeholders from both the doula service and hospital may benefit from understanding the identified areas which may enhance or limit overall individual and organisational change towards implementing and sustaining a community-based doula service in the hospital setting (i.e. the target behaviour) (Atkins et al., 2017; De Leo et al., 2021; Michie et al., 2011).

All transcripts were analysed by SMK, and feedback was provided throughout different stages of thematic analysis and COM-B and TDF frameworks which was checked by members of the research team (MAB, CSEH) and community-stakeholders (KO, RD).

2.7. Ethics

Human research ethical approvals were sought and granted from The University of Melbourne (2021-21783-18828-3) and the Victorian maternity tertiary hospital Human Research Ethics Committee (XXXXX/XXX-XX-XX). Approvals were also sought and granted from both organisational and maternity departments involved.

2.8. Researcher reflexivity

All authors acknowledged their expertise may influence the study and therefore engaged in reflexive practice throughout each stage: public health and maternal health research (MAB, CSEH and KO); midwifery (CSEH, SMK); and community-based doula programmes (RD and KO). SMK is an Australian-born, second-generation Chinese Malaysian migrant woman. Her background as a midwife and public health practitioner shaped her research interests in migrant and refugee women's maternal health. These positionalities were disclosed to all participants prior to their participation. SMK has been trained in qualitative research through as a student and researcher.

3. Results

3.1. Sample

Thirty people participated in this study, of 37 directly invited. Interviews were conducted by SMK from June 2021 through July 2022, through Zoom calls (Zoom Video Communications Inc, 2024). The COVID-19 pandemic social distancing measures prevented in-person interviews.

Participants included: Birth for Humankind volunteer doulas (n = 10) and managers (n = 2), hospital-based midwives (n = 11), doctors (n = 2), a maternity manager (n = 1) and social workers (n = 4). Table 1 shows demographic and work characteristics of the participants, including age range, years of experience and roles and occupations at the time of their interviews. Participants' ethnic backgrounds were mostly white Australian (83%). Other participants' ethnic backgrounds (17%) will not be shared due to the limited sample sizes preventing anonymity.

3.2. Findings from inductive thematic analysis

The qualitative methods and diverse range of participants engaged in this study provided in-depth perspectives on how to implement and sustain the Birth for Humankind. Fig. 1 presents the inductive thematic analysis findings, categorised by the COM-B framework.

Fig. 2 then shows factors affecting the implementation and sustainability mapped as barriers (brown), facilitators (dark blue) or mixed (both barriers and facilitators; yellow). Mixed factors reflect factors which may support or challenge the implementation and sustainability of a community-based doula services. For example, an emotional factor when doulas provide trauma-informed care is a valuable service for clients (facilitator), however, doulas have expressed the challenges of providing this care on their own wellbeing (barrier).

3.3. Capability

Capability reflects the interviewees' perception of the capability of the community-based doula service and hospital to both physically and 'psychologically' implement and sustain a community-based doula service (Michie et al., 2011). Capability was facilitated by individuals' knowledge of the doula service; well-established individual relationships, and adapting to change to enhance the quality of care for clients. A barrier to capability was providers' limited knowledge of the scope of the doula service.

3.3.1. Facilitators

3.3.1.1. Knowledge of Birth for Humankind. Most providers encountered Birth for Humankind's doula service and their doulas when caring for a woman in the birth centre. As a midwife expressed:

Table 1
Characteristics of participants.

Characteristic	n (%) n = 30
Age	
20–29	11 (36.7%)
30–39	11(36.7%)
40–49	3 (10.0%)
50–65	5 (16.7%)
Years of experience	
0–2	8 (26.7%)
3–5	12 (40.0%)
6–8	5 (16.7%)
≥9	5 (16.7%)
Birth for Humankind participants	(n = 12)
Bicultural doula	1 (8.3%)
Doula	9 (75.0%)
Doula manager	2 (16.7%)
Maternity hospital participants	(n = 18)
Midwife	11 (61.1%)
Obstetrics and Gynaecology Registrar	2 (11.1 %)
Social worker	4 (22.2%)
Maternity manager	1 (5.6%)

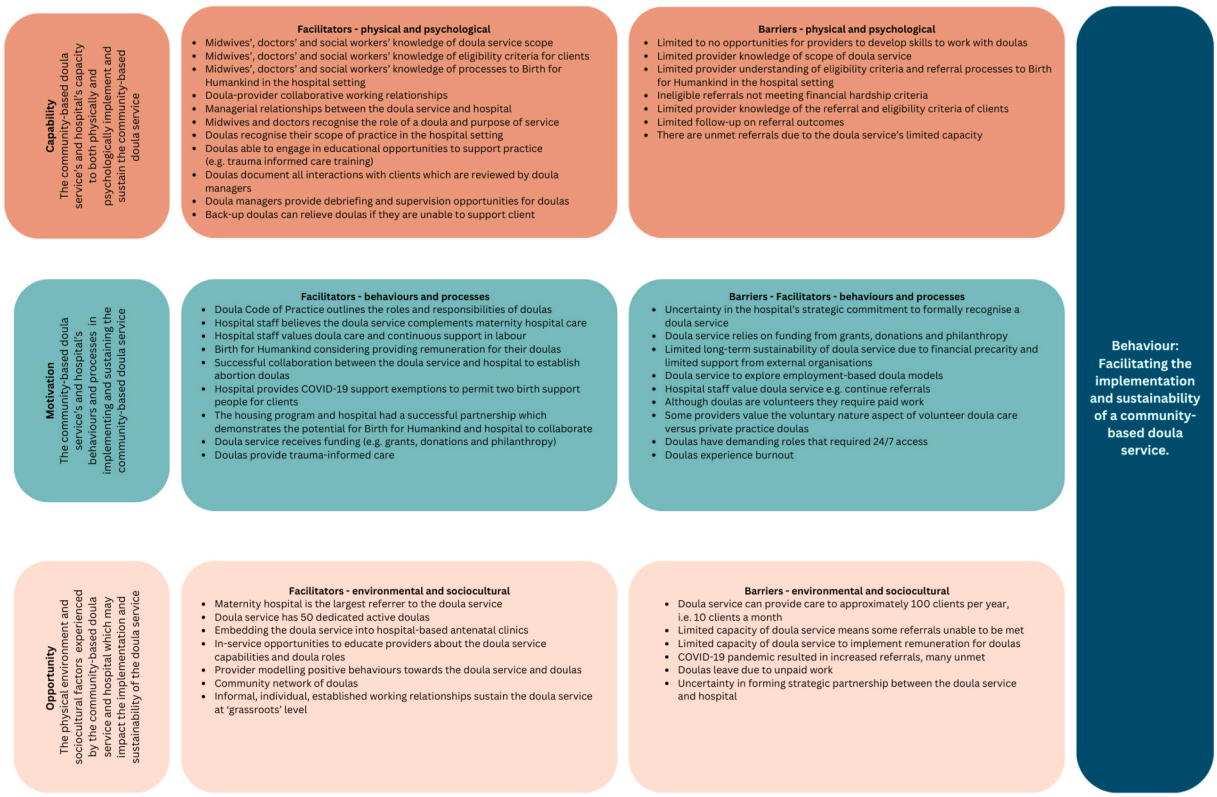

Figure A. Findings from thematic analysis, mapped to the COM-B framework to demonstrate the facilitators and barriers of the behaviour of interest – implementing and sustaining a community-based doula service.

> And it was really lovely hearing about it from her [doula]. It [Birth for Humankind] was a service I didn't know existed. So I was very impressed that was in existence. (Midwife 11)

Providers had positive perspectives of doulas when they understood that most clients were migrant and refugee women who 'might not have family members in Australia' (Doctor 2) or be from other systemically marginalised communities, and understood the value that doula support provided.

The social workers were aware of the service saying that the doula service was 'well known within the social work department' (Social worker 4) and promoted the service via word-of-mouth. The hospital's social work team were the 'main referrer(s)' (Social worker 2) to the doula service where 'most of [their] clients are booked' (Doula manager 2). Interviewees demonstrated a clear understanding of the doula service, and mentioned referring prospective eligible clients, who were primarily experiencing financial hardship in addition to other intersecting identities or experiences (e.g. migrant or refugee status, homelessness). Birth for Humankind's staff team members reinforced social workers' efficiency at providing 'the right amount of information to get a good understanding about the client and their needs' (Doula manager 2), illuminating a congruent relationship between both organisations.

3.3.1.2. Well-established individual working relationships. The relationship between doula managers and hospital social workers appeared to be well-established, from the inception of Birth for Humankind being at the hospital setting itself. Some social worker and doula manager participants expressed this relationship began in 2014 when a young woman who had no birth support was referred by a hospital social worker to another social worker who was doula that provided free doula support. The doula service, being community-based, was 'separate from the hospital, but were accepted by the hospital as well' (Doula manager 2). The relationship between both organisations was described as 'very informal and based on interactions about clients most of the time' (Doula manager 2). As the maternity manager observed:

> … even though we haven't met a lot of them. We've had a lot of email conversations … overall, I think we have a pretty good working relationship with people at [hospital name]. (Maternity manager 1).

This reflected the maternity manager's and doula managers' ability to foster collegial working relationships.

3.3.1.3. Adapting to change together. Participants from both Birth for Humankind and the hospital demonstrated their capabilities of working together to enhance the experiences received by doula clients. The relationships between doulas and providers and supervisors from both organisations (e.g. social workers, managers) were strengthened, especially during the COVID-19 pandemic – mainly due to the impact of staffing issues and in-person hospital restrictions.

For example, Birth for Humankind enhanced care by introducing a late-term abortion doula support service, informally initiated by the hospital due to limited support options for this service in COVID-19 pandemic. Birth for Humankind doulas provided socioemotional birth support for clients with 'additional vulnerabilities' (Social worker 3) who had late-term abortions requiring physiological birth. As the maternity manager explained:

> … this woman had not told anybody she was pregnant … she was very vulnerable … I had heard that Birth for Humankind were providing abortion doulas … I reached out, 'Look, we're really ramping up the service, we're finding, due to COVID.' (Maternity manager 1)

Despite the doula service not having a 'dedicated [abortion] training pathway … they were still happy to jump in and provide the care' (Maternity manager 1). The birth doula services were adapted and were able to allocate doulas to provide abortion support. This partnership

COM-B component	TDF domains	Relevance of domain	Factor type
Psychological capability	Knowledge	Midwives', doctors' and social workers' knowledge of doula service scope	Mixed
		Midwives', doctors' and social workers' knowledge of eligibility criteria for clients	Mixed
		Midwives', doctors' and social workers' knowledge of referral processes to Birth for Humankind in the hospital setting	Mixed
	Interpersonal skills	Doula-provider collaborative working relationships	Mixed
		Managerial relationships between the doula service and hospital	Facilitator
	Memory, attention and decision processes	Midwives and doctors recognise the role of a doula and purpose of service	Facilitator
		Midwives and doctors recognise the referral and eligibility criteria of clients	Mixed
		Social workers and maternity manager recognise the role of a doula and purpose of service	Facilitator
		Social workers and maternity manager recognise the referral and eligibility criteria of clients	Mixed
		Doulas recognise their scope of practice in the hospital setting	Facilitator
	Behavioural regulation	Limited to no opportunities for providers to develop skills to work with doulas	Barrier
		Doulas able to engage in educational opportunities to support practice (e.g. trauma-informed training)	Facilitator
		Doulas document all client-doula interactions, which are reviewed by doula managers	Facilitator
		Doula managers provide debriefing and supervision opportunities for doulas	Facilitator
		Back-up doulas can relieve doulas if they are unable to support client	Facilitator
Reflective motivation	Professional, social role and identity	Providers understand the role and scope of doula practice and relationship to their scope of practice	Facilitator
		Doulas understand the role and scope of providers and relationship to their scope of practice	Facilitator
		Uncertainty in the hospital's organisational commitment to formally recognise a doula service	Barrier
		Potential opportunities for both organisations to engage in joint funding partnerships	Facilitator
		Doula Code of Practice outlines the roles and responsibilities expected of doulas	Facilitator
	Beliefs about capabilities	Hospital staff believe the doula service complements maternity hospital care	Facilitator
		Hospital staff understand the benefits of providing doula care and continuous support in labour	Facilitator
		Hospital staff collaboratively work with external organisations to provide continuity of care	Facilitator
		Hospital staff commit to continuity of maternity care models	Facilitator
		Hospital staff enact a social model of care	Facilitator
	Optimism	Birth for Humankind consider providing remuneration for their doulas	Mixed
		Successful collaboration between the doula service and hospital to establish abortion doulas	Facilitator
		Hospital provides COVID-19 support exemptions to permit two birth support people for clients	Facilitator
		The housing program and hospital had a successful partnership which demonstrates the potential for Birth for Humankind and hospital to collaborate	Facilitator
		Doula service receives funding (e.g. grants, donations, philanthropy)	Mixed

Figure B. Mapping TDF domains against components of the COM-B model that relate to the desired behaviour – implementing and sustaining a community-based doula service.

demonstrated strong rapport and improved the quality of care provided by the hospital, particularly when staffing issues limit provision of continuity of care for these clients.

Another example of enhancing the provision of care for doula clients was through social workers and maternity managers ensuring in-hospital support was available to Birth for Humankind clients during the pandemic when only one person was permitted. As a social worker explained:

> … there's been a couple of times where clients have come to appointments with their partner and their Birth for Humankind doula, and then someone's not being allowed to enter, whereas if we're aware that there's a doula we can already apply for an exemption to be allowed to bring an additional person. (Social worker 2)

Doula birth support for clients was also beneficial to providers during the pandemic. As a midwife expressed:

> And everybody's super stretched [in the hospital], which is all the more reason why these women need extra support because health-care professionals at the moment are just running on empty. (Midwife 2)

These examples demonstrated the invaluable nature of the doula service in which individuals from both organisations went beyond their

COM-B component	TDF domains	Relevance of domain	Factor type
	Beliefs about consequences	Limited long-term sustainability of doula service due to financial precarity and limited support from external organisations	Barrier
	Intentions	Doula service to explore employment-based doula models	Mixed
		Hospital staff value doula service, e.g. continue referrals	Mixed
	Goals	Doula service desire to establish remuneration to doulas	Facilitator
		Doula service desire to increase capacity and provide more doula support	Facilitator
		Doula service desire to partner with external organisations (e.g. hospital)	Facilitator
		Hospital desire to increase continuity of care, and see role of doula service in this	Facilitator
		Hospital's values align with doula service (social model of health)	Facilitator
Automatic motivation	Reinforcement	Doulas are volunteers but require paid work	Barrier
		Some providers value the voluntary nature aspect of volunteer doula care versus private practice doulas	Barrier
	Emotion	Doulas are highly motivated to support women and gender diverse birthing people	Facilitator
		Doulas have demanding roles that require 24/7 availability for birth support	Barrier
		Doulas provide trauma-informed care	Mixed
		Doulas experience burnout	Barrier
Physical opportunity	Environmental context and resources	Maternity hospital is the largest referrer to the doula service	Mixed
		Doula service has 50 dedicated active doulas	Mixed
		Doula service can provide care to approximately 100 clients per year, i.e. 10 clients per month	Barrier
		Limited capacity of doula service means some referrals unable to be met	Barrier
		Limited capacity of doula service to implement remuneration for doulas	Barrier
		Embedding doula service into hospital-based antenatal clinics	Facilitator
		In-service opportunities to educate providers about doula service capabilities and doula roles	Facilitator
		COVID-19 pandemic resulted in increased referrals, many unmet	Barrier
		Doulas leave due to unpaid work	Barrier
Social opportunity	Social influences	Provider beliefs about doulas and roles	Mixed
		Provider modelling positive behaviours towards doula service and doulas	Facilitator
		Community network of doulas	Facilitator
		Informal, individual, established working relationships sustain the doula service at 'grassroots' level	Facilitator
		Uncertainty in forming formal strategic partnership between doula service and hospital	Barrier

Figure B. (*continued*).

usual scope (e.g. making referrals) to improve quality of care within their services.

3.3.2. Barriers

3.3.2.1. Limited provider knowledge of the scope of Birth for Humankind services. While well-established individual relationships were a substantial enabler, in contrast, limited knowledge of the scope of doulas and the doula service presented a barrier. Providers highlighted limited knowledge of the scope of doulas and the doula service, eligibility criteria of prospective clients and referral processes. Despite the doula service operating for eight years (at the time of the interviews from 2021 to 2022), there appeared to be misconceptions of doula roles in the hospital. As one midwife explained:

> I think … depending on the provider and their bias towards doulas can really sort of either be warm or it can be quite challenging and confrontational … Yesterday I [heard] somebody started talking about a Birth for Humankind doula, 'Oh, she's in there doing this and that. She's been in there for two minutes. She [the client] needs water and she needs this and she needs a drip put out, the doctors ordered that.' I said, 'Well, she's advocating for her client,' … I just couldn't believe how horrible they were being – [she was] doing her job. (Midwife 10)

The majority of midwives and doctors met doulas in labour and birth, meaning they had limited knowledge of referral processes and eligibility criteria to the doula service and desired to learn more. As a doctor expressed:

> I think it would be nice if we knew more about the service and what they had to offer. (Doctor 1)

Confusion about client eligibility criteria and referral process led to ineligible online referrals, which put a burden on the doula support

service. A doula manager shared an example of a flow-on challenge from this confusion – telling prospective clients they did not meet eligibility criteria:

> And we've had to … then have difficult conversations with a client who's been told by a social worker they can get a service from us … and I understand that you might feel financially stressed … but that's not the same as most of our clients who are on Centrelink, [or] Status Resolution Support payments for asylum seekers … (Doula manager 1)

Social workers expressed that another limiting factor was not receiving outcomes of their referrals to Birth for Humankind 'until … a month later [when] talking to the client' (Social worker 2). Providers felt their limited knowledge of the doula service was attributed to the hospital being a 'big, busy place with high staff turnover, [and] fragmented care' (Midwife 2), which was significantly exacerbated by the COVID-19 pandemic.

3.4. Motivation

Motivation refers to the 'behaviours' and processes of the community-based doula service and hospital in implementing and sustaining the community-based doula service (Michie et al., 2011). Motivation was facilitated through the professional community-based doula service and dedicated volunteer doula workforce. However, limitations to motivation were the doula service being a small non-profit organisation, reliance on a volunteer doula workforce and limited capacity of the doula service.

3.4.1. Facilitators

3.4.1.1. Providing a professional community-based doula service. Birth for Humankind was perceived by providers and doulas as the 'most organised non-profit' (Doula 2) professional service, which was attributed to: the Doula Code of Practice; supportive program and administrative services for doulas; and an overall sense of community among doulas. The service's Doula Code of Practice, which created clear expectations and boundaries of a doula's role, strengthened the professionalisation of the doula service. Doulas knew that they were responsible in 'representing an organisation … [being] careful of maintaining the reputation of Birth for Humankind' (Doula 5). Additionally, some doulas appeared to appreciate the framework providing credibility to their practice because at present, 'there's no professional body, there's no … criteria for professional standard [for doulas]' (Doula 4).

The doula service had a multifaceted program supporting doulas to engage in reflective practice through: supervision and debriefing opportunities; having back-up doula support available; and professional development opportunities. All doulas expressed that their managers and the organisation are 'extremely supportive' (Doula 1), with supervision and debriefing opportunities to ensure 'volunteering [is] sustainable for people' (Doula manager 1), particularly those with difficult experiences, as one doula highlighted:

> … sometimes the stories our clients share with us are very difficult to hear … the way their birth unfolds is very difficult. And so, it's very important to have the opportunity to share that with a professional who understands and can really hold the space for that. (Doula 2)

Another responsibility of doulas is the requirement to report their interactions with clients, which was then reviewed by the managers, encouraging doulas to engage in reflective practice. As a doula explained:

> I have to remind myself boundaries make for good relationships … because sometimes I feel, 'Am I overstepping the boundaries?' Or 'Is this appropriate in this case?' and I want to bounce it off someone. (Doula 2)

Many doulas expressed the attractiveness of the doula service managing administrative aspects (e.g. paid volunteer insurance). This allowed the doula to be 'totally focused on the role of the doula without having to run a business' (Doula 3). Some Birth for Humankind doulas who also worked in private practice described their 'business' as an often 'lonely existence' (Doula 2). In comparison, the community network of volunteer doulas was described as comprising: 'back-up' doulas who can 'relieve them for a little while' (Doula 5); high quality training and professional development opportunities (e.g. trauma-informed practice) where doulas are able to 'share insights and experiences' (Doula 8) with each other in 'support circles' (Doula 9); and an overall '[bringing] together the local doula community' (Doula 2).

3.4.1.2. Having a dedicated volunteer doula workforce. Overall hospital managers and providers were very positive about the Birth for Humankind doula service, which received 'huge acceptance' (Social worker 4) across hospital departments when the value and benefits of doula support and the service were recognised. As a maternity manager explained:

> The Birth for Humankind team has an overwhelming amount of respect from all disciplines and that's really evident – our consultants … our registrars … our midwives value Birth for Humankind. (Maternity manager 1)

Some social workers perceived working with doulas as a 'partnership' (Social worker 3) and particularly valued doula roles in 'advocacy, information provision and reinforcing medical information provided' (Social worker 3), actions that were not feasible within social workers' own large caseload.

Doulas were described as having 'high motivation' (Doctor 2) despite not being paid and providing 'support [that] is 100% free' (Doula 2), with evidence some doulas volunteered for a long time (over five years) and exercised flexibility in accepting clients 'due within the next week … because they like the quick turnaround' (Doula manager 1).

3.4.2. Barriers

3.4.2.1. Being a small non-profit organisation. The doula service is a small non-profit organisation, which means it is reliant on fundraising, 'philanthropy, small grants and donations' (Doula manager 2). This makes it challenging to be a sustainable entity. Funding can support, on average, no more than 10 clients a month. Despite having a volunteer workforce and with the 'bulk of philanthropic funding … [being used] to run the organisation' (Doula manager 1), 'there's still costs involved' (Doula manager 2).

The running costs mentioned included: hiring doula managers who were highly qualified in managing the doula support program; organisational operational costs; and doula training. A doula manager expressed the challenges in advocating for more funding for existing programs to grow the service:

> … one of the barriers is that when you've provided something for free, asking for money to do the same thing is quite challenging … The grant funders don't want to give you money for something that's already happening. They want you to do some new thing and they'll give you money for that. (Doula manager 1)

3.4.2.2. Reliance on a volunteer doula workforce. The complexities of a volunteer workforce were evident to doulas and their managers. The transient nature of the workforce was a particular issue at the time when interviews were conducted, especially in relation to midwifery students, whose time was limited when they were 'on [clinical] placement because [they're] on call' (Doula 9) and were often 'only there for the

lifetime of their university degree' (Doula 5). Similarly, doulas with family commitments had limited availability and tenure during school holidays. This resulted in doula managers being more selective in favour of long-term volunteers and ensured they avoided 'putting people through the training to then not have them do any volunteering' (Doula manager 2).

Most doulas expressed the challenges of financial instability when volunteering. Although all doulas received a 'little stipend for each birth' (Doula 4) to cover parking costs, doulas may be faced with having to 'give up any other paid work to be there for that client' (Doula manager 1). One doula explained the precarity of paid work versus volunteering:

> … because I work casually, it costs money every time … over a year, thousands of dollars in lost wages each time I attend a birth. (Doula 5)

Bicultural doulas were often not able to continue as volunteers due to their own financial needs. One doula manager also expressed concern about the volunteer program perpetuating 'systemic issues that a migrant or refugee woman might face herself. She might be really interested in being a doula, but not find that's very financially sustainable in the long-term' (Doula manager 1). Doula managers reported that this resulted in doulas leaving the workforce out of necessity.

Another aspect of the challenges faced by doulas was burnout. The unpaid volunteer role requires long hours and was 'sometimes [a] stressful job to do … on-call' (Doula manager 2). Specifically, the trauma-informed practice required to support women and gender diverse birthing people filled a gap in maternity care 'relying on unpaid volunteers to stop women potentially being traumatised or re-traumatised' (Doula 8) in the maternity care system.

3.4.2.3. Limited capacity of the doula service. Doula managers described the capacity of the doula service, having 50 active volunteers with about 50 clients at any one time. Each doula is expected to support three clients in an 18-month period. The doula service only has capacity to support about 10 clients a month for birth support and three for extended postnatal support, and sometimes client waiting lists remain unfilled due to unavailability of doulas.

Despite providers suggesting more advertising of the doula service was needed, doulas and doula managers disagreed with more promotion. As a doula manager revealed:

> … the biggest barrier is not over promoting ourselves where we get so many referrals. We can't actually service all the referrals, and that's our biggest problem at the moment, is that we don't have enough volunteers. (Doula manager 2)

During the COVID-19 pandemic there was an increased demand for doula support, which increased the doula workforce to 'the highest number [they've] ever [had] … 70' (Doula manager 1) at one point. However, it was challenging to meet the volume of referrals. Some doula managers and social workers questioned the doula service's responsiveness to emergency situations and saw the precarity in 'relying on volunteers … in terms of the ability to respond to events that can happen quickly, [like] a sudden wave of refugees …' (Social worker 3).

3.5. Opportunity

Opportunity reflects the physical environmental and sociocultural factors experienced by the doula service and hospital staff, which impact the implementation and sustainability of the doula service (Michie et al., 2011). Factors which facilitated opportunities included: creating a doula-friendly hospital environment; strengthening existing relationships between the doula service and hospital; and consideration of implementing remuneration for doulas. Limitations which hindered opportunities included processes in establishing remuneration for doulas, and limited higher-level partnerships that require formal organisational commitment.

3.5.1. Facilitators

3.5.1.1. Creating a doula-friendly hospital environment. Hospital providers saw great value in doulas and made efforts to make doulas 'feel safe [and] welcomed' (Midwife 10), and ensured doulas did not 'feel ostracised … [rather] feel valued' (Midwife 2). Positive role modelling during the change-over of shifts was valued by doulas, for example:

> … it makes a big difference, who the in-charge [midwife] is, how they speak to everyone … their opinions come through clear … I think having that unconditional positive in-charge having phrases … 'Hey, always welcome your doula in.' (Doula 9)

Some participants suggested a partnership between the doula service and the hospital – for example, through a midwifery caseload group model involving doulas – may align with the hospital's commitment to increased continuity of care. Doula and maternity managers recognised the gaps in continuous labour and birth support currently available, and how doula care played an important role. For example, drug and alcohol support services could only provide continuity of antenatal care provider but the midwives 'don't do the intrapartum care … ' (Doula manager 1). As a midwife explained:

> 'Cause often these women [clients of Birth for Humankind] don't get continuity of care … they don't advocate [for] themselves well, so they're not in the [caseload] programs … They miss out [on receiving continuity of care]. (Midwife 7)

Therefore, a prospective partnership between both organisations, creating a doula social support model, was welcomed by provider participants.

> … the hospital could run something with Birth for Humankind. [We] have a program like our [specialised First Nations] caseload … Why not have Birth for Humankind [doulas] within the hospital? (Midwife 10)

Participants reinforced the value in clients having their 'own inbuilt doula [in the hospital], someone who knows you, understands your challenges and can advocate effectively for you and tailor support for what you need' (Midwife 11). This model of care may align with both organisations' shared values in providing 'evidence-based, holistic care for women from all walks of life based on the social model of health' (Midwife 2).

3.5.1.2. Strengthening existing relationships between the community-based doula service and hospital. Many participants shared prospective opportunities for the doula service and hospitals to formalise partnerships through a variety of strategies: collaborative opportunities; hospital educational in-services on the doula service; hospital protocols consolidating doulas' roles and responsibilities; embedding the doula service within the antenatal space; and re-establishing in-person casework meetings that include midwives and doulas.

A recent hospital-based program aimed at providing secure housing to pregnant women who are homeless or at-risk demonstrated the potential for external organisations and the hospital to work collaboratively and source funding. Some of these clients were referred to Birth for Humankind for additional doula support. This reflects how doulas naturally 'come and fit in with the hospital' (Social worker 3); interviewees observed that some clients involved in the housing program perceived their doula was from the hospital. The presumed association of the doula service with the hospital, as a result of referral pathways, illustrates participants' desire for a more formal 'collaborative relationship, rather than as an add on' (Social worker 3). Collaborative opportunities appeared to align with 'hospital's latest strategic plan …

about partnerships with other organisations' (Social worker 3).

Doulas and providers highlighted potential opportunities to strengthen doula-provider relationships through formal teaching programs in the hospital – known as 'in-services'. The majority of doulas and providers had no formal training on fostering doula-provider relationships. As a doctor discussed:

> … they [providers] never had any training on how to manage [doula] interactions and what [doula] roles were. (Doctor 1)

Having education on 'the value of having a support person who's got a trusting relationship with a labouring woman' (Midwife 8), and how to foster collaborative working relationships between hospital providers and doulas may reduce 'stigma towards doulas' (Maternity manager 1). Overall, participants felt it was essential that doulas and providers 'respect their role(s) in the woman's care' (Midwife 4).

Additionally, a hospital protocol for engaging with doulas '[may] need to be formalised' (Doula 3). Interviewees perceived a protocol would be useful in highlighting the expectations and responsibilities of doulas through 'clear boundaries' (Doula 1) and building understanding that the doula role includes 'pure support and emotional role' (Midwife 5) and not 'intervene with [clinical] management' (Doctor 2). Providers were receptive to the role of the doula, which may improve through 'connections and the knowledge of each other's roles and relationship building [which] has to be constantly built on' (Doula 3). This may include guidance on collaborative relationships among doulas and providers with clear introductions and acknowledgment of each other's presence and roles when they first meet. Many providers suggested promoting the doula service to prospective clients through 'a welcome pack from their booking appointment' (Social worker 2), or to engage with providers working in antenatal clinics, as it is a 'place of engagement and referral' (Midwife 11), an opportunity to link clients early on in pregnancy, embedding the doula service within the antenatal space. Midwives felt that doctors should have 'more understanding of who a doula is … clarifying each other's roles … knowing [the doula's] scope of practice' (Midwife 4), especially if they identify 'high risk women in [the] antenatal clinic … [with] limited social supports … ' (Midwife 6).

Lastly, doula managers and social workers had limited face-to-face contact in the hospital during the COVID-19 pandemic which 'made maintaining the relationships and improving relationships a lot harder … ' (Doula manager 1). Therefore, re-establishing in-person hospital casework meetings for social workers and the doula service was seen as invaluable in developing relationships. A social worker commented on a recent meeting:

> … they've [doula service] recently came to a staff meeting … to ensure everyone knew about the program and service … There's been a lot of re-establishing relationships … post-COVID lockdowns … and providing information to new staff about the service and how it can be utilised by their clients. (Social worker 3)

3.5.1.3. Advocacy for doula remuneration. Participants described that unpaid doulas were not a sustainable workforce for the volunteer doula service. All doulas expressed desire to be recognised and paid. A doula succinctly voiced:

> … I'd be able to take on a lot more clients. I would actually be happier because I wouldn't have to try and balance volunteering with other commitments. And when I don't have the capacity to take on clients, I find that quite hard because I have to prioritise money and paid work. (Doula 10)

Doula manager participants expressed that having doulas employed by Birth for Humankind would result in more doulas being available for unmet referrals. Investment in paid doula work may incentivise prospective doulas, increase the doula workforce and 'make it sustainable and more accessible by clients' (Doula 10).

Possible avenues to secure employment opportunities for doulas were suggested through 'funding the [doula] program in partnership with [the hospital]' (Doula manager 2). As a doula manager explained:

> … for the sustainability of our organisation we do need to be looking at partnerships where there's actually a financial investment in the work that we're doing … (Doula manager 1)

3.5.2. Barriers

3.5.2.1. Uncertainty in paying doulas. Despite the need for paying doulas, there was limited knowledge among participants regarding how to transition from volunteer to paid community-based doulas. There were conflicting ideas and uncertainty as to whether the hospital or doula service had capacity to employ and pay doulas. A doula manager expressed uncertainty 'how it would work and who would pay for it' (Doula manager 2) or whether it would be embedded within the hospital's midwifery caseload group. A maternity manager hypothesised 'there could be capacity within the [doula] organisation [themselves] to look at a paid model rather than a volunteer model' (Maternity manager 1).

Another point of contention among doulas and providers was the perspective that doulas needed to remain external to the hospital, i.e. placed outside in the community, to maintain impartiality and avoid 'layers of hierarchy' (Doula 3). Doulas felt that being paid in a hospital-based doula service would mean 'more constraints on what you do and [how you] operate' (Doula 5).

Regardless of the need for doulas to be paid, there was some hesitation among some providers regarding doulas' motivations in seeking remittance. This may be from confusion as to who will pay the doulas: the client or Birth for Humankind. A doctor voiced their concern:

> Because the refugee or migrant women who they serve may not have the means to pay for this service, if there is a shift to it being paid for, and I think the women who really need the service are those of lower socioeconomic backgrounds, who otherwise would miss out on accessing it. (Doctor 1)

In contrast a doula manager clarified that a community-based doula:

> … means that it's a doula who is available for anyone who needs her, not just people who can pay for services. (Doula manager 1)

These different perspectives appear to originate from provider misconceptions and limited understanding regarding community-based doula roles and the doula service itself. These misconceptions were further evidenced by the contradictory value providers placed on volunteer doulas compared to private practice doulas, despite some volunteer doulas also being private doulas. Some midwives expressed that private practice doulas may be more confrontational and 'push their own agenda a little bit' (Midwife 5), possibly due to their own 'personal or professional bias' (Midwife 11). In contrast, providers' receptiveness to Birth for Humankind doulas appeared to be related to the perceived value of doula support for their clients, who often have limited social support. As a doula who also practises privately reflected:

> I get almost a sense of relief from the midwives [when supporting a Birth for Humankind client] … because it's hard for the midwives too if there's no partner or mother or sister. And a sense of relief there's some ongoing relationship … [in contrast to] they [private clients] know what they want and they are going to be a bit sceptical about what you tell them. (Doula 2)

3.5.2.2. Strategic partnerships require formal organisational commitment. Most participants demonstrated uncertainty around formalising hospital and doula service partnerships. Although the doula service participants viewed the hospital as a prospective funding partner, the funding

limitations of a public hospital became evident from social workers' own difficulties to source funding to 'pay for training' (Social worker 4) and fund existing projects. Social workers and the maternity manager recognised that strategic partnerships would be required to pay doulas, which meant engaging with different levels of 'management, to the Directors of the Department' (Social worker 2). However, providers noted this process may be limited by 'a lot of red tape and procedures [which] can limit creativity' (Social worker 2), resulting in competition for hospital resources. As a maternity manager expressed, funding the doula service may be out of their scope of budget:

> I guess more brainstorming [is needed] as I cannot speak to what capacities [hospital name] would have. I think any financial backing would have to come from philanthropy to be honest … I don't think the budget for [the] birth centre would cover that … It would have to be from an external influence, which has risk that it's not sustainable and long-term … (Maternity manager 1)

Sustaining and implementing the doula service through hospital support requires organisational dedication and commitment from both sides. As a social worker noted:

> I guess there's opportunity there, but it would involve, on both sides, commitment and patience to work through the kind of bureaucratic structures of a hospital and a community organisation to work together. (Social worker 3)

Lastly, participants stressed that organisational change takes time, with 'strategy planning for implementing programs [being] a big organisational shift' (Midwife 11). A provider compared limitations with the implementation of the midwifery caseload program, which remained at limited capacity despite high demand:

> It's funding, it's timing – the process of implementing programs takes upwards of two years. Staff turnover is really high due to maternity leave, so recruitment and retention … it requires [a] change in rostering and how clinics are run.' (Midwife 11)

4. Discussion

Our findings illuminate how a community-based doula service sustained their high-quality service in an Australian maternity setting. Overall, our study reveals that well-established individual relationships – particularly between doula managers and hospital social workers and a manager – and providers' knowledge and perceived value of doula services sustained the doula service. These relationships developed organically and often remained informal in nature. The doula service created a professional organised space which provided doulas with supported training, supervision and debriefing opportunities; guidance through their Doula Code of Practice, and administrative support – all of which sustained doulas' motivations to volunteer. However, despite a highly motivated doula workforce, long-term volunteerism was potentially untenable, due to the transient workforce and demanding nature of doula work as an 'around-the-clock' service. These findings align with a recent systematic review, which found that unpaid doulas experienced burnout (e.g. the physical and emotional toll of being on-call) and financial challenges with balancing paid work opportunities, ultimately limiting volunteer retention (Khaw et al., 2022).

Participants in this study highlighted that unpaid volunteer doula roles may reinforce potential financial disadvantage, particularly among bicultural doulas who may share similar disadvantage with the clients they serve. These concerns were also raised in research with lower paid Swedish bicultural doulas and Indigenous Canadian volunteer doulas (Cidro et al., 2023; Essén & Eriksson, 2023). Similarly, there was a paradox of volunteer doulas being unpaid yet highly valued (Essén & Eriksson, 2023) and interestingly more respected than paid private practice doulas, despite some volunteer doulas interviewed being private practice doulas themselves. These misconceptions reinforced the need to educate providers on the scope of doulas and the doula service through a more formal mechanism, such as in-service training.

From a systems perspective, there was an implementation gap reflective of limited top-down strategic engagement from an organisational and leadership level which is reflected in recent Australian research on culturally-responsive care for migrant and refugee women from non-English speaking backgrounds accessing (Olcoń, Rambaldini-Gooding, & Degeling, 2023). Participants theorised promising avenues that built upon the doula service's work and aimed to strengthen existing relationships through collaborative educational in-service trainings on the doula service and roles of doulas, as well as embedding the doula referral process within the antenatal space. Additionally, establishing late-term abortion doula services during the pandemic crisis demonstrated joint organisational potential in forging more formal partnerships. Overall, participant findings reinforced strategic partnerships, meaningful formal organisational commitment from both the hospital and community organisation, are required to recognise Birth for Humankind's purpose and vision. Our findings evidence that strategic partnerships must extend beyond philanthropic funding and small grants alone. These results reflect that the level of organisational commitment in implementing and sustaining successful employment-based models for community-based doula services requires support from local government councils (Gomez et al., 2021; Marshall et al., 2022; Schytt et al., 2021) and/or public health funders (Bredström & Gruber, 2015), and recognition of community-based doulas as a public health response in maternal health equity for communities experiencing financial and social disadvantage.

4.1. Strengths and limitations

Our study had both strengths and limitations. Firstly, Birth for Humankind supports all women and gender diverse birthing people. However, we focus on providers' and doulas' perspectives to limit duplication from a recent evaluation of the doula service from the perspective of clients and doulas (O'Rourke, Yelland, Newton, & Shafiei, 2022). Additionally, we discussed with Birth for Humankind given the complex social identities of clients it would be inappropriate to recruit them for this study (Birth for Humankind, 2023a). The absence of possible decision-makers, such as hospital administrative leadership, local government council members, and/or public health funders, may be an additional limitation. Second, there may have been recall bias as the study was retrospective – eligibility criteria included experience working for, or with, Birth for Humankind in the past two years. There were also limited doctor and bicultural doula perspectives, meaning their perspectives were triangulated within the larger participants groups; however, data sufficiency was reached, indicative of in-depth and detailed findings. Thirdly, the timeframe during the COVID-19 pandemic when data was collected may impact the transferability of these findings. Despite the timeframe, as a majority of clients have no birth support due to being socially isolated Birth for Humankind doulas continued to be in demand and utilised (Birth for Humankind, 2023a).

This is the first study using both robust qualitative methods and behavioural change frameworks to explore and map factors that may support or limit a doula service implemented and ultimately sustained within an Australian setting. Our study included multiple participant perspectives; this served to provide a holistic overview from interpersonal to systemic factors that may enhance or limit the doula service. Additionally, SMK's insider-outsider positionalities evoked rich participant insights and enhanced interviewer-participant rapport (Burns, Fenwick, Schmied, & Sheehan, 2012). SMK being positioned as a midwife in the maternity space and someone interested in doula research enabled her to gain rapport with all participant groups interviewed. These positionalities were shared with all participants prior to conducting interviews. SMK's role as a midwife also facilitated hospital recruitment during strict in-person restrictions during the pandemic.

4.2. Implications for practice and research

Firstly, there is a great need for improved communications about Birth for Humankind, doula roles within the hospital and regarding referrals. Hospital-wide education could include: incorporating formal education about the purpose of doulas and their roles and responsibilities; collaborative educational in-services; and sharing and adapting the Doula Code of Practice into hospital Clinical Practice Guidelines. Secondly, transitioning into paid doula services with external organisations (e.g. hospital-funded, government, philanthropy) is an integral next step. Since the conclusion of this study, Birth for Humankind has undertaken a promising self-funded pilot of a Doula Group Practice, which currently comprises two doulas employed and given a set number of clients to support (Birth for Humankind, 2024). From ongoing monitoring and evaluation of this innovative model, and iterative learning, it is hoped that the doula service can secure more long-term funding to retain their doulas. However, greater hospital recognition and organisational commitment to a top-down approach that acknowledges Birth for Humankind's role in improving maternal health equity for women and gender diverse birthing people is needed. Critical next steps may be through joint grant applications fostering paid doula services. Lastly, Australian state and federal Departments of Health need to recognise community-based doula services as a potential cost-saving measure against long-term health complications associated with preterm labour and caesarean births as evident from recent American doula research (Greiner et al., 2019; Kozhimannil et al., 2016). Therefore, we recommend exploring quantitative cost-benefit analysis of community-based doula services in the Australian context. This would serve to strengthen the case for long-term investment into complementing existing maternity care services and improving the continuity of care for communities who may experience socio-economical disadvantage, such as migrant women (Young, 2022).

5. Conclusion

Birth for Humankind's community-based doulas provide invaluable support to women and gender diverse birthing people, such as migrant women, within hospital settings where continuity of care options are limited. It is evident that informal individual working relationships between doulas and providers, and management of both organisations sustained the service at a grassroots level. However, our findings suggest that higher-order recognition of the doula service, through potential financial partnerships, is necessary to sustain the doula service. This would ensure its visibility, capacity and accessibility to communities experiencing social disadvantage who benefit the most from continuous support throughout the perinatal continuum.

CRediT authorship contribution statement

Sarah Min-Lee Khaw: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Caroline S.E. Homer:** Writing – review & editing, Supervision, Methodology, Investigation, Formal analysis, Conceptualization. **Red Dearnley:** Writing – review & editing, Formal analysis. **Kerryn O'Rourke:** Writing – review & editing, Formal analysis. **Meghan A. Bohren:** Writing – review & editing, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

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Appendix A. and B Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2024.100501.

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