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Calgary's volunteer birth companion programs: discovering stakeholder views

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ABSTRACT

Continuous social support during childbirth has been demonstrated to yield positive health outcomes for mother and baby. Using a qualitative, multiple case study approach to discover stakeholder opinion regarding salient program features, two programs that provide social support to pregnant women by trained volunteers (birth companions or doulas) were contrasted and compared. Thick, rich description of the background and current state of the two programs was succeeded by description of the composition, activities and outcomes of a committee struck to plan and implement a regional program model for labour support provision by volunteers. Themes of stakeholder opinion that emerged in the data yielded two key findings: the regional program model lacked the focus of a stated program problem to orient its goals, activities, and outcomes; and, issues of power and control over decision-making in the birthplace presented challenges the committee and the regional program did not overcome. The relevance of these findings to labour support and health policy was discussed, with recommendations and suggestions for change.
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1 BACKGROUND

1.1 Introduction

Both professional and lay provision of continuous social support during labour and birth in hospital is an area of growing interest in which studies have demonstrated positive health outcomes to mother and baby. Beyond the Canadian traditional nurse-physician hospital team, providers of labour support may now include any combination of family members, midwives, and/or a birth companion variously known as a labour coach or doula. Despite these changes, literature that describes models for provision of childbirth support via birth companions is lacking.

Currently in Calgary two programs provide social support to pregnant women by trained volunteers; one of the programs is hospital-based, the other based in the community. The co-existence of two programs providing similar service by volunteers within one city presented an opportunity to contrast and compare important program features. Furthermore, the possibility of development of a regional program of volunteer birth and labour support had provoked interest and discussion.

The purpose of this research was to discover and describe program features considered salient by key stakeholders within Calgary’s current volunteer birth companion programs. This work can be used to inform decision-making about the programs within the Calgary Regional Health Authority (CRHA), and to extend understanding of programs that provide the service of social support during labour and birth.
1.2 Literature Review - Social Support during Childbirth in Hospital

Social support during labour and childbirth varies with the birth setting and can be provided by a number of caregivers familiar or unfamiliar to the mother. Intrapartum social support is typically provided by the more or less continuous presence of the supporter, is predominantly unidirectional (caregiver to mother) and usually includes advice/information, comfort measures and coping strategies (Hodnett 2000). Support providers can be professionals such as nurses or midwives, and/or familiar persons such as family or friends and/or trained lay supporters known variously as labour coaches, doulas or birth companions. This case study addressed social support during labour provided by trained women volunteers through the comparison of two programs operating within one city.

1.2.1 Randomized Controlled Trials of Social Support during Childbirth

In 1980, Sosa, Kennell, Klaus, Robertson and Urrutia conducted a seminal randomized controlled trial (RCT) in Guatemalan primigravid women in which the experimental group received constant support from an unfamiliar and "untrained lay woman" (Sosa, Kennell et al., 1980). The authors reported significantly decreased length of labour in the experimental group. Co-investigators in that trial, Klaus and Kennell continued this work in subsequent trials using trained lay workers in Guatemala (Klaus, Kennell et al., 1986) and Texas (Kennell, Klaus et al., 1991), coining the word "doula" as a name for the supportive woman (see (Raphael 1988; Klaus, Kennell et al., 1992)) and publishing a book about doulas in the lay press (Klaus, Kennell et al., 1993). The results of the 1986 Guatemalan trial included significant differences between the experimental and control groups for perinatal complications, caesarean sections, oxytocin augmentation and
infant complications, with all outcomes favouring the supported group (Klaus, Kennell et al., 1986). In the Texas trial the women were studied in three groups – supported mothers, control mothers, and mothers monitored by an inactive observer. Statistically significant beneficial differences were found in rates of caesarean sections, forceps deliveries, epidural anaesthesia, and length of labour, including the comparisons between those who were simply observed to those who served as controls (Kennell, Klaus et al., 1991).

A 1991 South African RCT reported by Hofmeyr et al., also used trained volunteer laywomen to provide continuous labour support (Hofmeyr, Nikodem et al., 1991). In this study, a statistically significant but modest effect was observed in analgesia use by the experimental group. However, statistically significant differences observed at six weeks favoured supported mothers who felt they’d coped well during labour, were more likely to be exclusively breastfeeding, and had less postpartum depression (Hofmeyr, Nikodem et al., 1991; Wolman, Chalmers et al., 1993). The latter was upheld at three months postpartum (Trotter, Wolman et al., 1992).

In the Canadian setting, Hodnett and Osborn (1989) reported a randomized clinical trial where one-to-one support was supplied by a monitrice - a community “lay” midwife or apprentice already well-experienced in provision of labour support (Hodnett and Osborn 1989). In this study, supported women were less likely to use medication, and more likely to have intact perineae. In addition, supported women who did not use medication had shorter labours and higher levels of perceived control during labour (Hodnett 1989). Another Canadian randomized trial comparing one-to-one nursing support with regular
intrapartum care found reduced use of oxytocin stimulation, but no significant
differences between experimental and control groups for any of the studied obstetrical outcomes (Gagnon, Wagborn et al., 1997). It is important to note the contrasting conditions for the labouring Canadian mothers compared to earlier studies.

Finally, more recent studies have been conducted in Mexico (Langer, Campero et al., 1998) and Botswana (Madi, Sandall et al., 1999). The 1998 study of Langer, Campero, Garcia and Reynoso provided labour support via doulas. At one month postpartum the frequency of exclusive breastfeeding was significantly higher in the experimental group. This group also experienced shorter lengths of labour, and rated their control over the labour experience higher than the control group (Langer, Campero et al., 1998). In the Botswana trial, labour support was provided in hospital by a female relative chosen consistent with traditional cultural practices (Madi, Sandall et al., 1999). Supported women had higher numbers of spontaneous vaginal deliveries, and significantly lower rates on interventions such as amniotomy, analgesia, and oxytocin administration. The authors recommended labour support as a low-cost intervention in developing countries where female companionship is still the traditional practice (Madi, Sandall et al., 1999).

To conclude, the randomized control trials described above vary widely in their settings and in the usual standards of care received by the control groups. Nonetheless, the studies consistently reported benefits in the supported mothers and their babies, with many observed differences reaching statistical significance. Moreover, no adverse effects of the provision of social support during labour were reported.
1.2.2 Review Articles and Meta-analyses of Social Support during Childbirth

As literature on RCT's investigating labour support has increased, so has the number of review articles and meta-analyses. The pooled results are presented below. Odds ratios (OR) with 95% confidence intervals (CI) are presented for the latter two meta-analyses as they represent the most recent and comprehensive analyses of the trials to date.

In 1993, Chalmers and Wolman reviewed the literature describing labour support provided by fathers, family or friends, professional supporters and lay supporters. They concluded that lay female supporters consistently achieved "positive effects on obstetric and psychosocial outcomes", and called for research to discover the optimum conditions for labour support provision (Chalmers and Wolman 1993, p.1). Likewise, in their 1997 review, Klaus and Kennell discussed father support compared to doula support and attributed the presence of the doula to the observed benefits in outcome (Klaus and Kennell 1997). Like Chalmers and Wolman, Klaus and Kennell called for more research as to the mechanisms by which labour support improved outcomes, including a comparison of intermittent support to continuous support.

Three meta-analyses of social support in labour have been found. The first, compiled by Zhang, Bernasko, Leybovich, Fals and Hatch (1996) (Zhang, Bernasko et al., 1996) includes four trials (Sosa, Kennell et al., 1980; Klaus, Kennell et al., 1986; Hofmeyr, Nikodem et al., 1991; Kennell, Klaus et al., 1991). From this early compilation, the authors concluded that the demonstrated benefits of labour support may have great implications for
inner-city hospitals and disadvantaged populations (young, low-income, unaccompanied women).

The Cochrane Library's Database of Systematic Reviews includes the unit “Support from caregivers during childbirth” (Hodnett 2000). A number of the trials reported above (Sosa, Kennell et al., 1980; Klaus, Kennell et al., 1986; Hodnett 1989; Hofmeyr, Nikodem et al., 1991; Kennell, Klaus et al., 1991; Gagnon, Waghorn et al., 1997; Langer, Campero et al., 1998; Madi, Sandall et al., 1999) were chosen for this fourteen trial review, pooling the data on more than 5000 women. The results of the combined analysis of these studies showed supported mothers had a reduced likelihood of analgesia use (OR 0.59, 95% CI (0.52-0.68)), decreased rate of operative vaginal delivery (OR 0.77, 95% CI (0.65-0.90)) and caesarean delivery (OR 0.77, 95% CI (0.64-0.91)), and a reduced likelihood of the infant’s 5-minute APGAR score being less than 7 (OR 0.50, 95% CI (0.28-0.87)) (Hodnett 2000). Hodnett reports that despite inconsistency in the trials’ conditions, there is considerable consistency in the trials’ results concluding, “Given the clear benefits and no known risks associated with intrapartum support, every effort should be made to ensure that all labouring women receive continuous support” (Hodnett 2000).

A recent meta-analysis re-examined the data of eleven of the fourteen trials included in the Cochrane database review, with the specific aim of distinguishing the trials by the consistency of support received by the labouring mothers (Scott, Berkowitz et al., 1999). A continuous support trial was defined as the uninterrupted presence of the supporter (except for toileting) over the entire duration of labour and birth for all experimental mothers in the trial, anything less was considered intermittent support (Scott, Berkowitz et al., 1999).
When examined this way, Scott et al., found significant results for all trials that provided continuous support to mothers, but no significant differences for the intermittently supported groups, when the groups were compared to controls. The outcomes with respective odds ratios for the continuously supported group are: analgesia (OR 0.64, 95%CI (0.49-0.85)), oxytocin augmentation (OR 0.29, 95%CI (0.20-0.40)), forceps (OR 0.43, 95%CI (0.28-0.65)), and cesarean section (OR 0.49, 95%CI (0.37-0.65)). The weighted mean difference in labour length was -1.64 hours (95%CI -2.3 to -0.96) (Scott, Berkowitz et al., 1999). Of note, the characteristics of the supporter could be a potential confounder. The five continuous support studies all used lay women or lay midwives for supporters; whereas, only one of the six intermittent studies used lay women, the rest using midwives or student midwives. The authors consider this factor one possible explanation for the results, speculating that differences in philosophy and training of caregivers may change the nature of support and thus outcomes (Scott, Berkowitz et al., 1999).

Finally, Scott, Klaus, and Klaus reviewed the three meta-analyses, dividing the findings into three domains—obstetrical, postpartum and comparison of father vs. doula support (Scott, Klaus et al., 1999). As may be surmised from the work presented above, they conclude that continuous social support during labour and childbirth is clearly supported by the body of research conducted since 1980, suggesting, “a doula should attend to every laboring woman regardless of the presence of other supportive persons” (Scott, Klaus et al., 1999, p.1262).

Thus, the reviewed literature and meta-analyses presented above consistently indicate the benefits of social support during labour, with no known risks or reports of adverse
events. However, information for decision-making is not limited to quantitative measures and analyses. For this reason, research studies and reports other than RCT's and meta-analyses are summarized below.

1.2.3 Qualitative and Program Research of Social Support during Childbirth

The literature reported above describes social support during labour for the purposes of a study, and concentrates on quantitative obstetrical outcomes. Additional studies have compared father support to doula support (Bertsch, Nagashima-Whalen et al., 1990; Lohn, Kennell et al., 1992), examined cross-cultural components of labour support (Chalmers and Meyer 1994; Chalmers, Wolman et al., 1995), and studied psychological aspects of its results on parenting (Manning-Orenstein 1998). However, qualitative research or research that speaks to programs and processes of providing labour companions to women on an ongoing basis is scant.

The RCT conducted by Langer et al., (Langer, Campero et al., 1998) included a qualitative study of social support during labour, the only qualitative study found on this topic in the published literature to date (Campero, Garcia et al., 1998). Sixteen in-depth interviews compare the birth experiences of eight mothers who received support with eight that did not, the former reporting more positive feelings of the childbirth experience, with improved self-perception and sense of control. The authors state that qualitative research "provides an insight into the processes underlying the intervention's effects, and the barriers and facilitating factors that should be considered for its adoption on a routine basis" (Campero, Garcia et al., 1998, p.401). Furthermore, they call for additional qualitative
research in this area to "deepen our understanding of the reported findings as well as to provide a basis for comparative analysis" (Campero, Garcia et al., 1998, p. 402).

A few references in non-academic journals present labour support programs. One Canadian program provides community perinatal advisors (CPA) throughout the perinatal period, including labour support (Kranz 1996); another provides service to mothers on a Canadian military base (McMillan 1997). One book and a short description of U.S. hospital-based programs have been found (Dames and White 1998; Elias and Block 1999). In addition, two workshops at the 1999 5th International Conference of Doulas of North America (DONA) presented information on U.S. hospital-based doula programs and one example of a community-based program (Glink 1998; Elias and Block 1999).

Communication with the current DONA president (Lindstrom 2001), the author of the U.S. hospital doula program book (Perez 2001), and the DONA organization suggests the existence of up to 40 U.S. hospital-based doula programs with about a dozen that identify using volunteers. Efforts to obtain similar information about Canadian programs yielded little, though there is some evidence of other programs in Alberta and at least one program in each of B.C., Ontario, and Manitoba.

1.2.4 Summary of Literature

In summary, the randomized control trials, reviewed literature and the meta-analyses are uniform in their demonstration of beneficial results exhibited by mothers supported in labour, without any reports of increased risk or harm. Authors of literature reviews and meta-analyses of the RCT's recommend that continuous one to one support during labour be made available to all labouring mothers. Despite the growth in quantitative research,
qualitative research on social support during childbirth is scant. Although labour
support programs exist, no published research regarding effective program models for
 provision of labour support by doulas or birth companions has been found. These areas are
 identified gaps in the current knowledge as presented in the research literature.

1.3 Volunteer Birth Companion Programs in Calgary

Volunteer labour support programs have existed in Calgary since the early 1990's.

Through the use of trained women volunteers, these programs provide social support to
referred women, sometimes prenatally, and almost always throughout labour and delivery in
hospital. One of the programs is community based, now housed under Healthy
Communities within the CRHA. The other program operates within a hospital setting.

Province wide regionalization of health care took place in Alberta during 1994/95. Under
the auspices of the CRHA, a birth companion planning committee was formed to investigate
the potential for a regional program. Representation on the committee included volunteer
coordinators from the community program and all three hospital sites, staff from their
labour and delivery units, and CRHA representatives. Although the committee held a
number of meetings and conducted some inquiries into regional program possibilities,
including expansion to the other two hospital sites, the work stalled in 1998 without formal
decision or dissolution of the committee. One joint training session for volunteers and a
common volunteer birth companion handbook were developed.

1.4 Research Question

Given that Calgary has two volunteer birth companion programs that operate from
different settings, and given that they have already been considered for change, the
opportunity to compare and contrast the programs seemed both timely and appropriate. Furthermore, qualitative research regarding program models would add to the current understanding of social support during labour and birth, addressing a gap identified in the literature. To this end, the research question this proposal addressed was:

What features do key stakeholders identify as salient in Calgary's volunteer birth companion programs?

1.4.1 Objectives

To elicit important program elements, three objectives were considered:

1. A description of the background and current state of the two programs within the CRHA.
2. A description of stakeholder opinion regarding key program features.
3. A proposed program model or models with implementation suggestions.

1.4.2 Supporting Questions

The following questions framed data collection and analysis in each program (case):

1. What needs are served and how?
2. What are the strengths, weaknesses and resources of each program?
3. What are the underlying program theories and are they complementary or compatible?
4. Is there a perceived need for change? What are the perceived barriers and facilitators to program change?
5. Based on stakeholder input, what are the best ways these programs can be delivered in the CRHA?

The methods by which the research was conducted are detailed in the following chapter.
2 METHODS

2.1 Research Paradigm

The qualitative paradigm assumes that multiple views of reality as seen by the study participants are valid, that the nature of research is value-laden, and that the researcher interacts with the participants. It is a paradigm whose methods are well suited to inductive processes, allowing the research to evolve as themes and patterns emerge from the study context (Creswell 1994, p. 5).

Qualitative researchers themselves are the primary investigative tools, and according to Goering and Streiner (1996) are “viewed as adaptable and responsive ‘instruments’ who guide and shape the discovery process” (Goering and Streiner 1996, p. 492). As the author has an affiliation with one of the described programs, a qualitative method allowed recognition of the inherent bias of the researcher and its acknowledgment as both a strength and limitation of this work.

2.2 Case Study Research

2.2.1 Case Study Method

Creswell describes the case as a "bounded system", the study of which involves situating the case within its context (Creswell 1998, p. 61). Moreover, Marshall & Rossman (1999) suggest that qualitative research studies focusing on "a group, a program, or an organization, typically espouse some form of case study as an overall strategy; this entails immersion in the setting and rests on both the researcher’s and participants’ worldviews" (Marshall and Rossman 1999, p. 61).
According to Yin, the method by which researchers pursue their study is dependent on three conditions: 1) the type of research question; 2) the extent to which the researcher can or will control behavioural events; and, 3) whether the phenomenon under study is primarily historical or contemporary (Yin 1994, p. 1). A case study "investigates a contemporary phenomenon within its real-life context" and is especially useful when "the boundaries between phenomenon and context are not clearly evident" (Yin 1994, p. 13). He suggests that a case study strategy is well suited to projects in which the form of the research question is "how" or "why". However, a "what" form of research question is acceptable in case study research, if the nature of the research question is exploratory. In addition, if the research does not require control over behavioural events and focuses on contemporary events, it meets Yin's criteria for using a case study strategy (Yin 1994, pp.5-6).

This research concentrated on contemporary events within two programs to answer a "what" question of an exploratory nature (Section (1.4)), without intended manipulation of behavioural events. Each program was considered a bounded phenomenon within a common context – the CRHA. That is, each VBC program was considered one case.

### 2.2.2 Multiple Case Study Research

Miles and Huberman suggest "multiple cases offer the researcher an even deeper understanding of processes and outcomes of cases" (Miles and Huberman 1994, p.26). If more than one case is to be considered within the study, Yin states that the cases should be selected with "replication logic" (Yin 1994, p.51). That is, the cases are selected such that a comparison of each case will be sensible and possible in the analysis. Two programs
providing similar service (labour support by volunteers to identified mothers) within one context (the CRHA) seemed an apt comparison. Moreover, the supporting questions Section (1.4.2) guided data collection and analysis in each case, to aid contrast and comparison.

Thus, the selected cases, data collection methods and analysis meet Yin’s requirement for replication logic, and allowed the current work to be considered a multiple case study. Therefore, the discovery of salient features of the VBC programs in Calgary was conducted as a qualitative, descriptive multiple case study.

2.3 Data Collection

Data collected for this study included a comprehensive review of documents and the input of key stakeholders via interviews.

2.3.1 Sampling

For this work sampling was conceived in two levels, the selection of cases for comparison, and sampling within each case. Assigning the larger sampling frame as the Calgary Regional Health Authority, both cases were included as they were the only programs providing volunteer labour support within the CRHA – a comprehensive sampling strategy (Miles and Huberman 1994, p.28).

According to Miles and Huberman within-case sampling should consider which entities to sample (e.g. activities, processes, events), be iterative, and be theoretically driven (Miles and Huberman 1994, p.29). Data collection within the cases combined two qualitative inquiry sampling strategies, snowball and stratified purposeful sampling (Miles and Huberman 1994, p.28) and proceeded in an iterative fashion. Collection priorities, scope
and depth were set as follows: (a) Prior to data collection the student, with thesis
committee review, identified a broad range of key stakeholder groups. (b) Interviewees
were chosen such that all originally identified groups were represented for each program.
(c) Data collection and analysis were guided by the same supporting questions for each
program. (d) Recommendations for other important sources of information (documents, key
informants) were sought from each interviewee. (e) These recommendations were
documented, discussed with the research supervisor, and guided further data collection.

The initial stakeholder groups are outlined in Appendix II. The first informants were
identified by the researcher's previous experience with the programs. In addition, each
interviewee was asked to suggest others who might have valuable information to add to the
research, whether names of individuals or a stakeholder group whose inclusion would be
important. These recommendations were part of the audiotaped, transcribed interview and
coded separately in data analysis to document and determine the need for additional
interviews. As a result, two stakeholder groups were added to the original list. These
decisions are reported in Section (3.2). As interviewing progressed, later interviewees were
chosen to fill in gaps identified in the data, and the researcher directed the interview in
attempt to address these gaps.

### 2.3.2 Procedures

#### 2.3.2.1 Interviews

Informants were contacted by the student researcher with a letter and/or a phone call that
introduced the study, and a request for an interview at the informant's convenience. A
sample letter of introduction is included in Appendix III. An exception to this was the method of contact for program clients and volunteers. Client interviews were obtained by asking the volunteer coordinator of the program to contact English-speaking clients who had participated in the program and were likely agreeable to participation. If the volunteer coordinator obtained permission, the student researcher contacted the client to set up an interview time. Volunteers of one program were informed of the study in a presentation at a group meeting. Those interested in participation were contacted subsequent to the presentation and an interview time was arranged. Volunteers in the other program were recommended by a long-term program participant. Potential interviewees were contacted by telephone and if agreeable to participation, an interview time was arranged.

Without exception, the student researcher travelled to the interview location the interviewee preferred, and all interviews were conducted after signed, informed consent. Interviews were semi-structured using the question guide presented in Appendix V. These open-ended questions around the research questions were modified as appropriate in order to encourage and elicit a broad range of thought and opinion on the labour support programs. The interviews were audiotaped; one transcriptionist who had signed a confidentiality agreement transcribed all interviews verbatim. The student researcher reviewed each transcript while listening to the tape, ensuring accuracy and completeness, and making corrections where required. Corrected transcripts were entered into Nudist for coding.
Each interviewee was given the opportunity to receive a copy of an initial case report. Included with the report was a letter of appreciation individually thanking the interviewee for their participation, and inviting them to comment on the enclosed report. A sample letter is included in Appendix VI.

2.3.2.2 Document review

Informants were asked if they had knowledge of and/or access to documents that contained information pertinent to this study. All documents obtained in this manner were reviewed by the student researcher, and kept within the case study databank, Section (2.4). Program documents (such as volunteer evaluation forms, recruitment brochures, meeting minutes) were numbered, and a list created that described each numbered item(Appendix I).

2.3.2.3 Volunteer experience

Throughout this work the student acknowledged her previous role as an active volunteer within one of the programs. Prior to data collection, she was known to some of the key informants as both a volunteer and a student who intended to perform research within the volunteer birth companion programs. The student researcher purposely communicated her research intention with key members of both groups, and refrained from active participation in either one for about one year prior to commencement of data collection. In addition, the consent form (Appendix IV) informed each interviewee of the student researcher's previous role as a volunteer. If it fit the context of the interview, the student researcher openly mentioned her experience as a VBC, and answered any questions concerning it. Furthermore, the student researcher kept extensive field notes observing her
experiences, feelings, perceptions and thought processes. These field notes were written into the case study notebook, and/or recorded in audiotaped interviews, and/or included as memos within Nudist during data analysis, and discussed with the research supervisor.

2.4 Data Management

A case study database was created for this study, and to avoid confusion with the computer based term, was coined the databank (Yin 1994; Creswell 1998). The databank took the form of two file boxes. One file box stored the original tapes and interview transcripts, and any revised transcripts that were printed after student researcher review. Interviewees were assigned a study number, and only that number was identified on interview material. Comments received about the written case reports were also stored in the case study databank.

The second file box stored documents received during data collection. This allowed all materials received in the research process to be recorded, and aided references to the documents in the thesis. The student researcher’s case study notebooks were also included in this file box. Finally, a copy of the original research proposal, a computer disk copy of the Nudist files, and a final version of the thesis are stored in this databank. Thus the databank serves as the storage of both the raw data and its finished product, and as evidence of the linkages between the two.

2.5 Data Analysis

Although it is outlined in categories for ease of understanding, in this study data analysis most closely matched the iterative process conceived by Miles and Huberman
The categories described below were neither sequential stages, nor mutually exclusive.

2.5.1 Interviews

Prior to data coding, the supporting questions outlined Section (1.4.2) were used to create an initial framework or coding tree within Nudist. Codes were included for the type of information (e.g. interview), and the interviewee’s group (e.g. volunteer coordinator). The supporting questions were grouped under broad categories (e.g. program service), with codes specific to the supporting question (e.g. what needs are served). Additional codes covered answers to specific questions the student researcher asked each participant (e.g. referrals for future interviews) or areas of which the student researcher wished to be mindful (e.g. field notes). The same coding tree was used in each case.

For the purposes of coding three cases were considered – the community volunteer program, the hospital-based volunteer program and a “regional” case. Interviewees were coded according to the program with which they were primarily affiliated. For instance, a volunteer of the community program would be coded under Case 1, and a volunteer of the hospital-based program would be coded under Case 2. The third case captured interviewees who were not clearly associated with one program, but perhaps were members of the regional planning committee, CRHA administrative staff or an interest group such as physicians. When an interviewee fit more than one category they were coded according to the case about which they had the most information, and perhaps coded under more than one stakeholder group. For example, an interviewee who was both a volunteer of the
community program, but also a nurse at a hospital that did not have the in-hospital VBC program would be coded under Case 1, as a volunteer and as a hospital nurse.

2.5.2 Documents

Documents obtained from participants or received by the student in her previous volunteer role were included in the case study databank. Documents were reviewed and information was included if relevant, guided by the following questions: (a) Does this introduce new information or support/counter previous information? (b) Would its inclusion enhance case description? (c) Would its inclusion/exclusion change the conclusions? Affirmative answers to (a) and at least one of (b) or (c) determined relevance.

Issues of bias that arose during the research process were reviewed by the student, and discussed with the research supervisor or other committee members. Need for further action was not identified.

2.6 Standards Of Quality And Verification

According to Yin, the characteristics of an exemplary case study are: the significance and completeness of the case; that it considers alternative perspectives; that it displays sufficient evidence; and finally, that its report is well written (Yin 1994, pp. 147-152). More specific to qualitative research, other authors discuss credibility, transferability, dependability, confirmability and applicability to judge the soundness of the work (Miles and Huberman 1994, pp. 277-280; Marshall and Rossman 1995, pp. 143-145). Creswell suggests procedures to verify qualitative research work and gauge the standards of quality by which it was produced. To ensure this research was verifiable, and produced with rigor to meet high standards of quality, Creswell’s guidelines were followed as listed below.
1. **Clarifying researcher bias.** Student researcher bias was addressed on the consent form and declared throughout the thesis, including its documentation, assessment, and consideration of its effects on the research.

2. **Triangulation.** The use of multiple sources allowed for convergence of information by triangulation.

3. **Member checks.** The opportunity for study participants to review and present feedback on the case study report, with documentation of the decisions made regarding feedback, represents the student’s consideration of the interviewees’ input at multiple stages of the research work.

4. **Peer review or debriefing.** The student had regular contact with the research supervisor and/or the members of the supervisory committee and discussed issues that arose in the fieldwork or research process. This was facilitated by recording issues in the student’s field notes.

5. **Rich, thick description.** A rich, thick description of each case was presented in the case study report, and the thesis. This allows the reader to judge both the quality and depth of the research, and whether the cases and findings are transferable to their own setting.

6. **External audits.** The case study databank provides an explicit chain of evidence to allow external review of the entire case study procedure.

### 2.7 Ethical Considerations

This research was undertaken in the spirit and belief that the opinions and views of the interviewees were a valid and valued input to the research process, the program recommendations, and research dissemination. As such, the student strove to ensure the research was accurate, useful for planning purposes, and representative of a wide range of stakeholders. Effort will be made to present the results to program decision-makers and the wider research community, guided by stakeholder recommendations for dissemination of the work. These actions represent respect for persons.

Respect for persons was further shown in that individuals were interviewed with appropriate ethics approval of the work, after informed consent, and were free to refuse
discussion or withdraw from the study without consequence at any time.

Confidentiality of the participants, as well as those who refused to participate, was respected. They will remain anonymous unless written permission to reveal their identity is obtained. To maintain confidentiality, descriptions of the data at times remained general.

The study’s only transcriptionist signed a confidentiality agreement. Individuals were assigned a code on the transcripts, with the master list linking names and code stored in a separate secure location. Quotes were edited to remove clearly identifiable information such as names, locations, or positions. The likelihood of harm to the participants was slight.

The case study databank will be kept in a secure location as per university requirements, and secondary analysis by other researchers will require ethical approval.
3 RESULTS I: PROGRAM DESCRIPTION

3.1 Introduction

To discover and describe the features considered salient by key stakeholders in Calgary's volunteer birth companion programs, three objectives were considered. The first objective was to describe the background and current state of the two programs; the second to describe stakeholder opinion regarding key program features (Section 1.4.1). This chapter responds to Objective One in that it describes the background and current state of Calgary's VBC programs. In doing so, it partially satisfies Objective Two, as stakeholder opinion was a determinant of the identified elements.

The chapter opens with characteristics of the data sources used in this work. The results of the interview analysis and document review are then used to describe the context in which Calgary's VBC programs were initiated. The portrayal of the background of each program is succeeded by an in-depth examination and characterization of the current state of the two programs. Description of the regional planning committee, with discussion of its actions and events is presented in the latter part of this chapter.

3.2 Data sources

Seventeen potential interviewees were contacted, and sixteen interviews were conducted. In declining the interview, the one refusal relayed her belief that there was little interest in the VBC program at her institution and that her information was outdated. Information concerning the VBC program and that institution was obtained through other interviews and in document review. The sixteen interviewees were all women who fit the
categories of interviewees identified in Appendix II. Many participants fit multiple categories. For instance, an interviewee might be both a trained nurse and a volunteer birth companion. To preserve confidentiality of the respondents, the numbers of interviewees corresponding to each stakeholder group are not included. However, each of the categories was represented by at least one interviewee. Recommendations from interviewees added to stakeholder groups to the original list in Appendix II, physicians and midwives.

The interviewees were coded as per Section (2.5.1): six interviewees as community program, three as hospital program, and seven as regional interviewees. When quotes are used in the thesis, they are attributed to an interviewee only using these three groupings. However, when multiple quotes are presented in succession, they are from different sources. As previously mentioned, a number of interviewees had rich information about more than one program by way of dual roles or role transition (e.g., a move from one hospital to another). Of the 15 case reports sent to interviewees, comments from six were received by the closing date. Comments were generally positive, few changes were suggested, and none were made.

Documents included for review in the thesis were the minutes of the Birth Companion Volunteer Program Regional Steering Committee, and various documents pertaining specifically to each program. An example of the latter would be a volunteer job description, or a client evaluation form used by the program. Documents supplied by interviewees, such as letters to the editor, or papers and reports concerning midwifery or nursing were also
included as data sources. No archival material such as number of volunteer-client
matches in a program or results of client evaluations was obtained.

3.3 Context

This section describes the historical setting in which the two programs originated,
chronologically listing seminal events. Events were included as seminal if they were
mentioned by interviewees and/or they were present in documents. Healthcare
organizational events such as the formation of the CRHA, or changing trends in healthcare
with respect to doulas and midwives are also included. Ordering the events chronologically
presents a rich description of the influences that shaped the initiation and evolution of the
programs, as well as the regional planning committee.

Through the mid to late 80's and early 1990's in North America there was a growing
awareness and interest in labour support other than that provided by hospital-based
personnel such as nurses and physicians. This rise is traced in the published literature
reviewed in Section (1.2) and is seen in the popular press [as example see (Barrington 1985;
Simkin 1989, Perez and Snedeker 1990; Klaus, Kennell et al., 1993). A concurrent trend in
Alberta was the changing face of health care service provision. In 1988, the Premier’s
Commission on Future Health Care for Albertans recommended the Nursing Job
Enhancement Fund (JEF) as one response to repeated nurses’ strikes. Another outcome of
the Premier’s Commission was The Rainbow Report of 1989, which highlighted the
formation of local Health Authorities as one direction for change among its
recommendations (Premier’s Commission on Future Health Care for Albertans 1989).
Beginning in 1989 and continuing for four years, the JEF provided funding for projects that addressed the working life concerns of Alberta nurses (Alberta Management Group 1993). The nurse-midwifery program at the Foothills Hospital was one of the projects funded, and its effects on the VBC programs are detailed in Section (4.3.2.2). Another project put forward at that time proposed to provide the services of volunteer doulas at the Peter Lougheed Centre. Interest in provision of additional labour support is also evident in the 1992-93 initiation of the Volunteer Labour Companions group by Calgary Health Services. The growth and development of the volunteer programs are described in detail below.

In 1994, The Regional Health Authorities Act divided the health care system of Alberta into geographic regions with appointed local health authorities. Like the others, the Calgary Regional Health Authority (CRHA) had legislated responsibilities for the provision of health care services (Casebeer and Hannah 1996). One result was the transfer of maternity services from Calgary's Grace Hospital to Foothills Hospital, 1994 - 1996 (Rutherford 2001). Health care system transition and the provision of labour support by volunteers coalesced in 1996 in Calgary. In October of that year, a committee was struck to discuss a "Regional Birth Companion Volunteer Program (see Appendix I). The activities of this committee and their outcomes are described in Section (3.8).

For ease of reference, these events are summarized into a timeline; see Figure 3.1. Awareness of labour support trends and health care system changes within Calgary sets the context within which each program developed. The remainder of this chapter describes the
history of each program - origin to regional planning committee, succeeded by description of the current state of each program.
FIGURE 3.1: Timeline of Events

<table>
<thead>
<tr>
<th>DATE</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>Guatemalan RCT of lay labour support (Sosa et al.)</td>
</tr>
<tr>
<td>1988</td>
<td>Nursing Job Enhancement Fund (JEF) initiated</td>
</tr>
<tr>
<td>1989</td>
<td>&quot;The Birth Partner&quot; (Simkin)</td>
</tr>
<tr>
<td>1989-1993</td>
<td>JEF Funding (includes Nurse-Midwifery Project)</td>
</tr>
<tr>
<td>1992-1993</td>
<td>Author joins as volunteer, 1993</td>
</tr>
<tr>
<td>1993</td>
<td>Initial Proposal for Doula Program (?)</td>
</tr>
<tr>
<td>1994</td>
<td>CRHA formation</td>
</tr>
<tr>
<td>1994-1996</td>
<td>Low Risk Maternity from Grace to Foothills</td>
</tr>
<tr>
<td>1995</td>
<td>Initiation of Doula Program at PLC</td>
</tr>
<tr>
<td>1996-1998</td>
<td>Planning committee: Regional Birth Companion</td>
</tr>
<tr>
<td>1998</td>
<td>Volunteer Program</td>
</tr>
<tr>
<td>1998</td>
<td>Author begins MSc program at CHS</td>
</tr>
<tr>
<td>2000-2001</td>
<td>Data collection for case study</td>
</tr>
</tbody>
</table>
3.4 Case 1: Volunteer Labour Companions, Community Based – Background: Origin to Regional Planning Committee

The history of the community based labour companion volunteers was found in three sources of information: program documents obtained by the student researcher, the student researcher’s own experience as a volunteer in the program, including documents received as a volunteer, and, information from interviewees. All referenced documents are listed in Appendix I.

3.4.1 Origin of Community Program, Best Beginning

An historical account prepared in 1994 documents the change in structure and service in the program currently known in Calgary as Best Beginning. In 1982, the Perinatal Program under the Nursing Division of Calgary Health Services (CHS), Calgary Board of Health, was established to reduce low birth weight babies in specific areas of the city. Although the scope and focus of the program’s activities varied over the years, a mix of professional staff provided services of prenatal education, nutrition, and health information to 200 – 350 clients per year. “Based on evidence that many poor pregnancy outcomes are preventable”, the program’s clients were most often pregnant adolescents or single expectant mothers. In 1993 the Perinatal Division was decentralized, program criteria were reviewed, and it was reorganized in the 1994 formation of the CRHA. Under Sexual and Reproductive Health, its name changed to Best Beginning and its mandate included all at risk pregnant women in Calgary. The purpose of Best Beginning was to “optimize birth
outcome and health of the infant born to high risk mothers in the Calgary region”
and was targeted at three phases: preconception, pregnancy and infant care up to one year.

3.4.2 Community Program Background - Purpose & Clients

The earliest reference found to the volunteer labour companions was a 1986 statement
in the Best Beginning History: “Labor companion classes begun to meet the needs of those
unable to attend a full series of classes.” The Single Women Program services were
described as “community based”, “without charge”, and included a “labour companion”. A
1993 volunteer role description stated the objective of the Labour Companion position: “To
provide support to a pregnant teen or single woman during pregnancy and throughout the
birth process”. A 1994 Best Beginning document included social support in labour and
delivery as a pregnancy-stage intervention.

Though not stated explicitly, a reasonable compilation of the above yields a proposed
purpose of the original volunteer labour companion program: to increase social support by
providing volunteer labour companions to identified women through pregnancy, labour and
birth. The program logic, one assumes, was that provision of social support would improve
the birth outcomes for mother and baby.

To be eligible for a labour companion, clients were to meet the Best Beginning (or
earlier program) criteria (i.e., were identified as high risk for any number of reasons such as
adolescent mother, low income, lack of social support). Best Beginning staff explained the
Volunteer Labour Companion option to identified potential clients. If the woman showed
interest, a volunteer request form was forwarded to Calgary Health Services’ Volunteer
Coordinator, who contacted the most appropriate volunteer after determining client
preferences (e.g., age and experience of volunteer). If the volunteer accepted the
match, she would sometimes contact the client by phone and/or have an initial meeting at
the first childbirth education class. Volunteers and clients were free to refuse or withdraw
from the match, clients at any time, however, volunteers were expected to honour their
commitment unless prevented by exceptional circumstances. The Best Beginning nurse
remained available for discussion with the volunteer and/or client if questions, difficulties or
concerns arose. Interviewees describe the program's first clients:

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"... when the program first got started, about seven years ago, most of the clients were
young girls um, or younger women who had who are at risk for a number of different factors
and had no support and various other things."
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Community Program Interviewee

A record of the numbers of clients supported during this time period was not found, but a
reasonable estimate would be less than 20/year. Program funding was minimal, supplied
through Volunteer Resources. In 1995, client eligibility expanded to include women who
did not meet Best Beginning criteria, but who were "socially isolated and have no other
support during labor and delivery".

3.4.3 Community Program Background – Volunteers & Activities

Having successfully passed general volunteer screening criteria, the Labour
Companion was required to have skills conducive to providing social support (e.g., non-
judgemental, an effective listener, maintenance of confidentiality) and to have an interest
and basic understanding of labour and birth. The role expectations included attendance at
childbirth education classes with the expectant mother, being present and remaining with
her throughout labour and birth, and one postpartum visit if mutually agreed upon. Labour
companion training consisted of the completion of a CHS prenatal education class series. Interviewees who were early volunteers with the program recall the training:

"When I started, there wasn’t a training program."

"Um, you know, I shouldn’t say I had no training. ‘Cause we did attend a pre-natal class."

Community Program Interviewee

The activities of the volunteer varied with each match, and were largely client driven. Some clients did not want to attend childbirth education classes, but wanted frequent telephone contact, others wanted a companion only throughout labour and birth. Volunteers were supplied with a pager as the mother’s due date approached. Clients were familiarized with the pager system, and instructed to call the volunteer when labour started. The volunteer was expected to support the mother throughout her labour and birth and of the baby. The nature of support was loosely defined.

"When I FIRST started it was peer support. The directive was basically um, someone to hold their hand."

Community Program Interviewee

At that time the less than ten volunteers, including the author, were all Caucasian women. Most had registered nurse and/or university education and were women whose interest in volunteering with expectant mothers also furthered their own career plans – nursing, midwifery, and medicine.

"I think I wanted to become a midwife. when I started. I think I had already tried to get into medicine. that didn’t work...I had my own other. I mean my prime reasons. I think, were to get some experience. I wasn’t thinking of it so much as, you know, a volunteer role...."

Community Program Volunteer

Each doing a couple of births per year on average, they met infrequently, but formed a cohesive and supportive group:
"The BEST group ever was that core, that core beginning group... I don't know, but we... we had more of a cohesiveness... I actually, I felt a lot of LOVE in that group... There was A LOT of support."

Community Program Volunteer

3.4.4 Community Program Evolution

In 1996, under the CRHA's Prevention & Promotion Services, the modified Volunteer Labour Companion program documents included a clear statement of purpose "to optimize birth outcome for at risk pregnant women" and "health of infants born to at risk mothers". Another change was the introduction of picture identification, to be worn by the volunteer when accompanying the client in hospital. Although reported problems were few, clarification of the labour companion as a trained volunteer was intended to ensure their role was explicit to hospital staff.

Matched clients commonly expressed the desire and expectation that the volunteer would drive the client to the hospital during labour, an uncomfortable proposition for both volunteers and Best Beginning staff. To address this, the role description explicitly stated that the volunteer could not drive a labouring client to hospital, but did allow optional tasks such as driving the client to appointments or childbirth education classes. Moreover, volunteers were provided with taxi vouchers to be used if they were supporting the early labouring mother at home, and needed to go to hospital.

In addition, the volunteers began to shape the activities of the group, strengthening the bonds between them through social activities. Increased frequency of group meetings allowed opportunity for exchange of birth experiences, and continuing education through inservices. Volunteers initiated changes brought about by their own interests. For example, one volunteer developed a comprehensive labour companion training manual as part of a
school project, seeking and incorporating feedback from group members. The original core group of about five volunteers remained constant, with an equal number of volunteers that fluctuated.

In the April 1996 Minutes of the Labour Companion Support Group Meeting discussion was recorded of the "number of requests from the hospitals for volunteer labour support as a result of a letter distributed to all hospitals describing our program and the role of volunteers during labour and delivery." As a result the volunteer coordinator planned to "initiate discussion for a proposal to establish a Regional partnership in Volunteer Labour Support at the Regional Volunteer Resource Council".

3.4.5 Summary, Community Program - Origin to Regional Planning Committee

Arising out of community health initiatives in Calgary in the early 1990's, volunteer birth companions provided social support in pregnancy, labour and birth to identified at risk mothers to improve birth outcomes. Program changes over the years reflected changes in the Best Beginning program and the CRHA. Clients were generally young, low income and lacking in adequate support. Trained women volunteers were matched to the client, often attended prenatal classes with them, and were expected to provide support throughout labour and birth in hospital. Volunteer training was minimal initially, but increased as the volunteers expanded their activities, shaping the group. Client feedback regarding transportation to hospital was addressed. The interest in a proposed regional program was documented in April, 1996.
3.5 Case 2: Volunteer Doulas, Hospital-Based – Background: Origin to Regional Planning Committee

The history of the hospital-based volunteer doula program was discovered primarily through interviews with program participants and a few program documents.

3.5.1 Origins of Hospital Program, The Doula Movement

The rise in interest in doulas has been traced in the literature review (Section (1.2)), and in the popular press (Section (3.3)). In Calgary the doula movement was spearheaded by a labour and delivery nurse whose interests included childbirth education and a focus on labour support that spread to doulas in the early 1990’s. Participation in the initial doula training program in 1994 spurred her suggestion that a volunteer doula program be considered at the Peter Lougheed Centre (PLC). Although there are discrepancies with respect to target funding for the initial proposal (one interviewee reported the JEF, others could not confirm this), it is clear that it was rejected. However, a second proposal was accepted in 1995 when the group gained a one-time grant from the volunteer resources department of the PLC as seed funding for the program called “Doula: A Childbirth Support Program”.

“And they, about five years ago, decided to try Birth Companions because there was so many women that were um, of um, such a multi-cultural base. And they were finding a lot of women that were co, arriving at hospital without any labor support. So they did it sort of as um, I guess a pilot project or a trial project.”

Hospital Program Interviewee

3.5.2 Hospital Program Background – Purpose & Clients

Documents used to train the first volunteers at Peter Lougheed Centre reflect the links with the DONA (Doulas of North America) doula training program. As such they
provide a description of the doula role, concluding with this statement: "The
acceptance of doulas in maternity care is growing rapidly with the recognition of their
important contribution to the improved physical outcomes of emotional well-being of
mothers and infants [sic]". Despite this statement there was some sentiment that doula care
would only be available to those who could afford to pay for it. Furthermore, there was a
perception that some of the hospital’s labouring clientele lacked adequate support in
childbirth.

"... (Name) suggested to her that we start a volunteer program, for people that
couldn’t afford it. Because they were starting to be offered you know, on a PROFESSIONAL
basis, and so people could pay for, for Doulas and, and bring them into the hospital with them
and that sort of thing. So, if you had money, you could have one. And, and (name) thought.
"Well, there’s so many people out here that DON’T have the money but could really use one
and, you know, there’s a lot of teenage mother’s, there’s a lot of um, immigrants. There was a
lot of um, um, people that were just on their own."

Hospital Program Interviewee

Although no documentation of the program’s original purpose and target population
have been found, a reasonable statement would be: to provide volunteer doulas to labouring
mothers who arrived at the PLC with inadequate support. Inadequate support seems most
likely to have been recognized in mothers who had no one with them and/or had language
barriers or cultural differences and/or were adolescents. The (assumed) program logic was
provision of the volunteer doula to a mother otherwise inadequately supported would
improve the physical outcomes and emotional well being of the mother and infant.

Initially in the hospital doula program volunteers were available by way of a call list
on which they had scheduled their availability for the month. The intended course of action
was: when a woman was identified as lacking adequate support, either upon entry into the
unit or later in the course of labour, the nurse would suggest the option of a volunteer. If the
mother agreed, the unit clerk or nurse would telephone the on-call volunteer, or proceed down the volunteer list until one was found. Upon arrival, the volunteer doula would meet the labouring mother, discuss various birthing options with her if appropriate, and begin providing support to the mother. Although not a specified part of the role, the volunteer would sometimes visit the mother postpartum, perhaps writing and bringing a story of the birth. Afterwards the mother had the opportunity to provide feedback on the doula and labour support process by completing an evaluation form.

3.5.3 Hospital Program Background – Volunteers & Activities

Having obtained funding, the hospital doula program recruited potential trainees from within the PLC volunteer pool, choosing a dozen women to begin the program. Qualifications included versatility, and an interest in and knowledge of birth, perhaps reflective of their own experiences.

"The initial group was um, a lot of them were. were, actually all of them I think were from our own volunteer pool. So there was um, um, more mature women who were just grandmothers and mothers who had you know, had um, had gone through the experience and were very flexible in their time that they could give, which is a definite pre-requisite for this program. So we had a lot of them, um, and most of the people initially, it was interesting weren't all that interested in a career in, in being a Doula or um, being in labor and delivery or going on to do something medical... "

Hospital Program Interviewee

The 14-hour doula training course covered the physical, emotional and psychological processes of labour and birth. A number of physical but non-medical labour support techniques such as changing position, light massage and relaxation were taught. Communication skills, ethics and standards of practice were also covered. One volunteer recalls the training:
“Well, the training was very intense. I think there was initially twelve of us um, oh that she was going to train. And then what we did was we met for um, six weeks, six or eight weeks for two to three hours once a week. And she did training on positions um, pain intervention um, you know, positive um, response back to the mom you know? And some negative situations. We did a lot of role-playing. We did a lot of hands on stuff. Watched quite a few videos. Um, had a couple guest speakers…”

Hospital Program Interviewee

The initial group of volunteers was comprised of women who had already identified interest in hospital volunteer work. The nature of the support provided by the volunteer varied with the mother, the stage of labour, and with the doula herself. Although all the volunteers had completed the training course, some simply relied on emotional support measures such as reassurance and praise. Nonetheless, these interventions were valued and viewed as effective, overcoming language or cultural barriers.

“But also at the Lougheed we have a lot of couples who are very nervous about the birth experience. It may be culturally or, or a variety of reasons. Um, and so even though it was a stranger beside her, it was one person who was there, it was wonderful for some of the Mom’s. And one of our, one of our older Doulas I knew, she was, was a, it was a very long labor and the Mom kept saying, ‘Don’t leave me or I die, don’t leave me or I die.’ And I mean, that was, that was wonderful for her and it was somebody she never met before. But it was wonderful, because she was doing the very much, motherly grandmotherly, you know, hugging and cuddling and probably not much else. For hours. And that was fine. And so those kinds of people I think really benefited from having a volunteer.”

Hospital Program Interviewee

The volunteers met approximately once a month to share their experiences, extend their labour support knowledge through presentations or videos, and discuss the growing pains they encountered as a new program within the hospital. In the first year of the program, records were kept of birth details and outcomes (e.g., pain measures, length of labour, number of support people).
3.5.4 Hospital Program Evolution

In the hospital program, a number of interviewees identified the growing problems not uncommonly associated with program initiation.

"... we REALLY weren't sure exactly what was important... Um, little things like we weren't sure whether a Doula needed to stay for instance for the Mom who got an epidural. And so we, there were questions like that we had to work through and nobody really knew the answers. We didn't know how to even set up our call system... All of those things were, were very awkward for everybody that, by an large, the Doulas were quite keen. And um, we all hung in, we had meetings all year. We talked about various things and how we could, what we could do. So by the end of the year, a few of them had decided that, "this was not what they wanted to do." It just didn't fit in with their lifestyle. Which was fair, and others stayed longer and so on."

Hospital Program Interviewee

Thus, as the first year of the program drew to a close, many of the original doula group left the position. Interviewees attribute volunteer attrition to a number of causes, such as family commitments and disillusionment with the role, either because it was too intense or conversely, because they were underutilized. This apparent discrepancy may be due in part to the nature of the work – attending births is unpredictable and can be demanding.

"Some of them, it got to be really hard on them physically because it was you know, long periods of time, seventeen hours, some of the births took, at once. And ah, so, I think, I think there was more that they just lost interest because they weren't getting called in, and felt that they could be better utilized elsewhere."

Hospital Program Interviewee

Another contributing factor may have been the mixed reaction of the hospital labour and delivery staff to the doula program. Although it increased in popularity with at least some of the labour and delivery unit staff, this was not uniform. Often the volunteers were simply not called. However, if keen volunteers made their presence on the unit visible by coming in on their appointed day, their likelihood of being asked to attend a birth increased. The staff became more acquainted with these volunteers, who then tended to become busier.
"When the project first began it was very intense 'cause there was only... the problem was we were VERY busy...and then we, and then we brought another group in because the initial twelve, some people discovered that that really wasn't what they wanted to do... they had family commitments or whatever and so, you know the group was lessening and lessening and the and labor and delivery were wanting more and more Doulas and there weren't people available so they had some more re-training."

Hospital Program Interviewee

These issues are explored further in Section (4.2.2). Though more volunteers were needed, the remaining funds were insufficient to cover new training sessions. However, the regional program planning committee talks were beginning.

3.5.5 Summary, Hospital Program – Origin to Regional Planning Committee

Through a growing popular interest in labour support via doulas, and one person's initiative supported by others at the Peter Lougheed Centre, seed funding was obtained to train volunteer doulas. The nurse or unit clerk introduced the program to inadequately supported labouring mothers arriving at the labour and delivery unit. Inadequate support seemed associated with language or cultural barriers, adolescence, or women who arrived with no other supportive person. If the client agreed, a volunteer would be called in to support her, with the aim of improving physical outcomes and emotional well-being of the mother and infant. The volunteers met monthly to exchange information and increase their knowledge of birth. The program was challenged by growing pains in its first year, and met with mixed reception by hospital staff. However, keen volunteers learned to work within the system, and were quite busy. Volunteer turnover at the end of year one required the training of new volunteers, at about the same time as discussion of a regional program of labour support began.
3.6 Case 1: Volunteer Birth Companions, Community – Current State

3.6.1 Current Community Program – Purpose & Clients

Recent role descriptions for the Birth Companion volunteer position reflect the continuing transition of Volunteer Resources within the CRHA. The 1998 description is listed under Promotion and Prevention Services, Community Health Resources; whereas, a 2000 role description lists it under Healthy Communities. The objective of the VBC position to "provide companionship and support... during pregnancy and the birth experience" is stated in the 1998 document specifying the client as a "Calgary Health Services client". The 2000 document simply states "client". Interviewees consistently describe the program's purpose in terms of support. Typical responses to questions about program purpose are shown below.

"The program purpose] "...is to offer them, offer support to women who don't have family or friends that'll be there for the birth of the baby."

"We provide, we provide support, um. to women in need through labor and childbirth."

Community Program Interviewees

Furthermore, the client descriptions in these quotes speak to the program's original and continued purpose of providing support to pregnant women who were identified as being in need or at-risk.

Changes in program focus correspond with changing client characteristics as eligibility criteria were relaxed. In the current state of the program Best Beginning clients are still eligible, but volunteer birth companions can be requested outside of Best Beginning for clients who are in need because of cultural differences, lack of social support, or struggling with issues such as abuse. Thus, compared to the early days of the program, some of the
current clients are older, and more may be new immigrants to Canada, and/or who may not have English as a first language. Words often used in description of the program’s clients are, “needy”, “low-income”, or “socially-isolated”. As one client sums it:

"Typically a Public Health Nurse will identify a client as high-risk. So it could be, it’s typically financial. Um, but there can be other things; social, um, drug use, lack of a partner. Um, teenage, you know there’s a lot of others. So... psychosocial risk factors."

Community Program Interviewee

Again, an explicit statement of the program purpose on program documents was not found. However, pooling the information from interviews and the volunteer role descriptions leads to a reasonable statement of the current program purpose: to provide support via volunteer birth companions to identified women in need through pregnancy, labour and birth. This definition is similar to the original program purpose, though the target population has changed to allow eligibility of women other than those already in a specific program like Best Beginning. Program funding is minimal, and supplied through the budget of Volunteer Resources. In recent years, approximately 40 clients have been matched per year.

3.6.2 Current Community Program – Volunteers

The program currently has about 12 volunteers, retaining a few from the original core group, some of whom are inactive. An inactive volunteer maintains an interest in the group by attending meetings and/or volunteering in areas such as training, but is not currently accepting clients. An interesting development is the mix of volunteers, which now includes a few VBC’s who are also members of the hospital-based group. Though the multicultural aspect of their clientele has increased, interviewees admit that their group does not reflect this, stating that efforts to include ethnic women as volunteers have been
unsuccessful. Many of the community VBC's are well educated and employed in areas other than birth, such as business.

Qualifications listed on the role description require the volunteer to be non-judgmental, a team player, caring and dependable, with excellent communication skills and an interest in childbirth. Given the target population, the ability to develop rapport and trust with women is key. Interviewees both inside and outside the program describe the volunteers in terms like, "compassionate", "understanding", "receptive", "open". A typical view of the community volunteer group is given below.

"ALL WOMEN. Um, tend to be all very well spoken. Um, not necessarily have many degrees behind their name but MUCH life experience that shows through. Um, compassionate. All of them are compassionate. All of them are very professional. You know, they, they don't necessarily and not all of them have worked out of the HOME even, but just have that manner. Good people skills, that comes through. And respect. Very respectful.

Community Program Interviewee

In addition, new volunteers are chosen for their compatibility with the current group. This is seen as a way of maintaining the support the volunteers give to each other.

"I also ah, feel that our GROUP um, because we are such a specific kind of a group, they really come together, one of the things... is how well they're going to fit in with the group that we have right now. And we have a very strong supportive network of volunteers that come together in this program and support one another and are very comfortable with one another and know they can say what they need to say.

Community Program Interviewee

Generally, group members share similar beliefs in their attitudes towards childbirth and their roles as volunteers. Members are encouraged to recognize their own reasons for volunteering, and to guard against assigning their own values and beliefs to the client. Indeed, within the group, volunteers who appear too outspoken towards the medical system, or who seem to "be on a mission" are viewed and spoken of with caution and sometimes rejected as volunteers if they exhibit these attitudes.
"Some people go in there to, because they've got a vendetta. I don't think there's too many people right now in our group if any, but the vendetta thing is a big one."

Interviewer: "Against?" "Well against the medical, or against births gone wrong or you know? Their own, their own. It's their own agenda. I think (name) does a good job of screening for those things. So that... we get people in for pretty much the right reasons."

Community Program Interviewee

What then, are the right reasons? Allowing women a choice. An interviewee puts it this way:

"We know the importance of support. Um, we feel because we're, you know, we're dedicated to what we do and we believe in it, we feel that everybody should have it. But in the final, when the final word is, it's got to be a choice."

Community Program Interviewee

When questioned about the benefits of volunteering some women speak to the practical issues of acquiring birth experience to further their own career goals. However, the most commonly expressed sentiment is the reward of altruism.

"It's always feeling like, "you just made it" even if it was just a little bit better. You just made it a little bit better: sometimes you make it a lot better. But, it's, it's the client that says, "Thank-you so much!" Um, "Thank-you for everything." Or you know, the most ridiculous one, but you know, the heart felt, "I couldn't have done it without you!" (Laughing)

Community Program Interviewee

3.6.3 Current Community Program – Activities

The current community VBC role expectations have changed little since the program's inception. Client referrals and the matching process have changed slightly. Now the initial client-volunteer introduction is usually a three-way meeting with the referring nurse. Since 1997, evaluation forms have been available to both volunteers and clients to provide feedback after each match is completed. Although the client evaluation is confidential, the client can request to have the information shared with the volunteer.

An additional role available to volunteers since the fall of 1996 is one of Childbirth Educator Volunteer. In this capacity the VBC attends one session of a prenatal class, or
perhaps a session at the Louise Dean school to promote the VBC program. Also,
in the autumn of 1997, volunteers were invited to attend hospital in-service sessions
initiated by the activities of the regional planning committee. These sessions were a means
of introducing hospital employees to the VBC program and its volunteers. The community
group were invited to tour the hospitals, and attend the regional program’s pilot training.

Despite the consistency of the VBC role with respect to the client, expectations for
volunteer education have changed substantially. The current training requires attendance at
a 12-hour training course and at two births with an experienced VBC, in addition to
attendance at one series of prenatal classes. The volunteers meet every three months to gain
information about program changes, share recent birth experiences, and for further
education.

Many of the group’s changes have been initiated and carried out by the volunteers
themselves, drawing on their work experience and talents. For instance, one volunteer
helped to restructure the volunteer interview format. A registered nurse experienced in
childbirth education, labour and delivery volunteers her time to teach the training course,
using an updated and expanded version of the earlier developed guidebook. These actions
support the view that the volunteers shape the group.

"The best people for talking about change and coming up with new ideas is the
volunteers themselves. The evolution of this program has definitely been driven by the
Volunteer Birth Companions."

Community Program Interviewee

3.6.4 Summary, Community Program – Current State

The community based volunteer birth companion group provides social support to
identified women in need, through pregnancy, labour and childbirth. Public health nurses
request volunteers for women who are Best Beginning clients and/or at-risk for predominantly psychosocial reasons - low income, inadequate support systems, cultural differences. The current volunteers now include members of the hospital-based group, and view themselves as a cohesive unit with a common philosophy who provide support to one another. The group members have effected change in the program by increasing training frequency and content.

3.7 Case 2: Volunteer Doulas, Hospital-Based – Current State

3.7.1 Current Hospital Program – Purpose & Clients

Role descriptions for the volunteer doula program at the Peter Lougheed Centre in 1997 and updated in 1999, consistently state the goal of the position: “to provide support to labouring women and their families”. Throughout the document the labouring woman is also referred to as the “client” or “patient”, with no descriptors attached. In addition, brochures offer the program to the “woman and her chosen companions” or “birthing mothers”. From this information, the hospital volunteer birth companion program seems potentially open to any woman in labour at PLC. How then is she identified as one who would benefit from a volunteer?

An obvious answer is the mother herself makes a request, and this has increased in frequency as the birth companion concept has grown. According to interviewees, women in need are also identified by many of the same client descriptors given at the program’s initiation, that is, when they are youthful, struggling with cultural or language barriers, when their labour seems to be difficult or prolonged, or their support seems inadequate
(e.g., no one accompanies the mother, the designated support person is uncomfortable or ineffective). One interviewee sums it:

"Um, sometimes a couple who are obviously unfamiliar with our hospital system, which may mean that they are new to Canada. Or a relative or, you know, having the first baby, they've never been here before, we feel that this may be a fairly long labor, and um, and they're just uncertain about what's going on. Ah, I must say that I have sometimes with teens thought, "Oh a Doula would be wonderful here." And there's no way they want somebody."

Hospital Program Interviewee

Interviewees also state that many women and/or couples outside of these descriptions are eligible for a volunteer birth companion, corroborating the volunteer role description and advertised offers of support to any labouring woman and her family:

"We were trying to, to get across and educate that it doesn't matter if they have a support person with them, they can still, they could still get, gain, value from having a Birth Companion because it takes the pressure off that support person, who you know is quite emotionally involved in the situation and that makes it a better experience for everybody."

Hospital Program Interviewee

Thus, the purpose of the program as presented in these sources of information is: to provide volunteer birth companions to support any labouring woman at PLC whose need of additional labour support is identified by staff or herself. Slightly expanded from its earlier purpose, the program seems aimed at both those identified as having inadequate support, and those who want additional support. An estimate of the rate of clients matched through telephoned staff requests is once a month. However, the total number of matches in the program can reach up to 50 per year, if the volunteer(s) is proactive by coming into the unit on the days she wishes to volunteer her services.

3.7.2 Current Hospital Program – Volunteers

The hospital-based VBC program currently carries up to twelve volunteers, usually with ten or so at any one time. As previously mentioned some volunteers are also members
of the community program. The qualifications listed on the 1999 PLC role
description require the volunteer to have completed the training program, to be supportive
and caring, respect confidentiality, and have excellent communication and interpersonal
skills so that they are able to work well on a team. In addition, new hospital VBC’s shadow
an experienced hospital volunteer birth companion or staff member. When the regional
program was considered, current hospital volunteers attended the in-service information
sessions at other hospitals.

Efforts were made to recruit volunteers from ethnic communities by inviting
women who exhibited strong labour support skills while accompanying labouring mothers
(friends or relatives) at PLC, that is, women already identified as natural helpers within that
community. However, often these women were precluded from long-term participation by
economic necessity – paid employment took precedence. Although the volunteers tend to
be Caucasian, interviewees report that some of the PLC volunteers do speak other
languages.

Most of the current volunteers have acquired their training privately, discussed in
more detail below. When asked to describe the PLC volunteers, interviewees consistently
present the VBC’s in the context of the volunteers’ career plans, using terms like
“professional”, “private” and “business”, along with characteristics like compassion.

"Um, the later volunteers that we got after that were all primarily interested in either
being, maybe midwives or professional Doulas or um, working at nursing careers or things
like that. So, they were all really focused on the medical side and, and wanting experience."
Hospital Program Interviewee

"Um, you still see the compassion, there was, you know all of those things. But I think
the tendency more. I think the, because you get many, many births potentially with this, if you
wanted to be a Doula, wanted to be a mid-wife or you wanted those experiences you would
gravitate more towards that program to get the birth. Um, so I think there is that element, not all of them, um, but that sort of guides them there to get many births.”

Community Program Interviewee

“Well, I, for awhile there, I saw a real movement of, of um, almost a rebel. I guess that’s the word (Chuckles) I’d use to describe it.... They started, they set up a business and you know, then they, you know, were carrying beepers and they were doing private clients more than they were ever doing volunteers and some of them got into aspects of the birth as in like aromatherapy, massage...”

Hospital Program Interviewee

The desire to obtain birth experience then, is viewed as a common characteristic of the current PLC volunteers. Indeed, one of the benefits stated on the volunteer role description is “increased knowledge and participation in the birthing process”. Yet, the desire to help others is evident, with the certification process being viewed as an assurance of quality.

“I look at it more as a ministry as a something that I can do, something that I can help you know a person with and you know, that’s the way I’ll go about it. But it, um, I continue to keep my current certification because I think that that um, if you’re in, if you’re doing it, you should be current...”

Hospital Program Interviewee

Acknowledgement of the private or paid role of the doula is often accompanied by statements that even in matches made outside of the PLC volunteer role, the doula will often work without pay, in the spirit of beneficence.

“We talk about it as, “The Paid Role”. Although they often volunteer. They often don’t get paid, they’ll come in with people and not get paid.”

Hospital Program Interviewee

What are the appropriate criteria, the “right reasons” for becoming a doula by the standards of this group? A desire to support the mother.

“I feel good about what’s happening with Doulas now. Cause I think, a lot of people know about them, a lot of people who are becoming, are becoming Doulas for the right reasons which is truly to support the mother, and not necessarily [words garbled] the medical system.”

Hospital Program Interviewee
3.7.3 Current Hospital Program – Activities

The role description of the PLC volunteer birth companion position is a thorough delineation of the duties and responsibilities of the VBC. Provision of support to the mother’s partner and/or other support persons is an expectation of the role. The volunteer is expected to provide continuous support to the patient and to stay until birth, or as long as she’s needed which is mutually decided by the “health care team and patient”. Careful attention is paid to defining supportive measures such as advocacy, or outlining boundaries for physical support by listing procedures outside the scope of the VBC’s role. Staff duties and responsibilities with respect to the volunteers are also listed. Evaluation of attended births occurs informally.

As stated in Section (3.5.4), when the original volunteers discontinued their involvement with the program, there were insufficient resources for training new volunteers. However, the discussions conducted as part of the regional planning committee intimated that the CRHA would be a potential source of training resources.

"And then the other thing too that happened was that um, we had the initial funding for a training program from um, the seed money from the volunteer um, association and then after that, the labor and delivery was supposed to cover the cost of training and we’d you know, sort of talked about it went back and forth and when we were going to go REGIONAL, there was money there. And when we didn’t go regional, there wasn’t money to do that. So um, we couldn’t offer a training program."

Hospital Program Interviewee

Other training options considered but rejected included funding through the labour and delivery unit’s budget, and/or finding staff willing to donate their time as trainers. The latter was thought to threaten the continuity required by the course, which was considerably longer and more involved than other volunteer training activities. Rather than cancel the program altogether, a decision was made to allow new volunteers into the program if they
had completed certified doula training courses. Some volunteers (especially newcomers) obtained their qualifications outside of Calgary. However, most of the current volunteers have paid for and completed their doula training privately, through attendance at DONA certified courses conducted by a PLC labour and delivery nurse. The doula group’s regular meetings have, for the most part, substituted for the previous PLC volunteer group sessions, as many of the current volunteers are active doulas.

“We also have the Doula Services Association and a lot of the Doulas who are, would have speakers every month. A lot of Doulas come to that every month. And that works out quite well for us as well.”

Hospital Program Interviewee

Participation in the doula training course preceding the volunteer role at the PLC provides an explanation for the detailed role descriptions, and the characteristics representative of volunteers. The current volunteer birth companions at the PLC often have a strong desire to be a helpful presence at many births, are keen to gain experience, and are doula-oriented. Those who have been with the volunteer program longest advise new volunteers, informing them that the most effective means of accruing births is to be a frequent presence on the unit, making themselves known to staff.

“And it’s very individual in the sense that if they had a Doula that they really liked, they’re not going to call THE PROGRAM, they’re going to call that specific person. If that person’s available great. If she’s not. “Well, we don’t know those other people.” And I try and impress to the Doulas, “Hang-out, get to know the nurses.”

Hospital Program Interviewee

The certification process is viewed by some interviewees as an assurance of the quality and level of skill the volunteers bring to the program, and proposed as one reason some of the labour and delivery unit staff have gained confidence in this role.

“And just the quality of the, the Birth Companion’s that we were able to bring in were excellent, um, professional and that just helped to, to you know, um, ah, IMPRESS staff
with the level of people we were getting in there and, and their expertise and their experience and things like that so, that helped a lot too."

3.7.4 Summary, Hospital Program – Current State

The hospital-based volunteer birth companions provide support through labour and birth to any labouring mother whose need for additional support is identified by herself or others. Support may be requested for the woman and her family if she is struggling with labour and/or because of language or cultural differences, or simply by the mother’s request. The current volunteers have completed certified doula training prior to their acceptance into the hospital VBC program. Those wishing to gain birth experience increase their frequency of birth attendance by proactively coming into hospital rather than waiting to be called.

3.8 Regional Planning Committee

Referred to briefly above, the CRHA initiative to create and provide a regional program of volunteer childbirth support was conducted by a planning committee. This committee and its activities are discussed in detail in this section. Stakeholder opinion is included in three ways: (1) as evidenced by the committee meeting minutes; (2) through interviewees’ description of the committee’s activities; and, (3) by report of the stakeholders’ opinions of, and reactions to, the committee, its actions and their outcomes.

3.8.1 Context

The year 1996 in Calgary was a time of rampant health care system change. Employees at many levels were challenged to conceive, design and execute modes of health care service delivery guided by the regional concept. Within the newly formed CRHA,
health care services and programs that had been provided to fit the needs of one
unit within one hospital, or designed as one program within a host of community services
were examined from a regional perspective. Programs providing what seemed to be similar
services were considered for amalgamation or change, with the goal of presenting efficient,
standardized and comprehensive service throughout the CRHA (Calgary Regional Health
Authority 1996).

“We recognize that we must move beyond priority setting, decision-making and
service delivery methods used in the past to create a system which will facilitate the seamless
delivery of health services across all organizations and levels of care within our jurisdiction.”
(Calgary Regional Health Authority 1996, p.14)

Thus, to facilitate the regional program initiative, eight planning and design
committees were struck, Maternal/Newborn being one of the identified key service areas
(Calgary Regional Health Authority 1996).

“Concurrent with, with regionalization, the region wanted ah, some planning to occur
for some major programmatic areas. And Maternal Newborn Services was one of the eight
programs that was selected for ah, planning, ah, detailed planning initiative to occur....And the
whole idea at that time of course was that, we would start running, we would start offering
services and organizing our services on a true programmatic basis... So, for about a year,
more than a year, we undertook this really wide planning initiative, involved hundreds of
people, subcommittees... and came up with a conceptual model of how we would see integrated
services for Maternal Newborn...”

Regional Interviewee

The regional program concept affected the volunteer birth companion programs in
multiple ways. From the volunteer perspective, as stated in Section (3.4.4), the community
program had considered a partnership for volunteer labour support in April, 1996, and key
stakeholders in the two programs had discussed this possibility.

“[W]e had discussions about doing a joint training... we’d get together and share
RESOURCES, which was great... And then (clears throat) when we went regional, um, we had
one um, Maternal Newborn Director, ah, she had, you know, was getting up to speed on... on
everything in all the AREAS and heard about this PROGRAM and thought, “Well, gee, that sounds great!” You know. “Why don’t we have it at all the other sites...”

Hospital Program Interviewee

From the Maternal/Newborn perspective, both the volunteer doula program at the PLC and the volunteer labour companions out of Best Beginning appeared to provide similar service.

“Part of our early work was to inventory ALL the Maternal Newborn Services that were in hospitals, community, not for profit, wherever they were, you know. And, and how were we going to start working together and coordinating resources? And then the Birth Companion Program, at the Lougheed became part of that inventory. As did, the, the program that was being run, I think out of Best Beginnings, initially, in the community.”

Regional Interviewee

According to the community program’s minutes, in September, 1996 an initial regional meeting had already taken place. It was reported that the CRHA was considering the two programs for amalgamation, standardization and perhaps expansion to the two hospitals that did not have on-site programs. The October, 1996 Meeting Summary of the Regional Birth Companion Volunteer Program was the earliest document found that records the details of this initiative. The committee struck to consider a regional birth companion program is referred to by many name variations throughout the subsequent meeting minutes and interviewees’ comments. For the purposes of this thesis, it will simply be termed the regional planning committee or (RPC).

3.8.2 Regional Planning Committee - Description

Minutes were obtained for six sessions of the regional planning committee meetings held between October, 1996 and June, 1998. A range of 12 – 15 committee members attended these meetings. The committee composition consisted of CRHA volunteer coordinators, staff from each labour and delivery unit, CRHA administrative personnel, and one community women’s group representative, and a family physician. The meetings of the
first session (October, 1996) and a survey undertaken to ascertain perceived needs are discussed in detail, as they lay the groundwork for the actions of the committee. The other five meetings are summarized in point form.

In addition, minutes for various sub-committees established to devise and discuss the details of a regional volunteer birth companion program were found for five meetings held between May, 1997 and July, 1998. The attendance at these committee meetings was usually five or six members. The activities as recorded in the minutes of these meetings are described in the Section (3.8.3.3).

3.8.3 Regional Planning Committee – Activities

3.8.3.1 RPC – October, 1996

In the minutes dated October 23, 1996 a number of presentations outlined and discussed CRHA policies regarding the development of volunteer programs, hospital policy on private providers of labour support in hospitals; and, an overview of the proposed implementation of a CRHA labour support program from the Maternal/Newborn Design Committee's perspective. Methods and standards for recruiting and screening volunteers were discussed, as were volunteer role description items such as advocacy and communication between patient and caregiver. Although there were presentations and discussion around the doula model of labour support, there was agreement that:

- The term birth companion would be used, rather than doula
- The role of the birth companion volunteer was “to support, enhance, and enrich the services of professional staff” and “to enhance a woman’s birth experience”.
In an attached appendix it was stated that a regional birth companion program could fit within the CRHA Maternal/Newborn program structure, provided it was clearly distinguished from the doula role. To ensure the distinction, the name doula would not be used, doula training would be modified, the volunteers’ services would not be guaranteed, and the role of the volunteer would primarily be to support and augment the services of staff. A needs assessment would be conducted at the three hospital sites, Foothills, Peter Lougheed, and Rockyview. An interviewee remembers the intent and focus of the committee’s work:

"I think a lot of what happened was ah, people airing potential concerns with ah how um, a Volunteer Birth Companion Program would work, ah, along side of nursing staff. Ah, whether a resistance would be experienced ah, at different centers related to that. Um, and what, I guess my primary interest ah, and FOCUS I suppose, that I THOUGHT we were working through um, sort of a, a job description a, and a, and a PROCESS by which you could minimize problems ah, interacting with nursing staff and interacting with medical staff that it, it would ah, FULFILL a potential NEED without being perceived as an essential service to ALL laboring women. Um, and also wouldn’t interfer, INTERFERE with medical care, would just be, a complement."

Regional Interviewee

3.8.3.2 Survey of Perceived Need

Subsequent to the October, 1996 meeting, a survey was designed by two committee members. After incorporating feedback from a CRHA employee, the survey was sent to the three hospital sites accompanied by a cover letter that specified the survey should be “passed to 100 clients at each site”. The survey opened with a short introductory paragraph explaining the survey purpose, followed by two sentences describing the role of the Birth Companion Volunteer, with reassurance that the volunteer would not replace usual care. On the five question survey the first two Likert-scale questions asked the respondents to rate how much physical support (Q1) or emotional support (Q2) they would have liked to
receive from their partner and caregivers; and, the second two asked them to rate how much physical support (Q3) or emotional support (Q4) they actually did receive from their partner and caregivers. Respondents rated their answers on a scale of 1 – 10, with 1 specified as “none”, 5 specified as “some” and 10 specified as “a great deal”. The final question asked the mother to respond by a yes/no answer whether she would have wanted a Birth Companion Volunteer during labour if she’d been offered one. Interviewees and the minutes refer to this survey as a needs assessment.

"[W]e... wanted to know through a needs assessment, if it was something that was needed on this site. And um, when the steering committee met, ah, we had agreed as the Acute Care Hospitals, we agreed that we would ah, put together a questionnaire which would be sent out or distributed ah, to the three sites; the Lougheed, the Rockyview and the Foothills. And each site distributed I believe one hundred questionnaires each. And based on the results of the questionnaire, that was the determining factor for this particular site."

Regional Interviewee

The survey results are discussed in the January 28, 1997 minutes. Of the 100 surveys distributed to each site, 17 were completed at the Rockyview (RVH), 25 at the Peter Lougheed Centre (PLC) and 57 at Foothills (FMC). From the survey summary it appears that results for the scaled questions were analyzed by finding the mean response rating for each question by site. Results were presented in the format of how much support was wanted, and how much support was received, by site. For example: Physical support: PLC (wanted) 7.7, (received) 9.0. The mean rating of support received was consistently higher than the mean rating for support wanted. The yes/no question was calculated as a percentage, with the range for “no” being 64% - 88%.

Concluding statements of the results were presented as good news/bad news, with the good news being “Expectations for physical and emotional support are presently being met.
and exceeded..., and, the bad news being "there does not appear to be a strong need for a volunteer birth companion program at each Acute Care site."

This survey was frequently mentioned as a deciding factor by the interviewees.

"So the decision was made to do a survey of the labor and delivery clients and if the service had been offered, would you utilized it, you know, things along that line. And we did up a whole questionnaire and got it checked by a person who does questionnaires, all that stuff, to make sure it was valid and ah, did that and the results were that um, you know, it wasn't hugely overwhelming. It was, I think it was, maybe ten percent at the Rockyview said, "Oh yes, we would have utilized it." Um. and it was maybe thirty or twenty-something at the Foothills and, and I thought I was being really low and like well, you know that, that's TERRIBLE results and (name) saw it as being, "Well, if even twenty percent want it, then we should be doing this. She saw it as being fairly positive."

Hospital Program Interviewee

"I think at that time we even did a bit of a survey. I can't remember how we did that to find out who would be interested? Who would have used a Doula? And um, what would the need be in other sites? A tiny, tiny, tiny percentage of women, and so it was deemed not valuable to be there."

Regional Interviewee

The author's comments on this survey are presented in Section (4.3.5.1). For the purposes of this section, the data is presented as found.

3.8.3.3 RPC — January, 1997 – June 1998

Minutes were found for five more meetings of this committee. Business and relevant points of discussion are summarized below:

January 28, 1997

- Entitled "Minutes of the Birth Companion Volunteer Program (Doula)"
- Re. survey... "general consensus was that results demonstrated a large enough need for a Doula Program" to be considered as a joint regional program; included with the survey results was an additional sheet of comments pertaining to the program, obtained from the labour and delivery unit nurses at Foothills
- Discussion of the importance of staff buy-in resulted in nurses from each site volunteering to promote the program in their home units
• Sub-committee assigned to review a draft of the proposed program; this four-page proposal was entitled a “Birth Companion (Doula) Program”, and contained a statement of mission and goals; outlined volunteer standards, scope of practice, training and experience; and, included a code of ethics.

March 19, 1997:
• Proposed terms of reference for the steering committee, including purpose, function, committee membership criteria
• Nurse-Program Champion teams to market program in hospital units
• Sub-committee struck to further develop program (now in its second draft)

July 2, 1997:
• Fourteen hour training program drafted by design committee presented for review
• Doula name continues to be mentioned in document

January 21, 1998:
• In-service information sessions have taken place at RVH for staff; volunteers have toured hospital
• Marketing of program discussed, with sub-committee set up to address this
• Pilot training session with community program’s volunteers as participants is planned for Feb/March, 1998
• Program outcomes need to be measured
• Ownership of program is discussed, partnership between Volunteer Resources and Maternal/Newborn is proposed
• Funding proposal

June 3, 1998:
• Clarification that Maternal/Newborn wholly owns program
• Outcomes of pilot training program reviewed, call for acceptance of terms of reference, standards of practice (all have been drafted, not adopted); training committee struck
• Administration of the program, suggestion that resources and funding required for one fulltime administrator
• Much discussion of resistance to program at Rockyview, and concerns that the volunteer role is neither well-defined nor welcome in hospitals
• "It was agreed by the committee that Volunteer Birth Companions should fill an identifiable need, (e.g. the woman lacks the necessary birth support system) and that the volunteers should be requested by the units to be there. It sometimes appears that the program is trying to force itself onto some units where there is not an existing request and this is not the mandate of a volunteer program."

• The next meeting was "to be announced"

This synopsis traces the activities of the committee over time, including issues and concerns that were points of discussion as found in the minutes. The activities of various sub-committees struck to address identified the issues and concerns are discussed below.

3.8.4 Sub-committees of Regional Planning Committee

Minutes were found for six meetings of sub-committees appointed by the RPC, dated May, 1997 – July, 1998. These minutes document a continued effort by five or six members of the RPC to design and operationalize a regional volunteer birth companion program, taking into account the issues and concerns as raised on the larger RPC. After the second draft of the program was discussed and the sub-committee struck in the March, 1997 RPC meeting (see above), in May, 1997 the sub-committee met to discuss program elements such as purpose, goals, ethics. In August, 1997 the committee discussed a draft of the in service sessions designed to introduce the hospital staff to the new program, its volunteers and past clients. A decision was made to implement the in-services at the Rockyview only. "The Foothills will not be in-serviced at this time, out of respect for what staff are coping with (staff and Head Nurse changes)." Three committee members met in September 1997 to complete this planning.

In November, 1997 the committee met to develop the training course content. The course was piloted in February and March, 1998, using the community program's
volunteers as students (of which the author was one). In April, 1998 the committee met to evaluate the training course. Concerns were shared on the funding provided for trainers (considered inadequate), continued use and intermixing of the doula term and role with the VBC’s role – and the potential confusion this could cause for both staff and volunteers. In addition, concerns were raised that the nurses at the Rockyview were not comfortable with the volunteer role. These issues were brought to the June, 1998 meeting of the entire regional planning committee, as stated above. In July, 1998 the sub-committee met once again. In this meeting the group agreed that its “mandate was to provide training for Volunteer Birth Companions at the PLC and Community Health Resources”, and these sites would continue to have regular meetings of their own groups. “No date was set for the next meeting.”

In summary, the regional planning committee was composed of two community representatives, and about 15 members representing various levels and departments of CRHA personnel. In their meetings between October, 1996 and June, 1998 common activities and points of discussion included the naming of the program, an assessment of need for the program, program planning and design details, the training program for volunteers, and the introduction of the program to the hospital staff at Rockyview. Some of this work was carried out by sub-committees. No evidence was found of committee dissolution, the last minutes obtained concluding with their next meetings “to be announced.”
3.9 Conclusion

This chapter opened with a description of the data used in this research, and set the context in which the two programs were developed. Using interview data, information found in program documents, and from the student researcher's experience with the program, the background and current state of the two programs have been described in detail, responding to Objective 1. The two programs are discussed in terms of their purpose and clients, volunteers and activities, the community program arising in a public health initiative (Best Beginning), and the hospital program arising out of the doula movement. The current states of the programs are described in the same terms as the backgrounds, and evolution in the programs is discussed. The chapter concludes with a summary of the efforts of a planning committee struck in 1996 to form a regional volunteer birth companion program in the CRHA.
4 RESULTS II: CROSS CASE COMPARISON &
CROSSCUTTING THEMES

4.1 Introduction
The description of features considered salient by key stakeholders in Calgary's volunteer birth companion programs is partially satisfied by the preceding chapter in which the background and current state of the two programs was described. This was followed by an in-depth description of the CRHA initiative to create and provide a regional program of volunteer childbirth support via the regional planning committee, answering Objective One. Stakeholder opinion (Objective Two) regarding key program features was found in the previous chapter in program documents or committee meeting minutes and/or through interviewees' description of the programs' and committees' activities (Section (1.4.1)). However, although the third objective of this protocol called for the proposal of a program model or models with suggestions for implementation within the CRHA, a complete program model is not presented in this thesis.

Initially, it was believed that the work of this thesis would supplement the work of the regional planning committee, filling in gaps that might allow suggestions for the creation of a functional regional VBC program. Yet, once the author obtained the work of the RPC, including evidence of a well-developed regional program model, it seemed that much of the work had already been done. The obvious question arising from this was, why then was there no regional VBC program? Furthermore, in the interview data, stakeholder opinion was directed less at structural program issues such as funding or volunteer training.
and far more at values – the effects of the major changes occurring in their workplaces, personality differences, differences in philosophies. That is, the features the key stakeholders identified as salient in Calgary’s volunteer birth companion programs were not simply elements of the program model. In fact, as is argued in the conclusion of this chapter, the salient features represented larger issues. Therefore, although important program model elements are presented in this research, and features considered salient in the programs’ future structure(s) are presented in the recommendations, a new program model is not proposed.

This chapter opens with a cross-case analysis that contrasts and compares key program model features, including the strengths, weaknesses and resources of the programs, as identified by the interviewees. Stakeholders’ suggestions for change within the program are also presented. These elements will be important considerations in the proposal of a program model. Following the cross-case comparison, the data presented in Chapter Four are themes of stakeholder opinion. The themes arose as a result of the analysis of the attempted regional VBC program, drawing on the data in Chapter Three and reinforced by additional interview data. The research data not only provide the issues, but the stakeholders’ views of causes and effects, and the relevance of the issues to the regional program effort and the current programs. The themes are an amalgamation of stakeholder opinion as the results of the student researcher’s analysis. They are derived from recurring points of discussion raised by interviewees or on the committee, or were viewed as influential factors in the decisions made within or about the programs. Thus, this chapter
like the previous one, also responds to Objective Two while responding to the third and final objective of this research.

4.2 Cross Case Comparison

A summary of the identified salient features of each program is presented for review in Table 4.1. The cross-case analysis compares and contrasts the background and current state of the key elements, drawing upon their importance to and interaction with the regional planning committee when appropriate. The resources, strengths and weaknesses of each program are considered, including stakeholder opinion with respect to change in the programs. Suggestions or recommendations for program change are presented in the discussion.
### TABLE 4.1: Summary of Current Programs

<table>
<thead>
<tr>
<th>COMMUNITY-BASED PROGRAM</th>
<th>HOSPITAL-BASED PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background:</strong></td>
<td><strong>Background:</strong></td>
</tr>
<tr>
<td>• Arose in community health initiative (Best Beginning)</td>
<td>• Arose in one hospital (PLC) as a doula-focussed program</td>
</tr>
<tr>
<td>• Volunteers matched to client in pregnancy</td>
<td>• Volunteers matched on arrival at hospital</td>
</tr>
<tr>
<td>• Provided social support to identified at-risk women through pregnancy, labour and childbirth in any city hospital</td>
<td>• Provided support to women identified as lacking in adequate support through labour and childbirth in PLC</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td><strong>Purpose:</strong></td>
</tr>
<tr>
<td>• To provide support to identified women in need through pregnancy, labour and birth</td>
<td>• To provide support at PLC through labour and childbirth to any woman in need of additional support</td>
</tr>
<tr>
<td><strong>Clients:</strong></td>
<td><strong>Clients:</strong></td>
</tr>
<tr>
<td>• Women who are Best Beginning clients and/or who are at risk for psychosocial reasons (e.g. low income, youth, inadequate support systems, cultural or language differences)</td>
<td>• Women who request a volunteer or women whom hospital staff identify as candidates for additional support (e.g. youth, lacking a supporter or inadequate support, cultural or language differences)</td>
</tr>
<tr>
<td>• Can include spouse or partner</td>
<td>• Can include partner or family</td>
</tr>
<tr>
<td><strong>Volunteers:</strong></td>
<td><strong>Volunteers:</strong></td>
</tr>
<tr>
<td>• A cohesive group of about 12 white women, with a strong interest in birth and providing service to women in need</td>
<td>• A group of about 12 white women, with a strong interest in birth and providing doula labour support</td>
</tr>
<tr>
<td>• Some volunteer in hospital group</td>
<td>• Some volunteer in community group</td>
</tr>
<tr>
<td>• Many longterm volunteers have shaped the group and its activities</td>
<td>• Most volunteers have paid privately for doula training course; some run private doula services</td>
</tr>
<tr>
<td><strong>Activities:</strong></td>
<td><strong>Activities:</strong></td>
</tr>
<tr>
<td>• Training: 12 hour program, 2 births with experienced volunteer, prenatal classes</td>
<td>• Training: Volunteer pays for and completes certified doula training course (about 14 hours), training and orientation to hospital with experienced volunteer</td>
</tr>
<tr>
<td>• Matched with client in pregnancy</td>
<td>• Matched with client in labour in hospital</td>
</tr>
<tr>
<td>• Scope of role tailored to client, but usually support through prenatal classes, labour and childbirth in hospital, sometimes one postpartum visit</td>
<td>• Works closely with staff and client and family to provide support through remainder of labour and childbirth, sometimes one postpartum visit with birth story</td>
</tr>
<tr>
<td>• Can include community outreach promoting volunteer program at Louise Dean or prenatal classes</td>
<td></td>
</tr>
</tbody>
</table>
4.2.1 Background

A comparison of the background of the two cases yields a difference in their origins and focus of service that, as developed throughout this chapter, turns out to be crucial. The community program centred around a one to one individually matched service, relationship building, social and emotional support – with labour and childbirth being only one piece of that match, albeit the culmination.

"I think there, the knowledge base of the volunteers was somewhat different than our volunteers in the sense that, I think there was a philosophy in the program that, the volunteer was there to sit and hold hands. And not, necessarily know too much more about labor and what was happening. But I think that has maybe shifted a bit, in the last few years, when the idea of Doulas became known."

Hospital Program Interviewee

The hospital program was built on a model of paraprofessional training focussed on one to one support in labour and delivery that required an immediate formation of a relationship, intense in its relatively short duration, not unlike nursing.

"Um, the service is similar, ah, in what they do. I think though that if you were to analyze really specifically the scopes of both of them, I THINK that um, the, sometimes the scope of the Lougheed one is a little bigger. Or, should I say, there's more lenience in, in things. Because it's very much Doula, not that's not a bad thing or a good thing, it's just that, that's how I would describe it, is Doula. Um, so they're practicing more in that vein and so the scope is a little bigger sometimes. It's more um, oh, I don't know if it's [pauses]. I'm not sure what the reason. There's a couple of reasons why, but you know, there's a tendency sometimes for the volunteers to ah, how should I say it? Like maybe offer more medical related teaching."

Community Program Interviewee

Many of the issues that arise in the themes of stakeholder opinion relate to the difference in background and history of the programs, and as illustrated by the quotations above, a belief that the services were different. For these reasons, issues related to comparison of the backgrounds of the program are considered in the latter part of this chapter, Section (4.3.2.2).
4.2.2 Purpose and Clients

The purposes of the programs are not stated in the program documents, but have been drawn from the research data as presented in Chapter 3. Apart from the length of relationship and the variation in hospital site, the purposes seem similar. Yet, clues to the underlying differences in the aim of the programs are visible in their definition of clients.

Since its inception, the community program intended only to focus on women in need. The program’s criteria of “need” have changed over time, but are overtly defined—in the absence of the volunteer, the labouring mother would be without dependable, adequate support in labour, that is, she’d otherwise be alone. Furthermore, to strengthen the social relationship, and influence attendance at prenatal education, the match is made prior to birth. Usually, the community health nurses refer the clients, and the volunteer coordinator matches the volunteers. That is, the community health nurse determines the “need”, and the volunteer coordinator attempts to fill it.

In the original hospital doula program, the intended client was stated as one who would benefit from doula support, recognized because she arrived in hospital with no support, inadequate support, or was struggling with a long labour or cultural differences—not much different from the community program’s target population. In contrast, in the current hospital program, eligible clients clearly include any woman who states her wish to have a volunteer, with staff being welcome to refer any woman to the program, whether or not she’s identified for the stated reasons. However, then and now, volunteers who are an active presence on the hospital unit are matched much more often than if they wait at home “on-call”.

This point presents interesting and important considerations. In the original program, it is possible, but unlikely, that more women in "need" of a doula arrived on the units only on the days when a volunteer was present; however, a number of other factors seem more likely. One possibility is that the "need" remained constant but a higher percentage of appropriate referrals were made when the volunteer was present. That is, the nurse saw the patient, and recognized the "need" more often when the volunteer was a visible reminder of the program. Another possibility is that when the volunteer was present on the unit, the definition of "need" slid to include many women who did not fit the stated criteria - perhaps because the volunteer was there and the staff wanted to give her something to do, perhaps because the staff person knew and liked working with the volunteer, perhaps because the volunteer was asking to be included, and so on. In either case, the nurse was able to obtain the volunteer's services with minimal effort.

The sliding definition of clients in the hospital program, as well as the variability in usage of the volunteers' services, speak to a covert purpose of the hospital program: to increase awareness and availability of trained doulas in Calgary.

"And ultimately if we ended up with, people in the city knowing about Doulas and able to get a hold of a Doula, maybe for free that would probably be the ideal. And not have it run as a hospital program."

Hospital Program Interviewee

Thus, though the stated program purposes of each program appear similar, underlying differences reveal that the programs have dissimilar working definitions for their target populations. The community program's definition of appropriate program clients has broadened over time, and eligibility is determined by a public health nurse prior to the match with the volunteer. The hospital program's client definition has also expanded, and
speaks to a second, unstated, program purpose of increasing awareness and availability of doulas in Calgary. Thus, almost any woman delivering at the PLC could be eligible for the services of a volunteer.

4.2.3 Volunteers and Activities

The community program has retained many of its original volunteers, whose work over the years has shaped the program and its activities. Although many of the original volunteers had career goals like nursing, or midwifery as one objective for their work, this seems less true of the current volunteers who speak more about the beneficent aspects of their role. The volunteers maintain a cohesive group of like-minded individuals, who meet regularly and have formed close relationships over the years. On the other hand, many of the hospital program's volunteers seem to flow through the program – staying for a time, and then leaving the group. For the most part, the volunteer doula meetings have devolved to those of the larger doula association. Although many of the original hospital volunteers were not interested in career goals, most of the current volunteers are interested in obtaining birth experience. This forwards the volunteer's interest in providing labour support as a certified doula, a role in which she often provides service pro bono.

It is interesting to compare the evolution of volunteers' objectives for volunteering in the two programs: in the community program career focus lessened over time, in the hospital program it increased, and in both programs all volunteers are interested in providing support to women in childbirth. Furthermore, about half of the current volunteers are members in both the hospital and the community program.
Although the clients of both programs are often of different ethnic origins or are new Canadians, all of the current volunteers are white women, with few who speak any language other than English. There is evidence of educational efforts to increase multicultural awareness in the current volunteers, and effort has been made to recruit women from other cultures as volunteers. The few ethnic women recruited into the program as volunteers were prevented from long term participation when pressures of everyday life, such as commitment to paid employment took an understandable priority. Men are deliberately excluded as volunteers, though only one or two males have inquired about the position. The primary reason given for their exclusion, especially in the community program, relates to the nature of the target population – often the clients are women who have a history of abusive relationships with men. Thus, program personnel state, males would neither be welcome nor beneficial in this volunteer role.

The qualifications of an appropriate volunteer are similar in each program, as are the length of the training program and the requirements of attending birth with an experienced volunteer. The emphasis in training is slightly different, related to the differing purposes of the programs. As the volunteer-client relationship during pregnancy is frequently the lengthiest portion of the volunteer role, community program volunteer training pays much attention to social and emotional support aspects of relationship development. Furthermore, developing a strong volunteer-client relationship is viewed as facilitating a good outcome – the logic being the client’s strength of trust in the volunteer aids the mother in labour and birth. Therefore, in the community program less emphasis is placed on the physical supportive measures in labour, though the volunteer endeavours to discover and discuss
maternal preferences in areas such as pain relief etc. In contrast, for reasons stated later in this chapter, the volunteers in the hospital program are only matched to an already-labouring mother upon her arrival in hospital. Based on the doula certification program, these volunteers tend to concentrate on the physically and emotionally supportive measures undertaken in labour, more than relationship building. Establishing trust with the mother is important, but higher emphasis is placed on the volunteer's role in helping the mother through labour and delivery.

4.2.4 Program Theory, Program Evaluation

In the community program, trained women volunteers are provided to identified women who might benefit from social support during pregnancy, labour and childbirth. The outcomes that will be achieved by this activity are not clearly defined, but assumed to be better birth outcomes for mother and baby. In the hospital program, trained women volunteers are provided to any woman requiring additional support during labour and childbirth. One interviewee spoke of one objective of the program – to preserve the birth memory for the mother. Other outcomes are assumed to be similar to the community program, better birth outcomes for mother and baby.

Both programs collect evaluations of individual matches. Using similar forms, in the community program both the volunteer and the client have the opportunity to individually rate their feelings about the match. The client may elect to share her feedback with the volunteer; otherwise it remains confidential. The purpose of data collection seems to be quality assurance. In its initial year the hospital program kept detailed records of its matches, including birth details such as length of labour, pain relief measures, birth
outcomes. More recently these evaluations have diminished to informal reports of volunteer-attended births, when the program players noted they actually had little purpose assigned to the data collection effort.

4.2.5 Program Funding

From their inception, both programs have been and continue to be, run on shoestring budgets. The minimal funding supplied through volunteer resources is currently sufficient to supply sundries like photocopying, an occasional pizza night, or to reimburse volunteers for parking. The programs both make use of in-house resources such as paid staff to provide in-service education or hospital labour and delivery accessories such as birth balls.

"And the funding, the funding just comes out of a general budget... As far as support for other things we do have any number of professionals here that work with us that will come in to speak to the group."

Community Program Interviewee

"We have actually on the unit; we have a lot of resources that Doulas use as in birth balls, massage lotion. By and large, there is lots at the hospital... Ah, so there isn't very I, if there was something that we specifically needed, for instance: sometimes when we have meetings, we'll order in Pizza and the volunteer budget for that. 'Cause there's still a bit of fund left in the original, uh, in the original budget. Uh, and the volunteers also get, parking passes and if they're there for a period of time, they get lunch passes.

Hospital Program Interviewee

Although the regional planning committee undertook its work with the understanding that funding would be in place, (as example, see quotes in Section 3.7.3, and Section 3.8.1), information about RPC resources was sketchy and vague in the interviewees' responses.

"All I know is that we had the money (Chuckles) to, to um, [pause] I know that, some of it, well it came out of the pot for "Maternal Infant" and at times some of our resources actually come from our manager on the unit... So I'm not sure. It was a bit of an odd thing there. Yeah, a little convoluted (Chuckles)."

Regional Interviewee
Indirect references to limited funding are found in the sub-committee meeting minutes e.g., discussion of the minimal funding for training or the expense of printing program brochures. Also, it is interesting to note that discussion of funding is not recorded until the last two sets of reviewed RPC meeting minutes, coinciding with discussion of program ownership and administration (Section (3.8.3.3)). Thus, at the regional level, the interview data shows an unclear commitment to funding.

4.2.6 Program Strengths, Weaknesses, Areas for Change

The information presented in this section is a synthesis of the information found in the interview data. Although the interviewees were forthcoming on strengths of the program, it was rare for an interviewee to comment directly on weaknesses of the programs, even when asked about it directly. Instead, interviewees tended to relate weaknesses indirectly, giving examples of negative experiences with individuals. However, at times an interviewee would make suggestions for change. Some aspects of the issues discussed in this section are represented or further explored in the themes of stakeholder opinion found in the latter part of this chapter. For instance, the role of advocacy for the client was sometimes seen as beneficial, sometimes as being anti-medical.

Furthermore, a critical analysis of salient program characteristics is discussed with suggestions or recommendations for change in the discussion chapter that follows.

"An ideal program would have a stable of voluntary birth companions who are comfortable with the relative system and work probably within that system. Um, so they're not treading on the toes, not putting up people's backs. SOLELY being there as a companion for the laboring person. Um, similar to how the sister of the laboring woman or the husband of the laboring woman or her significant other functions. VERY similar. Um, if those people are present but not fulfilling the role, then the birth companion would, would help, help them fill whatever portions of that role they were capable of doing and sort of supplement the rest. Not, not relegate them to ah, a lesser role than what they have the capacity to be. Um,"
and my understanding is a, as I said, for the volunteer program at the Peter Lougheed it was where those supports were perceived to be missing or, or ineffective that um, the volunteer was called in, I've certainly seen instances where the paid Doula seems to be doing the role that in ideal circumstances I would think the husband would be doing."

Regional Interviewee

As in the quote above, there is evidence that the stakeholders value the current programs, especially when the volunteer is matched with a woman who would otherwise be alone in labour and childbirth. Interviewees were consistent in applauding the role of the volunteer who accompanies a woman with no support. The following quotes are typical.

"I would say, probably um, if you can supply and provide somebody you know, a support person for somebody that does not have anybody. I think that's valuable."

Regional Interviewee

"... because for the woman who finds herself in a situation, she just has no one to support (her) is very vulnerable. Um, and so to be able to offer that is, is fantastic. And um, it's just to have, to have it available."

Community Program Interviewee

"Because it is a a tremendous service. Um, you know, I mean I, I really feel sorry for these people coming in, 'cause you know I, at Foot I mean, I see women there you know like, I think, 'Man this lady sure could have done with a Doula.' You know? You know, volunteer, paid or whatever."

Hospital Program Interviewee

Some interviewees also valued the volunteer accompanying women in labour as an additional support person, especially if the existing support seemed inadequate. However, the definition of "additional" is open to interpretation, and as the following quote illustrates, people viewing the same situation can reach opposite conclusions.

"Yet, there is still that element where, "Why do we need you?" "You" being the volunteer. "Why do we need another person in the room?" And you know, there is still that small little element. Or, "Why do we need to take the time when it looks like the husband's there?" 'Cause I think there's some misconceptions. Just 'cause you have a husband or a grandma, or whoever in the room, doesn't mean it's effective support. It just means there's a body in there. And I think the nurse walks in - "Oh, well, there's two people there, there, she's fine."

Community Program Interviewee
Thus, when the volunteer was viewed as an additional support person, interviewees presented conflicting views of the value of the role.

A consistent weakness identified with the hospital program is that its service is restricted to the volunteer meeting the client only at the time of labour. The interviewees felt that the volunteer being matched ahead of labour was an advantage that allowed the client-volunteer relationship time to build, and allowed both the client and volunteer to make other choices if the match was not a good one. Allowing the meeting to occur ahead of time was a common suggestion for change within the programs.

Other pieces of the current programs received conflicting criticism or comments in the interviews. For instance, if the father was present at the birth, some interviewees felt the volunteers’ role in supporting the father of the baby was valuable. They believed the volunteer reassured and encouraged the father, reinforcing his value to the mother. Others viewed it with caution, feeling that the presence and actions of the volunteer devalued or distanced the father from the birth event. Interviewees making these comments thought the volunteer’s presence or actions prevented the father from assuming a key role in the birth. This, they believed, limited the potential for birth to strengthen the relationship between mother and father, and detracted from the bonding of the new family relationships.

Another issue that was discussed with mixed comments was the availability of volunteers, and the marketing of the program. On one hand, some thought the program should be made more well-known, and proposed suggestions like marketing it through health care providers or pamphlets, posters, and so on. On the other hand, some felt that a recent lack of available volunteers was a concern. This may be related to limited resources
in each program. The lack of funding especially restricts volunteer training. The community program has fortuitously been able to address this by extensive use of volunteer time, including the development and operation of its training program. The hospital program has responded to lack of funding by allowing those who have paid for and completed doula-training courses to attend births as volunteers — essentially "student doulas".

"They had to pay for their training though because they wanted it on a professional basis as well. So, you know, it's, it's not ideal that you offer a program and there's no money for training. And um, you know. I guess we could have said, "Well, then we're not going to offer this program anymore." And um, which is probably, you know, that was probably the thing that should have happened and then, but the program would have died."

Hospital Program Interviewee

Thus, the lack of funding in the hospital program is a barrier that restricts the volunteers, to those who could afford to pay for the training.

"We were definitely losing people just because they didn't have experience and they hadn't taken the course. And that's not, you know? That's not the way it should be. You should be able to refer the right person and you should be able to offer training and, and get them started."

Hospital Program Interviewee

As the following quotes illustrate, increased funding is viewed as a facilitator for program change. However, stakeholders recognize that other factors like the program's effects on staff and ensuring adequate funding must also be considered.

"It would have to have, financially, staff support. And, and you know. I'm sure that, that there, you would be able to get it. I think if you, if you, you know, put together a proposal and said this is why you're doing it. And because now, the people that are there know about the program and know about when we went, tried to go regional, and know the history and, and know the value of it? So I think you would. You'd be able to sell it... Yeah, I think it would definitely change the mix of volunteers."

Hospital Program Interviewee

"I definitely can tell you the need exists at the Foothills as it does at the Rockyview and so I, you know. I think the program should be offered right across the city. I just would hate to.
well I wouldn't want it, watered down. It's just, you know, like that's fine. But staff it. Put the resources in for it.”

Community Program Interviewee

Thus, limited funding has affected the programs by requiring extensive volunteer support in the provision of training or by requiring the volunteers to acquire training privately; this in turn limits the volunteer pool to fewer numbers or to those who can afford to pay. That is, insufficient funding for training excludes some potential volunteers. Stakeholders suggest that increased funding would facilitate program change as one component in consideration of expansion to a regional program.

4.2.7 Summary, Cross Case Comparison

This chapter has discussed examples of the differences and similarities of the hospital based program and the community program in terms of program elements such as volunteers, activities and clients. Stakeholder-identified strengths and weaknesses within the current programs, and the interviewees suggestions for change are also presented. Although the programs’ backgrounds differ, their purposes, clients, and volunteers share many similarities. Interviewees consistently valued the volunteer’s role in supporting an otherwise unsupported mother, and this was viewed as program strength. Many interviewees preferred the option of matching the volunteer to the client ahead of time where possible, and this was a common suggestion for change. Program funding is minimal in both programs, and has especially restricted volunteer training.

4.3 Prominent Crosscutting Themes

In this section, the values and views that emerged in the in-depth interviews are grouped into themes of stakeholder opinion. The categorized themes are neither distinct nor
mutually exclusive. Interviewees mentioned some topics (e.g., program champion) less often, and thus their discussion is mostly contained to one section. However, other topics such as the contrast between doulas and birth companions is a common point of discussion in the interviews, a source of tension on the regional planning committee, and an area in which interviewees present conflicting views with regard to the future of the programs. Thus, the doula or birth companion question is mentioned in multiple sections of this chapter, though its repetitive influence in the data warranted its inclusion as an individual section.

4.3.1 Regionalization

As described in Chapter 3, the regional planning committee was initiated when the CRHA undertook to inventory and streamline all of the programs operating within its boundaries. The effects of regionalization are evidenced in the programs and on the regional planning committee in numerous ways including the uncertainty created in staff, and even the volunteers of the program. The widespread and multiple changes over time created what some view as an emotionally charged context.

"... and there was a lot of anger and hostility anyway because of all the changes that were occurring..."

Regional Interviewee

Although some speak positively of the opportunity for regionalization to provide improved methods of program operation, difficulty in achieving region-wide programs was not uncommon in the newly formed health authority.

"Ah, first of all we equalized... oh, we set common standards... Or tried to set common standards. Um, over time, oh, we managed, in the time I was there, and I know they're still working on it and still trying, to standardize policies and procedures, of how, how we do things"
like inductions, how they’re run. Um, and, and what was good on one unit would, we had the opportunity to transport it.”

Regional Interviewee

“None, none of the programs that we, that we looked at, that existed in different formats, and started bringing them together, it was not easy on any of them. For all the reasons, I mean there was ownership. There was pride in the service. There was a culture behind it. There was different rationale for why these programs existed. There were different target ah, populations for the service. I mean, it, it was very heterogeneous with sometimes the ONLY thing that was in common were maybe one or two names.”

Regional Interviewee

Even if the names of programs had been similar, another effect of regionalization was the reorganization and multiple name changes within CRHA departments. These were still occurring within the data collection timeframe for this thesis, as evidenced by the repeated name changes for community volunteer resources (Section (3.6.1)) and other public health departments. This interviewee speaks to the resulting loss of employee identity with the workplace, and the wearying effect of continuous change.

“I mean we’ve gone through major changes. And lots of people support them. Well, we’re just getting a little tired of it... and I think we’re, in Public Health, we’re not done yet. I think they’ve changed our name four or five times. And they’ve changed our structure. In fact, we heard this morning, we said, “Who are we, like and who, who?” And they’re still working it out so they still haven’t quite settled it. So, that has quite a, you don’t mind it once or twice. Yeah, you kind of. “So what are we called today?” And you know the name change and the amount of energy and it was just thinking about that today you know. It takes enough energy and resources and all that...”

Community Program Interviewee

Not the least of those programs affected by name changes were the labour companion/doula/birth companion volunteer/volunteer birth companion (doula)/volunteer birth companion programs! This affected even the volunteers

“Sometimes it’s hard to remember the name of the program, ‘cause it kept changing there for a while. (Laughing).”

Community Program Interviewee
Although key players in the two programs had already considered maximizing their resources by combining training, the stakeholders viewed the move to a regional program as a top-down decision that came from outside of their programs.

"Because of the regionalization, um, I think it was mandated that if it exists everywhere else, it exists at the Lougheed, could, would it be valuable to also to exist at the Foothills and the Rockview? And hence, I think that committee was struck."

Regional Interviewee

The use of the word "mandate" is notable in the previous quote and the following one, the latter portraying another feeling common in the data – frustration.

"Um, not just simply because it's a mandate to regionalize... 'cause I know we wasted tremendous, we wasted money resources, we wasted energy, emotional resources, on something that I think from the get go, we knew would be a very shaky merger anyway."

Community Interviewee

As this interviewee attests, the turbulence of change brought about by the formation of the CRHA was one barrier to the realization of a regional VBC program.

"I think we have to go back in time though, as to where we were three years ago in the region and the formation of, of the Calgary Regional Health Authority and the whole concept of regionalization. And ah, I know that it was a period of um, tremendous change and growth. And I think that ah, there, there is a, at a certain point, people say, "You know what? I can't take on one more thing." Or, "I don't want to do anything different." Ah, it was, there was a real sense of instability I think. And I think that ah, people just wanted something that was consistently the same. Like "Don't bring in one, more, change."

Regional Interviewee

By 1998 the CRHA had shifted away from the program focus, relieving the pressure to force regional programs.

"And the whole idea at that time of course was that, we would start running, we would start offering services and organizing our services on a true programmatic basis. That never happened. But at, at the time when these programs ah, were in their planning phase, that was the intent. And that was Larry Bryant's legacy. Um, and he left and the, the people who came to replace him didn't have that same vision of how services should be delivered but in the mean time, these program planning initiatives had been launched."

Regional Interviewee
In its wake, the interviewees speak of standardized programs with caution when considering change in the current VBC programs.

"I think to expand it is, is a nice thought but I'm unsure of the need base. I mean um, I'm sure you're ah, wih, you, you know that the area that, at the Peter Lougheed Hospital Centre's not the same area that pulls the Foothills or pulls the Rockyview. So um, if there's a need, and it's been identified then I would support it standing but I'm, if it's expanded so that the present program at the Peter Lougheed suffers then I would challenge that. Because I know, ah, you know, we know where our vulnerable women are, we know where they are in this city and ah, they go to Peter Lougheed. There's just no question about that, in your, your ah, multi-cultural I mean, I guess I'm out protecting our own but if you know, that would be my only problem... Some of the challenges I find with our agency is we try and standardize and when you try and standardize you lose a bit of the flexibility to address your clientele... And ah, you know, it's good that we're all standardized and that, better than that, but it's just too bad that we aren't also allowed a little flexibility."

Community Interviewee

Yet, when asked what should be done with the results of the current research, interviewees expressed an interest in revisiting the concept of a regional program, with the hope that a less turbulent environment would facilitate a different outcome.

"Depending on what the research shows and what the recommendations are, it might be a very valuable document to have for us to look again at regionalization and is there a, is there a way now that we can do that?"

Community Program Interviewee

"I think your information; your research would be very helpful to us in revisiting this. And I would HOPE that by the time um, we're ready to go back and revisit this that things will have settled down a little bit more in the region. Um, I feel, ah, a greater sense of stability in the region."

Regional Interviewee

"Cause it's really, you know, as if they first were FORCED to get together. Um, it's five years, and you know, it'd be interesting to see if anybody there's mellowed out a bit or you know, and, and, throw in some new information that you have. What happens now?"

Regional Interviewee

In summary, though the CRHA's effort to standardize programs was an opportunity to expand the VBC programs and stimulated the formation of the RPC, the corresponding changes in the programs' context stymied growth. The interaction of an environment fraught with substantial change and the directive to regionalize resulted in resistance to the
committee's efforts. Stakeholders express some desire to revisit the concept of a regional VBC, in the hope that a more stable CRHA context might facilitate change within the programs.

4.3.2 Regional Planning Committee Discord

The CRHA context that created the regional planning committee is discussed above, and its composition discussed in Chapter 3. Representation from a wide range of stakeholders created challenges for the committee from its outset. Although both the community labour companion program and the hospital doula program may have appeared to provide similar service, and the CRHA was trying to standardize services, not everyone believed the formation of a regional VBC program was the answer.

"There seemed to be a fair amount of um, [long pause] what should, how should I word that? [long pause] Um, a, quite a bit of feeling that, that really wouldn't work very well. That's, what I would say. But... I have no, no, first time knowledge of that. The people that I would have heard say that would have probably been middle to senior management people in the CRHA, across the CRHA."

Regional Interviewee

Both interviewees who were on the committee and those outside of it allude to committee tension.

"It was an interesting process to go through, and oh, there were a, a number of us sitting around the table and let me tell you, there, we didn't always AGREE on everything. We had some VERY, VERY interesting discussions. Um, philosophically um, not everybody agreed. Ah, which was interesting, and oh, but that's why you strike committees. I mean, why would you have a committee if everybody thought the same way? (laughs)"

Regional Interviewee

"The other thing that was real clear though - I didn't get a sense of it so much from reading the minutes but certainly anecdotally - that things weren't going well, at the meetings. That people just had different views of it and there was just people weren't willing to give up what they've put a lot of time and really felt strongly about. And there, there didn't seem to be a common ground emerging..."

Regional Interviewee
In the interview data, the differing views and lack of agreement seemed to have two sources – the participants believed that the volunteer programs were different, and that the hospital sites were different.

4.3.2.1 Program Differences

Interviewees who were not associated with either program speak about program differences – different concepts, populations, and needs – but not with the same emotion that those within the programs portray.

"I mean the concept was maybe the same, but it was, it was different. It was different. It was a different target. ah population. It was a different process, it was, it was just different. It was organized different. The concept originated, the need was different where it come from. But anyway, there it was, was the, about the same title called A Birth Companion Program..."

Regional Interviewee

Interviewees who were associated with one or the other program speak in more detail about the programs’ differences. The top-down directive was forcing the change to a regional program when those inside the program had primarily been interested in pooling resources for training. Program differences were highlighted and feelings of program ownership and loyalty are evident.

"And the Best Beginnings Program, I think, it was just a program where, what would you say? The community was different. They had set up the program, they were working with different clientele. It was a fairly cohesive program. Um, and they just decided that it was just one more meeting, if they had to come to Lougheed meetings. We invited them to some of our meetings. Um, as far as I know, they didn’t invite us to any of theirs. And it just didn’t fly. And as I say, it might have just been one more thing for everybody to look at. And because the two programs were different, um, that’s the way it worked out. And so, I’m not really in the loop. And the big thing that we were trying to do was to set up a training program for the two volunteer programs. And um, we tried one where we did not get, the, there was a philosophy for volunteer programs, that the volunteer shouldn’t have to pay for their program."

Hospital Program Interviewee

"WELL, I think it was, BECAUSE we knew, from the beginning that they were diverse. I think we knew in the beginning that it would take a tremendous amount of effort if EVER to combine. So we knew that from the beginning. We were doing it because we were basically..."
TOLD I think, and, and it made sense. Sure! Okay! Yeah we're doing the same thing!

We WEREN'T doing the same thing. And um, so it was a waste of time to try to you know, fit, what is that saying? - the square peg in the round hole, or whatever. Um, not a waste of time necessarily to maybe see, evaluate if there were inefficiencies. That's always a good thing... Um, we were both, "NO, we don't want to change what we have, we like it!" And there was always resistance. You know? "NO, we like what we have!" And, and that's the personality thing that um, you know, the satisfaction things. The things that bind the volunteer to the program were in jeopardy potentially."

Community Program Interviewee

Other data suggests that at the committee level, a unified program was not readily achieved. Take, for instance, the length of time required reaching agreement on program details. Though the first sets of RPC minutes in 1996 provide evidence of a drafted program, sub-committees were still being appointed to work on program details such as volunteer training in June, 1998. Rather than feelings of animosity, the following quotes relay that key players preferred to think of the programs as distinct, and were simply resistant to being combined as one program.

"I think my sense was that, that each of the existing programs felt that what they were doing was, was good. Um, ah, without having necessarily convinced the others that there might be benefits in doing it oh, the other way around. Interviewer: So there was some ah, resistance to changing the way that that was matched up? Potentially. I don't remember it as being as drawn as that."

Regional Interviewee

"Whether or not there should be a region wide program? Well, with that effort, that we've put out to try and establish that, it really looked like there were two different points of view. Two different ways of looking at support. Two different facilities that have different policies and procedures, and NEEDS. There were just different needs too. So our core philosophy was the same. We thought maybe what we could do would be to partner more in um, oh, having speakers in and the educational part of it, maybe we could do more. And promoting each other's programs. Within our own agencies and facilities. Interviewer: Um, and how often do the two groups get together now, for some of the you know, you were talking about maybe sharing training or sharing things that way? Well, they don't. It's just sort of hasn't happened. Other than that um, there are a number of our volunteers that are also volunteering there. And so of course they get, they go to both."

Community Program Interviewee

There is little evidence to suggest committee stakeholders' will or drive to achieve a common program; rather, stakeholder opinion suggests the opposite - to combine as one
program was not their intent, and they resisted the suggestion of unification. As a result, the outcomes of the effort to combine the programs are made clear in the quote above — allow the other program’s differences, retain our own. “It just hasn’t happened.”

4.3.2.2 Site differences

Despite the “one hospital, four sites” CRHA touted motto, the interview data is plentiful and colourful in its exhibition of the individuality of each labour and delivery unit in Calgary.

“And so, the Foothills is obviously the King and think they’re wonderful. And the Rockyview’s still pretty good... ‘cause they’re, the what? They used to call the Rocky, um, the Hilton, the Rocky Hilton. And then us, poor lonely Lougheed sister.”

Regional Interviewee

The beliefs about “other” hospitals are exemplified in the following quotes. Furthermore, the participants share their insights into how those beliefs may have affected the volunteer birth companion program within each site. Note that the first participant sees Foothills as against natural childbirth, thus rejecting of midwifery and doula care, whereas, the second ascribes the failure of the VBC program to the strong belief in midwifery care at Foothills.

“But the belief, the basic belief at the Foothills isn’t around natural childbirth. Or even around um, women having control over their child birthing experience. More to the, more to the point hey? That’s not there because it, it’s ah, you have to interview a perinatologist to believe what you would hear. They absolutely truly see pregnancy and birth as an illness... And um, so, it makes NO sense to those people at all that a woman would choose a midwife when you could have an obstetrician who’s highly skilled and blah, blah, blah for this VERY dangerous event. The Doula thing, maybe that’s, they’ve ignored it in a sense too, they just see, they see Doulas and midwives as much the same. It’s all part of the same craziness to them.”

Regional Interviewee

“I would guess though that there was NEVER an interest, in fact probably some pretty strong opposition at Foothills ah, because of the um, ah Midwifery Program (Trial)... and how do you factor in the women who have Birth Companions? And then secondly, philosophically,
um. I doubt that there was room for that kind of um. support because it was a Midwifery um. oriented ah, kind of ah, birthing place where people ah, would be horrified to suggest that. ‘You’d need to bring in external volunteers to support women in labor when people pride themselves, nurses pride themselves and Midwives pride themselves in that that’s what they do that’s what they’re there for. So. Foothills, forget it. It just wasn’t going to happen.

Regional Interviewee

As the tertiary care maternity centre for the CRHA, Foothills deals with all medically high-risk maternity patients in the city. Therefore, the strong obstetrical focus on the risks of childbirth is not surprising. Furthermore, at the time the regional VBC program was being considered, the labour and delivery unit at the Foothills was already challenged with a multitude of changes: the Nurse-Midwifery program trial (Section 3.3), the addition of hundreds of the low risk maternity patients inherited from the closing of the Grace Women’s Health Centre, and multiple staff changes, including a recently acquired manager from another province (Section 3.8.4)). Interviewees also suggested that Foothills routinely deals with a complexity of caregivers - student nurses, and student physicians, interns and residents. Adding yet another entity -- a volunteer birth companion, seemed unlikely to succeed and the RPC decided to not initiate the regional program at Foothills at that time (Section 3.8.4).

Similar to the quotes about Foothills, interviewees assign opposing characteristics to the labour and delivery unit at Rockyview, proposing reasons the VBC program was resisted. It is interesting to note that some of the beliefs assigned to one site by one interviewee, will be similar to the characteristics assigned to another site by a second interviewee. For instance, some interviewees presented opposing views of “Foothills is pro-midwifery” and “Foothills is against natural childbirth”. Yet, as shown below the same phenomenon occurs with respect to Rockyview, that is, the “Rockyview focus is outdated,
too medical", the “Rockyview staff is innovative”. This may reflect an interviewees’ experience with, or loyalty to, a home site: our site believes this; their site believes that. Nonetheless, the interviewees viewed the differences in individual cultures of the hospital units as one factor in the non-functional regional VBC program. The first interviewee attributes it to an outdated, medical view of childbirth amongst staff.

“Rockyview a, they were just completely resistant to it. um, NO, we don’t need another person, you know? Uhhuh, if you want to be honest in, in the scheme of things, I think they are behind in their movement towards natural and empowerment and that it’s a very medicalized place still. Getting better, but it is.”

Community Program Interviewee

This interviewee, however, views the resistance as an example of the staff’s progressive model of care.

“And at the ROCKYVIEW well, I mean, they are who they are, they just, they’ve always done their own thing ah, they’re EXTRAORDINARILY um, innovative but they just never went ah; they just never considered themselves, I don’t think, as part of the main stream. They just wanted to be left alone and that’s still what we see at the Rockyview today. They want just to be left alone to do their own thing. Not just in birth, but in all areas of service. And ah, it was, I think that was just their, their approach....The other thing too is that they did have a bit of a different model of care there ...So they were very much into that supportive care in labor model already as part of their day-to-day, and they took great pride in that, and if you go and visit with them now, they, they still do that. So, that’s why I think it just, it just never took off at the Rockyview either.”

Regional Interviewee

The interviewees believe the Rockyview labour and delivery unit staff saw no need for a labour support program for two reasons: (1) the staff felt they were already providing high quality supportive care in labour, and, (2) most of their patients arrived with adequate support. Those who wanted extra support arranged it, and could afford to pay for it.

“You know. ‘YES! At the Lougheed we could see that you know, they, they deal with a. a different clientele that we do. Whereas here at the Rockyview’s, like uh, our people are upscale, they’ll hire their own people.” They don’t want Doula’s. The staff doesn’t, doesn’t want it. The physicians don’t want it, you know?”

Hospital Program Interviewee
The regional planning committee did make an effort to start one arm of the regional program at the Rockyview, marketing the program through appointed nurses, inservices for staff, and tours for volunteers (Section (3.8.3.3)). Despite these efforts, some nurses feel they didn't know much about the program.

"So certainly the management on our unit you know, kind of presented this program and, and knew some information about you know, what they knew or what they didn't know or what they planned to do. But, not a lot still. I didn't feel, I never did feel that we learned a whole lot about these women...And I THINK that there was a kind of an interviewing process with the management of our union or someone in CRHA, it's just all been very vague. And I think that's one of the problems, that we never really felt clear about the whole (Chuckling) program.

Regional Interviewee

Given the difficulty of initiating volunteer labour support programs at the other hospital sites, what allowed the success of the doula program at the Peter Lougheed Centre?

Interviewees attribute the initiation of the Peter Lougheed program to a variety of factors: needs that grew as a result of disgruntled staff, multicultural clientele, different unit policies. However, the most tribute is paid to the program champion.

"I watched the development of the Doula movement with interest...and I watched it evolve up there... "What was going on at the Peter Lougheed?" But I did later on see the reason for Doula's emerging there. And it was very different nursing stuff, very poor leadership...When I looked at the unit I, I saw some strange things, you know, HUGE proportion of the, the patients who had babies there, um, didn't speak English and so they didn't give nurses that same instant gratification where you'd go in, develop a relationship, you gotta really work together you know what I mean by that? That ah, that, that wonderful part of being a caregiver, one-to-one with the family. And of course that's next to impossible if, then, or we'd have to really work hard to make it happen. Then on top of that, um, they um...had an epidural service put in place ten years ago when they opened um, the Peter Lougheed and there was really a big push to use it. And you had, you, with an epidural service, as MUCH as I believe in that option for women, I ah see how very easy it is to ignore eh, your patient when she's had an epidural and she's doesn't need you....Then (she) set out to create the one-to-one care that she believed clients at the Peter Lougheed needed.

Regional Interviewee

"The places are different, the people are different. It happens with a lot of stuff but, you know, what works at one place and, and not another. Yeah, so I guess, somebody eh, eh, and my sense would BE, um, from what little I know, that somebody like name was very um..."
keenly interested and was the person that made it go there. Yeah. Somebody with a real desire to do it I think is what makes things happen in most of the hospitals. Interviewer: Um, even in the hospital where it was successful and is still running today, I think there was some resistance from the people who worked there? And if that's true, it makes it, it would for me. um, confirm my suspicion that there was a person who, who was um, well-respected and wanted to make it go and was able to start.

Regional Interviewee

However, even the interviewees knowledgeable about the hospital program admit that its success is limited, and that if anything, the volunteers are called upon less and less.

Interviewer: I'm interested to know what you perceived, the staff reception to the, to the program at the Lougheed?

Regional Interviewee: Poor! Continuing poor. Yeah. Even now, I think the numbers have dropped. ah, even more. Of requests for, just having them there. There's a lot of reasons for that. First of all the unit's so busy, to, so to take time to actually phone, 'cause it can take up to twenty minutes to half an hour. We don't have that anymore...Which is a really sad state, state of affairs. Um, and the other thing, I think is just the ah, perception that still persists that um, it, it is one of the most Doula friendly or Volunteer Birth Companion friendly places in the city and yet, there is still that element where, "Why do we need you?" "You" being the volunteer.

Community Program Interviewee

Though many attest to the benefit of the program's champion, most believe that without one, even the PLC program would pass.

Hospital Program Interviewee: "If (she) wasn't there...you know, so passionate about it...it might not happen or it might you know, might just just die out or whatever."

Hospital Program Interviewee: "And I have a sense that the volunteer program probably if (she) wasn't around, PROBABLY would just fold. Because I think that um, there isn't very many people who really see it as being a hugely valuable in it's current incarnation and um, nobody has, would take over and say, 'Hey this is something we absolutely have to do'."

Hospital Program Interviewee: "But I think, in the case of the Lougheed, what you have there is the tenacity of one individual. First of all, to get that vision um, implemented, and secondly to sustain it over a decade, against I mean, LITERALLY, all odds. I mean, it speaks to her tenacity. Now, as she's not there as much anymore, and doing other things and moving into retirement, that that program will just I expect, die away."

Regional Interviewee

Today the Rockyview does retain a rarely used list of volunteers that can be called in to support labouring patients. Occasionally, both the community and PLC programs receive
volunteer requests from other hospitals. However, the envisioned regional program of volunteer labour support actively providing standardized service to all sites does not exist.

4.3.2.3 Committee Standstill

The portrayal of stakeholder opinion about the individual programs illustrates strong feelings of loyalty, and the belief that the programs were different and should remain so. In their discussion of individual hospital sites, the interviewees reveal their perceptions that the differences between the labour and delivery units at each hospital precluded a regional VBC program. As these beliefs were represented on the regional planning committee, the description of the research participants' opinions on program and site differences provides insight into causes of committee tension.

Despite the evidence of disharmony on the RPC, it is important to recognize the work the committee did accomplish. The minutes alone provide evidence of the resources already invested in the programs by way of the effort to regionalize. An average of 13 people spending 2.5 hours at each of the 6 RPC meetings equals 195 hours, with another 60+ hours spent on sub-committee meetings (Section (3.8)) not including the time spent outside of the meetings in the planning and preparation of program details and documents. Other ready examples of the investment to date are the resources spent in the preparation and delivery of the pilot training program and the hospital in-services. The program documents referred to in Section (3.8) illustrate that much of the work required of program initiation has already been accomplished. This is viewed as a facilitator to change within the programs.
How did the committee finally resolve their issues? Some of the answer has already been described above. With the shift away from the programmatic focus in the CRHA and the feeling of no "common ground emerging" the interviewees explain that a regional program "just didn't fly", "just hasn't happened". The following quote speaks of one interviewee's decision to let go of both the committee and the regional volunteer birth companion program, and to let remain the programs that seemed to serve the city's needs.

"I really tried regionally, I gave it an honest go. Anyway, in the end, I had to give it up. We had to use it where it was best; uh, was working well. At the Lougheed it was well established, there was no point in interfering there. Um, the service existed citywide and so it made sense that anyone from the Rockyview or the Foothills could access (it), we made that available. Uhh, but I, I realized I was NEVER going to be able to create a regional program."  

Regional Interviewee

No evidence of the dissolution of the regional planning committee was found; rather, the minutes conclude with a message of "next meeting to be announced (Section 3.8)). Unlike the decisiveness displayed in the quote above, most interviewees speak about the committee's current state in more passive terms – it faded.

"And I think the Birth Companion Program, Volunteer Birth Companion Program, was um, maybe an example of one that wasn't, that didn't work out, in terms of creating a single program... So anyway, that's the last I remember of it that it was, it was a, and because it wasn't a large program, a lot of energy wasn't put into it... I think there was also a reluctance... to push the issue because it wasn't; there wasn't a big pay off... "It's just not worth adding to the boil." "And just let it go." And I think my impression is that, that the committee that was charged with getting together and figuring out how to regionalize this program. I think they just sort of sputtered along. But nothing ever came of it."  

Regional Interviewee

Some interviewees were perplexed at the committee's quiet demise, left without a sense of closure, and as evidenced in earlier quotes, frustrated with the work that now seems fruitless.

"(laughs) I guess a little frustrated. The thing just seemed to, to fizzle and I didn't know what direction things had taken. Um, well we, we seemed to be LOOKING at setting up a, a Volunteer Birth Companion ah, then it was going to a small working group was going to
be working together and then I heard nothing more. And it’s as if, as if they got shelved to, shelved to the back corner and didn’t really hear what was going on... So, I was quite nonplussed... when things just seemed to, to disappear, because I thought that we were NEARING a program.”

Regional Interviewee

Indeed, as a volunteer within the programs, the student researcher’s interest in this research began out of curiosity in 1998: what happened to the regional program? Upon hearing the purpose of this research, the one person that refused participation spoke with the familiar sentiment of frustration, in a tone of “not starting that again?” Thus, stakeholders’ residual feelings of frustration may be a barrier to change within the programs; however, others may welcome the chance to have their previous work come to fruition.

In summary, stakeholder opinion regarding the regional planning committee is a view of disharmony. Set within the CRHA context described earlier, and given that the programs’ key stakeholders did not themselves desire one blended regional program, the committee did not overcome the resistance created by the separate programs’ proponents. Though the interviewees displayed contrasting beliefs about the characteristics of “other” hospital sites, they were consistent in the belief that site differences partially prevented the assumption of a regional program. The establishment of the original program at the PLC is also viewed as a site difference – attributed to a strong program champion without whom the program would fade. Although progress was made in establishing a unified program design, neither a functional regional program has evolved from the process, nor has the committee formally dissolved. Although some accept the committee’s state of inaction, there is also evidence that some stakeholders were left with a sense of frustration and without a sense of closure. Thus, the committee’s work to date may be viewed as both a barrier and facilitator to program change.
4.3.3 Doula or Birth Companion?

One topic that was mentioned repeatedly in the interview data, was discussed in detail in the October, 1996 RPC meeting, and continued to arise in the minutes, was the persistent effort to distinguish doulas from birth companions. Or were they the same? As discussed in previous sections, the programs' names had changed repeatedly over time. The confusion around naming of this volunteer position was not limited to the committee members, and is still evidenced in the interviews of this research.

"The volun, the Birth Volunteer Program then, oh Volunteer Birth, the Doula Program..."

Regional Interviewee

The regional planning committee had officially adopted the term "birth companion" rather than "doula" for the regional program. The documents state the proposed volunteer program would "fit the policies on the role of volunteers" if it "was not a Doula Program" and the "name Doula is not used". Why did the committee members make this distinction?

One reason is intimated in the October '96 documents - "volunteers do not replace or displace paid staff". As detailed below, "paid staff" had two connotations - the private doulas working in Calgary, and the hospital labour and delivery staff.

To distinguish volunteer doulas from paid doulas in the hospital program (often the same women, acting in different roles) the precedent had been set that volunteers could not be matched with clients ahead of time.

"And the reason that we did not set that up as, with the volunteers was that we felt that it was not fair, the programs that were running...There's a philosophical debate about whether or not work should be valued and if the volunteer meets, if the volunteers meet people ahead of time, are you devaluing the work of the Doula? And so we made a conscious decision at the Lougheed that we would not set up a program where they were met, where they met them ahead of time. And that's why we did that and that's why it was not changed."

Hospital Program Interviewee
The regional planning committee members seemed to have reached agreement that their definition of "paid staff" also included private doulas.

"Ah, because that was one of the concerns that was voiced at the committee level, that we needed to ah, differentiate um, between a paid Doula and a Volunteer Birth Companion and um... we wanted to be very CLEAR in order to maintain the philosophy, that we all held, it was a common belief that volunteers do not replace the paid professionals. We wanted to be very clear that the role of the Volunteer Birth Companion would not um, be the same as a professional Doula. And that this body of people would not feel threatened suddenly by this group of volunteers."

Regional Interviewee

"Although there may ha, there MAY have been a bit of a, a conflict in the sense of ah, as you've said, "The fear that, that um, the volunteer program could ah, tread on the toes of paid Doula's." Um, but I think people felt that there could be space for a volunteer program."

Regional Interviewee

The committee's concerns about the reactions of hospital staff to the proposed volunteer position was a recurring point of discussion in the committee meeting minutes, and in the interviews, and are discussed in section (4.3.4)).

Another aspect of the controversy surrounding the use of the word "doula" is that its use or non-use was a proxy for program loyalty by some committee members. First, despite the committee's declaration that the doula name would not be used, it persisted on their documents at least until the July, 1997 meeting, and was still an issue raised by the sub-committee after the pilot training session in the spring of 1998 Section (3.8.4)). This speaks to the entrenched positions of those on both sides of this conflict – those who would not, could not release their hold on the doula name, and those who would not, could not accept it. On the committee, these differences were most sharply accentuated, not surprisingly, between those who were affiliated with the separate programs. In short, the hospital program volunteers thought of themselves as doulas – after all, that was their training – and the community program volunteers thought of themselves as labour or birth companions,
not doulas! A comparative glance at many of the quotes in this thesis quickly illustrates this. Those interviewees identified as “community program” rarely use the word “doula” and those identified as “hospital program” often do.

Moreover, whether it’s doula or birth companion, paid or unpaid or volunteer, these programs continue to perplex those outside them, and not only in the naming, but in the role.

“...with any of the volunteers that have come along either paid or unpaid.”

Regional Interviewee

The following section of quotes is lengthy but vividly exemplifies the bewildering haze of perceptions about the programs – their affiliation, purpose, volunteers and activities. All of the quotes are from different interviewees, none of whom are clients, two of whom sat on the RPC.

These two interviewees refer clients to the programs. One has the impression that they are the same program, and always mentions both to clients; the other doesn’t know about the PLC volunteer program at all.

“I thought they did combine. Um, I just got the impression from the coordinator of our program that they were um, the pool of volunteers were, were a similar pool or perhaps their training was similar. WHAT they were able to do in the way of supporting was similar. So I, I always thought it was the same philosophy. I think (name) had told me that they were naming themselves the same too but I could be wrong on that, but I always had a sense they, they were together somehow. I didn’t really see them as separate but I never really dug in and found out. ‘cause I know if I made the referral...and it wasn’t happening, I know that she would always say, “Do they know about the Peter Lougheed program?” And I’d say, “Yes.”

Community Program Interviewee

Interviewer: You had asked me earlier if there was another program about, you know for Volunteer Birth Companions in Calgary...There is a program that’s run at the Peter Lougheed Centre, and I’m not sure if you’re ab, familiar with that. Some people think of it more as the Doula Program.

“That’s a private, isn’t it? Where they pay the Doula, privately.”

Interviewer: My other question was you, what you knew about that program and what you’ve heard about it, if you have ever referred to that ah, program at all?
"No I haven’t. “

Community Program Interviewee

However, the following two interviewees associate the CRHA program only with the Peter Lougheed Centre, though they know about the community program.

“The only ah, Birth Companion Program ah. Volunteer Birth Companion Program that I’m aware of is the one at the Peter Lougheed Hospital. I understand that ah, following the um, work of a... Calgary Regional Health Authority Regional Steering Committee ah, that the Rockyview Hospital was considering the Volunteer Birth Companion Program but whether that has been implemented, I’m not aware.”

Interviewer: And there is a program that still exists ... that matches volunteers in the community with a client who might need extra support in labor. And those matches come in to deliver in all of the hospital programs.

“That’s right. I did know that, I’d forgotten about that.”

Regional Interviewee

“I know that there was one... set up out of um, Peter Lougheed which I believe is probably the only true, CRHA recognized um, program. Although, I know there is another one called Birth Companions or something, which is. I don’t know if it’s truly Doula. But, there’s one that I know a number of people who have volunteered um, mostly mothers who have had children or young women who are interested in ah, being support, and I think you get a, appointed to somebody and um, stay with them through their, be a friend to them through birth and labor. Ah, through, pregnancy, birth and labor. And then I believe there are a few private ones...”

Regional Interviewee

This interviewee illustrates the difficulties experienced distinguishing between paid and volunteer doulas.

“Actually I think is, that is one of the problems with all the programs, is that maybe we’re not totally up to date on exactly what is available? So when someone attends with women in labor, they might say, “This is my Doula, Patti or whatever”, for example. We don’t say, “Is this a paid Doula or a volunteer Doula?” We would never ask that. So I would have no way of knowing.”

Regional Interviewee

The varying perceptions are understandable; these are small programs. Yet, the following quote exemplifies a common phenomenon found in the interview data – the blending of the role of the volunteer with the private doula, despite the effort to keep them distinct.
"I really don't see that many Doulas coming in and through, truly. There's more um, paid Doulas now that we see. Like even at the Rockyview, there's getting to be more and more paid Doulas. And they are seen in a different light, I believe, than the volunteer ones. That it, it's quite different and there's been a few um, [pause] difficulties I think with some of the paid Doulas. How they present themselves and how their scope of practice and then they're undermining and not working in collaboration with, with the nurse. So it's a DIFFERENT thing than the program, I think you almost lump it together 'cause you say, 'Doulas' but it's quite different.

Regional Interviewee

This display of key stakeholder quotations illustrates that, as one interviewee so aptly identified, “one of the problems is that maybe we’re not totally up to date on exactly what is available”. Furthermore, although on paper they may be different, the names and roles of the volunteer birth companions are associated with the private doula. The difficulty in this is the negative perception ascribed to some doula.

“I think also some people feel that there have been bad experiences with Doulas. Well I can only generalize, and maybe not properly because I haven't really been there but my kind of gut feeling is that, on the whole it's being seen as "getting in the way". And how I determine that is, how they do that is either by; over advocating I think, you know, they're perhaps not over advocate but they're "SEEN" as over advocating you know ... and I think um, there's been such a "NEED" to, to protect women from the system or to advocate for them within the system, over time, caregivers in the system have come a long way and now feel that it's not as necessary. But some Doulas haven't quite caught up with that. And they're still really treating it as um, you know, a boxing match when in truth it could be much more collegial than, than that. And I think that has created a lot of friction."

Regional Interviewee

Despite concerns with some paid doula, interviewees reported few concerns with any volunteers, even when asked about it directly. However, some interviewees self-reported difficulties in the early days of the hospital program.

"Some people had a little grain of knowledge and they went really, very aggressive... um, and, and they come across that way and, and, and I think there was some, there was some too that, to some degree, I think some personality conflicts, people that just really oh overstepped their bounds as a volunteer. And I think that was partly because they weren't familiar with the volunteer program."

Hospital Program Interviewee
Other Doulas were do, did things that were probably not appropriate for Doulas. And because we REALLY weren't sure exactly what was important and they didn't work out very well and that was too bad and they ultimately quit.

Hospital Program Interviewee

These problems seem to have been fewer in the community program, perhaps due to the guarded reputation and cohesive nature that group exhibits and works to maintain.

"And the other thing I found is that um, you know, we can talk, if we hear a particular bir, um, Volunteer Birth Companion having maybe um, different perspective that might not be the best for her client ... I talked to (name) after a meeting about you know, a concern that. "You know, she's just, she's got a really strong personality and it's evident she was coming in here gangbusters, and just disrupting things. That she really needed to spend a lot more time ah, well she needed to cool down. She needed to take a lot more in her stride. She needed to realize that she wasn't in any form of control that she had this whole infrastructure that she had to work with. But that she'd actually raised her voice to a doctor. And I thought, "Where are you going to get yourself, where are you going to get your client, and what are you going to do to the program?"

Community Program Interviewee

The commonality between these quotes is that whether doulas or birth companions, paid or volunteer, there is the sense of an already established negative reputation. In her criticism of the volunteer, the interviewee illustrates her knowledge of the tacit boundaries in the hospital room. The unruly volunteer “actually raised her voice to a doctor,” disrupted things, challenged the whole infrastructure, and hadn’t realized “she wasn’t in any form of control”. The interviewee believed that such action would be detrimental to the volunteer herself, the client, and threaten the reputation of the program. Exceeding boundaries related to the scope of practice by unnecessarily or over-advocating for their client, and disrespect shown to the professional hospital care providers was often voiced in the interviews. The implication of these actions, to the health care providers is that some doulas are against the medical professionals.

"I had more of the sense that there was some concern that um, oh, and I think in part because some of the Birth Companions that we do see well, all of the ones that we see at the Foothills, because there is no volunteer program operative particularly. Um, is some, some of
those Birth Companions are anti-medical care as far as we can ah certainly the
flavour that we get. Um, and they tend to try to direct the patient to reject things, ah, ah,
suggestions coming from medical and nursing staff.”

Regional Interviewee

However, others portray their beliefs that attitudes are changing. As evidence, recall
the complimentary comments regarding the high quality work and professional attitude of
the doulas spoken about in Sections (3.72 & 3.73). This interviewee acknowledges the
previous difficulties, while expressing hope that they were being overcome.

“I think you know, I think we’re, I hope we’re getting by that. I think we are actually,
don’t you? I think, I think we’ve got people who have worked with Doulas that have been
really, really pleased from, at all levels. You know the nurses, the doctors and, ‘Man, that
worked out great’. And I, I that’s, I think that’s just the evolution of it. I feel good about
what’s happening with Doulas now.”

Regional Interviewee

Another interviewee suggested the opposite.

“I would SUSPECT if something were to start up again about Volunteer Birth
Companions if’d PROBABLY be having to start at square one, because the experience with
paid Doulas is expanding, and has been extremely variable. So, I think ah, people who scarcely
had any contact with a Doula in the past have had the opportunity to have one or two negative
experiences.”

Interviewer: “So your sense now is, if the whole issue was to be revisited, you
basically be starting from scratch? And maybe…”

“Below scratch.” (Laughter)

Regional Interviewee

In summary, the doula or birth companion conflict has been considered as a multi-
faceted issue. First, the name of the program(s) kept changing. Second, the same word
“doula” represented a volunteer and (privately) paid position. This was a source of
confusion at many levels, and allowed easy transfer of the reputation of a few individual
doulas to colour the perceptions about volunteers. Clearing the confusion surrounding the
birth companion programs will be an important consideration of change. Partially to avoid
threatening the work of paid doulas, the RPC chose the term birth companion. The
community program adopted and preferred this name, though "doula" persisted in use for some time on the committee. This was a source of continued concern in the data.

Whether the doula reputation will be a barrier or facilitator to change remains unclear. There is conflicting evidence that a more positive and professional image of doulas is emerging, juxtaposed with the view that some health care providers have accrued increased negative experiences. Health care provider reaction to the programs was also a concern on the committee, and is considered in more detail in the next section.

4.3.4 Health Care Provider Reaction

"So that my own standard is: "If this person is helping her, who am I to say they shouldn't be here?" So that some nurses have really hard time with Doulas. Or anyone else encroaching our territory if you will. And I say that facetiously because, it's not our territory. (Chuckles) It's the patient's territory. But it's there that those feelings are real. They're there that, "Who are these women, coming here where traditionally WE have helped these clients for years and years and years. I don't want to be that rigid. I'd like to welcome whoever can help someone but I'm not going to accept it blindly." -Regional Interviewee

Another issue discussed at multiple meetings of the regional planning committee was the reaction of hospital health care providers, especially nurses, to the program. Previous experience in the hospital doula program may have been guiding the RPC, as many agree that the initial reaction to the program at the PLC was poor.

"Initially you know, NOT GREAT, I think, um, a lot of them were really supportive of it but then there were a lot that were really suspicious as well. "Oh, why do we need this?" And, "We do that!" You know, and, and "We're there for the patient and we don't need any extra help" and see that it's just another, another um, way that that their jobs were being undermined. Or if you know, that oh, that um, trying to take work, work away and so that they can lay people off; things like that. So, so there was a lot of suspicion and it took a lot of time to, to educate and explain the role of the Birth Companion." -Hospital Program Interviewee

Another interviewee put it less diplomatically.
"In fact the nurses at the beginning, they didn’t know about Doulas and they weren’t at all keen and some of them were quite snarky and rude."

Hospital Program Interviewee

The community program volunteers seem to have experienced less of this. Unlike the hospital volunteers, the ones in the community were less visible - individuals attended occasional births with women at different times in different hospitals across the city.

Furthermore, although the volunteers now display identification badges, this was not in place initially.

"I never, and I was fortunate to never have um, a BAD experience where somebody told me to get out of the room or someone looked at me funny or you know, I, but I very much tried not to identify myself as a Doula, you know, I was just “Her support.” And un, for some things unwritten and there weren’t many policies."

Community Program Interviewee

That the regional planning committee was aware of, and planned for health care provider reaction to the programs is evident in the minutes of their meetings, and by their activities: staff members from all of the labour and delivery units in the city were incorporated on the RPC; hospital staff comments were included on the results of the needs survey; care was taken in the design of the program so that the name, scope of practice and training of volunteers was distinguished from nursing and the paid doula role; nurse program-champions were recruited for each site; and, the program was introduced to hospital staff via in-services. Yet, one of the most common reasons given by interviewees for the failure of the regional VBC program to take hold was primarily staff resistance.

"The staff and it BASICALLY came from the stuff in labor and delivery at both Rockyview and Foothills that, that “No, this is, it’s not needed, it won’t fly and why are you trying to ah, you know, stuff this down our throats? We’re the ones that work here, we’re the ones that know our clientele and it’s not needed.”"

Regional Interviewee
What are the sources of the tension between health care providers and the volunteer birth companions? There are multiple answers. Sometimes the nurses simply didn’t understand the volunteer’s role.

“We never sort of in labor and delivery had a place that we, we didn’t sort of know where the boundaries were, we (Clears throat) we sort of sat there but we didn’t sort of know what, and a lot of times people, nurses didn’t know what to do with us. They had no idea. And that was the other thing, the nurse themselves had not any idea of the experience that we had or the training that we had or anything else.”

Hospital Program Interviewee

“Sometimes you know, when you walk in to a hospital for the first time, even if, even if it’s just the Unit Clerk, and I say um, “Volunteer Birth Companion, this is my name and this is whom you’re here for (Laughing) You know? Like, “And who are you with?” “Are you a nurse?” I, I used to get that... not so much anymore... And I’d say, “No, I’m not a nurse.” You know? “I’m here to provide some support, um, and um, I leave the nursing entirely up to you,” you know, and you know, you kind of have to be, I mean you have to be a real ambassador at times.”

Community Program Interviewee

Furthermore, as described in previous quotes, boundaries were unclear to the volunteers in the initial hospital program, and sometimes overstepped in the eyes of the health care providers. As mentioned in the section above, some nurses had had previous and negative experience with doulas and whether or not these had been with volunteers, it created a wary tension in health care providers, as the following quote illustrates.

“It’s almost that setting up that barrier to say the nursing staff and the physicians are going to destroy your birthing experience, therefore you better do this. this. this and this and be really defensive and, and um. um, you know, “look out for your own rights because they’re going to take that away from you.” And that’s, that’s never the way that we’ve perceived it. And now we see more of the Doulas and it’s just crossing the line of you know, we’re trying to make this the best experience. “We’re here for you, we’re not here against you.” And sometimes, I’m not saying “all” but some Doulas will put up that barrier again to say, “you know, be careful, they’re not here for your best interest.” And that’s where it, it gets in the way of what you’re trying to do for that patient as a nurse. Yeah, and not all the paid Doulas are like that, truly some of them are very good. I’ve never heard that happen with a volunteer Doula.”

Regional Interviewee
More than one interviewee spoke of similar occurrences with the private doulas that in their opinion still happen on a regular basis. The following interviewees practice in different professions in different hospitals.

"And having a Doula saying, "Well, I don’t really think that’s necessary.” “I think you should do this, or that or I think you should refuse that standard of care.” Interviewer: And you’ve heard that? Absolutely. And I really think, on a regular basis! I’m going to have to pinpoint two or three individuals that in MY OPINION, regularly kind of out steps the boundary, the boundaries of what our staff consider their role to be, or their safe role to be. And so, I think you can see very clearly how that would put us in an adversarial position. That I am standing there with my experience and, and level of knowledge and training, and say, “You know, I really feel this would be the safest step to take right now.” And the Doula is there with her knowledge and experience, which of course she has, but it’s different than mine and saying, ‘Well, in my experience I’ve seen that this was more often harmful than good or I really think you should do this or that.’... Where does that put the patient?"

Regional Interviewee

"I think among oh, the, the ah, the opinions then I’ve heard from, from colleagues which I guess I, from experiences I’ve had, I’m, I’m sure it is, that it’s a very mixed experience. Um, there is, actually there’s one Doula that a number of us work with who just sour things in the ah, in the delivery room. Makes it EXTREMELY difficult for ah, good medical care to, to be there. Um, and, and others who’ve been terrific. Um, so when we hear that a patient has a Doula um, we’re very anxious to see who that is. (Giggles softly). It actually raises a little bit of level of anxiety to hear that a patient has a Doula. Because we don’t know what stripes that Doula’s wearing.” (Chuckles)...

Regional Interviewee

Not only does this quote describes the tension raised in health care providers but notably, a few sentences later, the interviewee provides yet another example of how impressions about private and volunteer doulas overlap, especially when one individual plays both roles.

I think, one of the, ah the women who had worked in the volunteer, ah well, sorry the paid Doula capacity as well as volunteer and talked about being intermediary there between doctor and patient. That just makes my skin crawl. Because the communication between doctor and patient is going to be WATERED down if there is someone who is trying to be in between. It’s best if it’s direct.

Regional Interviewee

It must be noted that in almost all of these quotes the interviewees tack on a brief mention of “there are some good ones”. Yet, the overall tone is coloured by their negative experiences.
Volunteers in both programs also report negative experiences with hospital staff as isolated experiences. In these examples, the interviewees report the nurses’ attempts to dismiss the volunteer, apparently without direction from the patient. In both cases, the volunteers questioned the nurse, consulted with the patient, and ended up staying with their clients, apparently with good results.

"I had made the connection with one client and, and the, and the nurse told me that they were going for a C-section and I could go home. And I said, "Well, actually I'd like to ask the patient if she wants me to go home?" And she (the patient) said, "Absolutely not. You're going in with me." And you know, in fact I en, ended up going in to the O.R. with her husband and her... And oh, but, so it was then, it was the nurse that wanted (Laughing) to send me home. But I mean, once we sort of get, you know, through that, that was fine. You know?"

Hospital Program Interviewee

In this second example, the interviewee relates pieces of this episode at two different points in the interview, and they are pieced together in this excerpt. This incident is included in detail as it illustrates many issues discussed in previous sections, and in the following section of this chapter: the relationship between volunteer and patient; multiple layers of conflict - between volunteer and health care provider, the inner conflict of the volunteer as she weighs her obligation to the client against her obligation to the program and her respect for the nurse’s boundaries; decision-making by the volunteer, the nurse, and the patient; and, an apparently successful resolution.

“She said, "Um, her sister is here now and really that's what she wanted. so you know, I don't think that, that she's going to, need you." And um, I said, "Well, did, did SHE say that to you or is this what you've, you know that you FEEL? Did she specifically SAY that?" And she said, "Um, no she hadn't said that." And then she said, she said, "Well you can talk to her if you want."

And I said (to patient), "Do you want me to come over?" And she said, "Sure." And um, so I sat there, and I remember... sitting there with the phone in my hand and going, "What am I supposed to do? I just don't know what I'm supposed to do." (Laughing) And then I thought, "Okay, my commitment is to my client, unless she tells me that she doesn't want me there. I'm just going to go with the same plan that we had at the outset, and, and I'll go. "And she told me all about, all of these family problems BEFORE. So that's the other reason I, I didn't want to BAIL on her at the last minute."
"And then, I met the nurse. as soon as I got onto the, onto the unit, and I said to her. “You know, I really appreciate your um, you know, your information. I really appreciate your, you know, TALKING to me and giving me your impression, but I had made this commitment to (name), and without her expressing and telling me that, “She did not want me to come,” I said. “I feel that I have to follow through on that commitment.” And you know, I think that sort of, struck a chord with her because she understood. I don’t know. she just seemed to understand. She said. “Oh, I, I understand what you mean or, okay, you know, that’s good, then, you know, you should go in.” It was okay with her? But it was, it was a real conflict point for me. It was real. I really didn’t know what I was supposed to do. It was a hard decision to make. And you know, I think I made the right one. There was, there was never, there was no complaint or anything like that. She had basically relieved me of my responsibilities. She was out of line. You know, that nurse was out of line. It was not her decision to make. And I actually worked with her later, like a couple of years later. And to she was very POSITIVE, too in meeting me. and it was kind of, SURPRISING because I thought, if anything she might not have felt that way? That maybe she felt territorial, you know, I was on her turf in the hospital um, it was her patient, and what she says goes. But, I didn’t, I didn’t get that from her. She might have, you know, learned a lot.”

Community Program Interviewee

As a volunteer, the author also experienced one episode of being asked by an anaesthetist to leave the patient’s room prior to epidural insertion, though there had been minimal, if any, interaction with him. Compliant, but surprised by what seemed to be an unnecessarily abrupt dismissal, the author left the room. Upon return, the attending nurse spontaneously apologized for the physician’s behaviour.

Another aspect of especially the nurses’ reactions to the volunteer position was the suspicion that it would undermine their own jobs. Some nurses were offended by the implication that they were not supplying adequate support in labour. Many interviewees described feelings of resentment - the volunteers assumed the most rewarding part of their jobs, as they were being relegated to technical duties!

“I think there’s a real sense of: “I’ll get left with all the Jo-Jobs.” And like you know, because in truth, um, the being there for the woman which is what we’re talking about really, right? Being there for the woman?...I’m pretty sure for the most labor and delivery nurses that the reason they come to work each day... To be for her and with her. And I think when for, as a nurse; if somebody else is going to come in here and they’re particularly with a Doula, because they’re, you know, they’re um, not doing any other of the nursing jobs but they
would come and have the plumb part of the role. And they'd be left with the leftovers. You know, 'cause, I could get a real understanding of why a nurse would feel that.

Regional Interviewee

Another interviewee also speaks to these feelings, placing her resentment not only on the doulas, but also on the system that creates the gap the doulas fill.

"And the other part of that equation is that I don't do this totally for a salary. And I think you'll find that, you gotta know this yourself, that any nurse, "are we there for the money?" I mean of course, we're not going to work this hard for no money, but is it our major incentive? But I don't think it is with the Doula's either, it just changes the equation a bit. You know? So I think, and that may change but the nurses coming into the area now would not just not ever have seen it any different way. And they will perceive that, "yeah the system doesn't allow ME to spend as much time with my patient anymore." So all these other interest groups, of course they're taking advantage of that and I think you'll see it done at, in other areas of medicine not just Doula's and Birth Companions in our area. And I guess that there IS someone to pick up the slack! It's just unfortunate that there's any slack to be picked up."

Hospital Program Interviewee

Another reason for the hospital staff reaction against the attempted regional program is found in the RPC minutes and the interview data, portrayed as incongruence in the philosophy and aims of volunteerism. One aspect of this issue is that volunteers do not replace or displace paid staff, and the steps the RPC took to address this have already been described. A second aspect relates to the origins of all three programs – hospital, community and regional.

First, the difference in the origins of the community and hospital programs yielded a subtle difference in purpose. In the community volunteer program, the primary aim was to directly help the client, thereby indirectly helping the staff. However, in many hospital volunteer programs, the primary aim is to aid the staff, thereby indirectly helping patients.

"Maybe I'm putting words in their mouths, my sense is that they see volunteers as augmenting nursing staff. Doing something that the staff does not have time to do. And in the strictest sense, Doulas are not really doing that. They are there to support patients."

Hospital Program Interviewee
Furthermore, the need for volunteer programs on the hospital units was traditionally established from the ground up (i.e., the unit or its staff identified the need), and requested the volunteer program. Indeed this is what had happened in both the original Best Beginning volunteer labour companions and in the PLC’s hospital doula program. When the CRHA tried the reverse process, (i.e., established the program then tried to implement it on the units), the reaction was one of a program being “shoved down their throat”.

“And you’re not going to, you’re especially not going to win them over by, with aggression or with something being shoved down their throat.” — Hospital Program Interviewee

Moreover, recalling the conflicting beliefs about the results of the needs survey (Section 3.8.3.2), neither the hospital staff who responded to it, nor all members of the RPC were convinced that a need for the program had been shown. In combination with the staff protest of “that’s what we do, and like doing”, this raised concerns on the RPC – forcing a program onto staff was not congruent with their philosophy of volunteerism. It was clear to the committee that the hospital staff did not want volunteers, so the committee withdrew its efforts.

“So, it was like, “Why are we, why are we doing this then if if they don’t feel the need?” And part of the whole premise of having the volunteer program is that you have a um, sponsoring department. And we don’t just go out there and say, “Oh, we think you need this volunteer program, you better have it!” If you don’t have a sponsoring department, and you don’t have their support, you don’t do it. And so, we went back, and said, “Look, that’s the bottom line! You know, we’re not, we’re not going to shove this down their throats. If they don’t want it then we don’t, we don’t want to do it.”” — Hospital Program Interviewee

In summary, the regional planning committee was cognizant of, and prepared for, health care provider reaction to the program, especially concentrating on hospital nurses.
Yet, nursing staff reaction against the programs was labelled as one of the main barriers to the realization of a regional volunteer birth companion program. Lack of clarity in the purpose and boundaries of the volunteer role were proposed as factors in this reaction. Moreover, some nurses felt the volunteer position undermined and devalued the nursing role, especially the supportive relationship they enjoyed with the labouring mother. The committee decided that a negative reaction by the host staff contraindicated the purpose of a hospital volunteer program, and halted their efforts to implement one regional volunteer birth companion program in Calgary. Determination of whether these issues have changed will be important in consideration of change.

4.3.5 Key Findings

The research protocol that guided this study proposed a research question regarding salient features within Calgary's two volunteer birth companion programs, with objectives and supporting questions designed to discover the salient features. Based on the data obtained from program documents and interviews, and the student researcher’s own experiences, Chapter 3 described the background and current state of the programs, as well as the regional planning committee, responding to Objectives One and Two. In the initial part of Chapter 4, the programs were compared through cross-case comparison, including strengths, weaknesses and resources of the programs. In the remainder of Chapter 4, stakeholder opinion was described as a collection of prominent crosscutting themes. These results are presented as the salient features of a program model, should the concept of a regional volunteer birth companion program be revisited. Thus, Chapter 4 responds to the
second and third objective of the project. Therefore, having addressed all three objectives, the preceding sections of results satisfy the research question.

This final section of results presents an analysis, synthesis and interpretation of all the results preceding it. Given the effort and investment of resources to date, what happened to the regional program, and why? The opinions of the key stakeholders are given above. This section presents the author's opinion, summarized to two key findings: the first addresses the results at the program level; the second addresses the results as a systemic issue.

4.3.5.1 What problem was the regional VBC program trying to solve?

"And I know we had talked at one time, "Oh, we're going to have the same program on every site." Well, that does not take into consideration a few things: the um, the clientele that we are all serving, 'cause we each serve different clientele; it doesn't take in the um, oh, well the DEMOGRAPHICS if you will; and the climate. And what works here doesn't necessarily work in another site, what works at that site won't necessarily work here. But we do have COMMON POLICIES, common philosophies, um, but the way we carry out the actual program, they differ. And perhaps on one site, um, there might be a little bit more flexibility in terms of what volunteers can or cannot do, as opposed to another site. And again, that goes hand in hand with the. I think with the working relationship between Volunteer Resources and the staff, and the Unions, as well, and how receptive they are? Um, I think it's how you approach them. And you just don't jump in and say, "Okay, this is what volunteers are going to do," and then later on you're doing this patch, patch, patch trying to fix it up, because you didn't do your work beforehand in planning it. And that's why I mean I. and I certainly with this committee, um, I was one of the people who was insistent that... we explored every part of it."

Regional Interviewee

This quote tidily sums many of the factors and issues that arose in the attempt to form a regional birth companion program – site differences, demographics, site climate, policies, and the people upon whom the success of the program depends. Furthermore, the resultant program must have the flexibility to withstand its implementation in multiple sites. The bolded section of the quotation highlights an important concept: ineffective program
planning leads only to patchwork. Yet, the results of this study describe considerable effort expended in the planning of the regional VBC program. Why then was it not realized? The author believes the attempted regional program had a fundamental flaw – it lacked a clear statement of the problem the program was meant to solve. Furthermore, the committee lacked clear leadership. In the absence of an effective leader and without a clear statement of the problem, the decision-makers (perhaps unintentionally) shifted their attention and resources away from the problem they assumed they were addressing.

Using the information presented in this study, a reasonable description of the problem the regional VBC program was meant to address might be: women presenting at public health centres or arriving on the labour and delivery units with inadequate support for childbirth. The regional planning committee concentrated on the formation of a regional program without a statement of the problem the program was trying to solve. Stated another way, the committee was addressing a different problem – how can we combine two programs to satisfy the requirements of regionalization? It is not that this question was extraneous; rather, it is the author’s belief that this question was secondary. If the stakeholders had first reached agreement on the problem, it might have facilitated agreement on the elements important to its solution.

This finding provides insight into some of the structural issues that arose within the themes of stakeholder opinion. For instance, the regional program tried to implement a volunteer program on hospital units, to solve a problem the staff didn’t believe they had, and, the program design required the hospital staff to make extra effort to implement the program. Whether or not there was a problem to be solved, this seems an unlikely solution.
If the program problem had been more clearly stated, with evidence of the need for its solution, and the resources made available to do it – a more likely solution might have evolved. As another example, take the needs survey undertaken by the RPC. Methodological issues aside, if a program problem had been stated, the intent of this survey might have been clarified. The questionnaire seems to have been directed to patients who’d arrived in labour in hospital with support in place, yet other information suggests that the program was to be targeted to women lacking support. Without statement of the program problem, it is difficult to assess the need, or the resources required to meet it at any given level of service.

4.3.5.2 Issues of power and control in the birthplace

“...So a lot of it, I guess does come back to philosophy. Ours versus theirs. And not always totally “versus” either. It’s just, I think it’s, a lot of it is years’ experience. But a lot of it is kind of feeling. “Why is everyone else trying to take over this labour?” I mean so many other interest groups Volunteer Birth Companions and Doulas’ and, and us, and Midwives and everyone. Um, but, but other than that - the whole commentary on childbearing - we won’t go there today! (Laughter) That’s too big! (Laughter)

Regional Interviewee

A higher construct of the findings is the one issue common to all of the crosscutting themes presented earlier. The struggles of the regional planning committee and its predecessor programs are representations of an underlying systemic issue – the struggle for power and control in the birthplace. As the interviewee above suggests, everyone else seems to be trying to take over labour. That is, everyone “else” is “taking over” from the unmentioned mother in labour. Examination of the prominent themes of stakeholder opinion reveals the stated reasons the regional VBC program failed to come to fruition – regionalization, committee discord, differences between programs and hospital sites, and
health care provider reaction against the program. Notable in its absence is the
consideration of mothers giving birth. Furthermore, examination of the regional planning
committee composition reveals that it was almost entirely composed of health care
providers, or those involved in the CRHA’s volunteer programs. Neither trained lay
volunteers, nor clients were represented on the committee. Methodological issues aside, the
needs survey did reveal two important concepts, hospital staff were not convinced of the
need for a regional program of volunteer labour support. Furthermore, neither were all
committee members.

If we reconsider the themes of stakeholder opinion, the illustrations of the struggle
for control are striking. This struggle, the author would propose, arises in the beliefs the
opponents hold about childbirth. And beliefs about childbirth lead to beliefs about who is
the primary caregiver (i.e., who has the right to make decisions in the birthplace). To make
the point, an oversimplification: at one end of the spectrum is the view that childbirth is a
totally natural process, rarely needing more than a helping hand and at the other end of the
spectrum is the view that childbirth is a medical event that at anytime can become life
threatening to mother and/or baby, thus requiring the constant and immediate availability of
the highest technology. If one believed the former, even the presence of nurses seemed
unnecessary. If one believed the latter, only specialists would deliver babies. If one
pictures a childbirth belief continuum listing “natural” at one end, and “medical” at the
other, any range of beliefs might be held between the illustrated polar positions.

As one example, consider the issues in health care provider reaction: some doulas
and volunteers had gained a reputation for “overadvocating” for their patient and were
viewed as stepping outside of "safe" boundaries. Why did this seem unsafe to
the health care providers? Because the health care providers believed - and strongly - that
their knowledge and experience made them better judges than the volunteers, of the events
that could happen in the birth. Better judges also, than the mothers. As another example,
consider the views stated about hospital sites. One site is deemed over-medicalized because
they resist doula caregivers; the same site is deemed innovative because they provide such
comprehensive care that doulas are unnecessary. Perhaps the first stakeholder would place
childbirth towards the "natural" end of the imagined line, the second towards the "medical".

The lengthy story related by the interviewee of being dismissed by the nurse,
(Section (4.3.4)), illustrates the struggle when beliefs conflict in the birth setting. Both the
volunteer and the nurse recognize the power the nurse has in this setting. The nurse feels
she can dismiss the volunteer, because she (the nurse) does not believe a supporter is
necessary if a family member is there. The volunteer by her words and actions recognizes
the nurse's territorial right, "after all, it was her patient," "her turf." The volunteer
challenges the nurse because she also believed the benefits of fulfilling her commitment to
her client outweighed the benefits of respecting tradition - and after all, "there'd been no
complaint". However, it is noteworthy that both the volunteer and nurse were able to
negotiate these differences, apparently to a satisfactory conclusion. Further exploration of
our society's accordnace of power to medical professionals is presented in the Discussion
(Chapter 5).

Do the interviews suggest that the interviewees care little about the mother and
childbirth process? No. In fact, the opposite is true. The interviewees speak about
childbirth in passionate terms, at times akin to ideological fervour. What else would allow a volunteer to spend 16 or 17 hours at a stretch with her client, thereby rendering the nurse envious of that role? And perhaps it is that very passion that heightened many of the conflicts that arose in the data. Furthermore, it is equally reasonable to suppose that the mothers themselves have wide-ranging beliefs about childbirth and the power of health care providers. Some caregivers reported mothers who arrived waving birth plans determined to have the baby by this method and nothing else, and others who demanded epidurals upon arrival.

The relevance of beliefs about childbirth to this research is the consequences it has about power for decision-making. Prior to the formation of the regional planning committee, the concept of volunteer labour support had already challenged the convictions of some health care providers. The regional planning committee represented health care professionals, but neither the lay volunteers nor the clients. Yet, enough of committee members were convinced of the benefits of a regional VBC program that they worked to implement it. Despite the efforts of the committee, the introduction of volunteer labour support in the birthplace juxtaposed the beliefs of volunteers against health care providers in ways that sometimes challenged the deeply held convictions of both sides. When the hospital health care providers resisted, the implementation of a successful regional program was not achieved.

4.4 Conclusion

This chapter has compared the current state of the programs, including stakeholder opinion of strengths, weaknesses and need for change. Themes of stakeholder opinion were
further described as issues relevant for consideration in the future of the VBC programs. This responded to the objectives of the research, by identifying the salient features of Calgary's VBC programs. The presentation of the two key findings represents the author's analysis of the results: that the RPC would have been better served by a clear statement of the problem the regional program was trying to solve; and, that conflicting beliefs about childbirth resulted in struggles that the initial model of the regional birth companion program could not overcome. Deciding which of these elements has changed, whether they are likely to change and how, will be important considerations in the future of Calgary's volunteer birth companion programs.
5 DISCUSSION

5.1 Summary of Findings

The research protocol for this thesis proposed the study of salient features in two relatively small programs within one setting, the CRHA. The study objectives and supporting questions were designed to discover information about a program model or models, with the intention of making recommendations for change. The data collected for this project satisfied these objectives and answered the supporting questions to build the recommendations as expected, partially answering the research question. What was unexpected was the wealth and breadth of data that emerged beyond the stated objectives.

In their interview responses the stakeholders did supply information about the programs and the unsuccessful attempt to establish a regional volunteer birth companion program. However, contrary to the researcher’s preliminary assumptions, the interviewees’ opinions on the salient features of Calgary’s VBC programs far exceeded the discussion of program model elements. The failure to realize a regional VBC program was related less to program structure, than to persistent underlying struggles in the birthplace.

Despite the thought and effort the regional planning committee put into the creation of a regional program, the prominent issues in stakeholder opinion regarding the programs contained several paradoxes and challenges: regionalization caused turmoil, and regionalization forced the programs to consider combination; the programs resisted combination with one another; the sites where birthing occurred were different from one another; doulas are not birth companions, nor are birth companions doulas; doulas are anti-
medical, and health care providers are gatekeepers; volunteers detract from the
nurse’s role in labour support, the nurses don’t have time to fulfill this part of the role; this
role description does not fit our definition of what is appropriate for volunteers, and,
volunteers should not displace (even privately paid) workers. In the wrangling over these
issues, the program focus was virtually forgotten.

It is interesting to note that the issues discussed by interviewees do not concern the
goal of the program, nor its clients. No one said, “This is not a good program for mothers.”
In the interview data the interviewees clearly valued the role of a volunteer to accompany
unsupported women in labour, and consistently revealed concern for the labouring mother.
However, the interviews provoke images of the volunteer protecting “her client” from the
medical system; and, images of the health care providers protecting “her or his patient”
from unsafe practice. Ironically, the supported mothers’ views are notably absent in the
data. This is, in part, a reflection of a decision made in the research process to interview
fewer clients than originally proposed, a limitation of this work that is discussed in Section
(5.4). Nonetheless, also remarkably scant is the interviewees’ mention of the mothers’
concerns or desires. Neither were program clients included on the planning committee.
Although a survey was distributed to ascertain need, it seemed targeted to mothers who
were already well-supported. Despite the CRHA’s stated philosophy of family-centred care
in labour and delivery (Calgary Regional Health Authority 2001), and to public
participation in policy development, the implication is provision of support to birthing
mothers does not require the input of the mothers themselves.
A second point of concern is the unmet health care needs that require the very existence of these volunteer programs. If research findings and caregivers are in agreement that women would benefit by additional support in labour, the question raised is why must these needs be met by volunteers? The interviewees reported an increase in women arriving in hospital with additional persons to provide labour support, even if the baby’s father was present. Thus, these mothers anticipate the care they will receive in hospital requires, or will be enhanced by, additional support that the health care system does not provide. This suggests the need for examination of the current model of care provided to birthing mothers in hospital, and whether their needs are being adequately met.

The interview data also reveals the negative effects of the process of organizational change as it was implemented within the CRHA at the time of the regional planning committee. It is clear that the interviewees had experienced much disruption from the changes within their work environment. Although there was goodwill to share training between the programs, the data suggests that few, if any, program stakeholders welcomed the merger to one unified program, nor did the hospital units welcome a regional VBC program. Challenged with the difficulties of organizational change and the task of bringing two small reluctant programs together, the committee members pressed on with the creation of the regional program model, losing site of the program’s goal. Displaying a lack of willingness to confront the resultant conflicts on the committee and within the hospital sites, the regional program of volunteer labour support was allowed to fade. Given the other pressing stresses and demands for change, this is perhaps not a surprising ‘solution’ to the conflict.
The interview data also portrays the struggle for control over decision-making in the birthplace. There is much discussion of differing philosophies of care, advocating or over-advocating for clients, disrespect or disregard for boundaries. Volunteers are viewed as being out of line when they question the practices of the health care providers, or raise their voice to a physician. Health care providers are viewed as being out of line when they dismiss the volunteer without consulting the patient, or advise patients of care procedures that they believe to be safe practice. Mothers’ views are absent. These conflicts are not representative of a multidisciplinary health care team presenting a family-centred model of care to the labouring mother. They are representative of the struggles that ensue when an established hierarchical model of care is challenged. A framework for understanding the origins of these conflicts is presented in Section 5.2.4.

5.2 Review of Findings in Comparison to Other Literature

5.2.1 Program Planning

One of the challenges described in the program evaluation literature is the phenomenon listed as the first key finding for this paper; the program’s planning was not focussed on a stated problem. One author’s definition of the program problem is a condition that will be unsatisfactory without the program intervention, and alleviated or prevented with the program intervention (Mohr 1995). Without such a focus there is a tendency “to focus on ‘objectives’ - what the program is ostensibly meant to accomplish-and the activities that are apparently designed to achieve them” (Mohr 1995, p.13). As shown in the previous chapter, in the absence of statement of the program problem the RPC focussed on mission, goals, activities, and so on. Moreover, Mohr states that orientation to the
program problem guides both program planning and evaluation to the outcomes “that will lend it strength and influence in the policy-making process” (Mohr 1995, p. 14). If the stakeholders move forward on the regional program of volunteer labour support, one recommendation from this research is that reaching agreement on a stated program problem be assigned a top priority.

In an article that develops conceptual frameworks to plan the maintenance of a program over time, Shediac-Rizkallah and Bone present three perspectives on sustainability (Shediac-Rizkallah and Bone 1998). A number of the concepts they propose are useful in understanding the findings of the current research. For instance, within organizations, the authors discuss institutionalization by presenting a theory of organizational change. The theory suggests that a period of mutual adjustment occurs when a new intervention is implemented, until both those implementing the innovation and others in the organization have accepted its existence as routine (Shediac-Rizkallah and Bone 1998, p. 94). This pattern fits with the somewhat rocky initiation portrayed in the background of the hospital-based program in Calgary, followed by the passive acceptance of the current program, albeit underutilized. Interestingly, in a recent personal communication from a key program player, the author learned that some staff nurses met the possible dissolution of the volunteer doula program at the PLC with dismay.

In community-based health programs, Shediac-Rizkallah and Bone discuss community participation, and suggest the level of ownership and involvement of the community members is important to program sustainability (Shediac-Rizkallah and Bone 1998, p. 95). The community-based VBC program clearly illustrates the level of
involvement and ownership the volunteers bring to the program, helping to ensure its sustainability. Their long-term commitment is evidence that the program is, at least, meeting the needs of the volunteers.

Finally, the authors gather the factors that influence program sustainability into three groups: (1) project design and implementation factors; (2) factors within the organizational setting; and, (3) factors in the broader community environment (Shediac-Rizkallah and Bone 1998). Some of the factors considered desirable to ensure program sustainability are already exhibited by the two individual programs (i.e., there is a training component to the programs, they have a preventative focus, there is leadership from the volunteers, and there is a program champion). Other factors that these authors include as important to program sustainability were not successfully addressed prior to the regional program attempt, and emerged as issues in the interview data, e.g. the political environment, project negotiation process, project duration and financing. Attention to these guidelines could aid program planning if the regional VBC project is reconsidered.

5.2.2 Lessons from Other Programs

Resistance of professional health care providers to lay health workers is not uncommon. A large, funded community-based prenatal program in Arizona described by Meister et al., (1992) shared some characteristics to the volunteer birth support programs described in this case study. Though not staffed by volunteers, the intervention trained local women as lay health workers to promote prenatal care and education and provide support to pregnant mothers in the community. An interesting factor built into the project was the anticipated mobility of the paraprofessional workers who were trained in the program.
Indeed, the attrition of trained workers who exited the program to progress further in education and employment was one indicator of the program's success. In the Calgary regional VBC program, consideration and measurement of the benefit to volunteers as one outcome in program evaluation may enhance program planning, should the concept of a regional program be revisited.

Nonetheless, although the Arizona program had gained acceptance in the community, when the lay workers attempted to accompany their labouring clients to hospital, the hospital staff refused entry to the companion, even if the mother was alone. In their discussion of the program, the authors report numerous examples of lay outreach programs in which the resistance of professionals threatened ongoing program effectiveness (Meister, Warrick et al., 1992). Though the program directors had worked extensively in the community, and the program design had included the development of a support network of health professionals, the authors felt they had overlooked the aspect of bridging the community to the hospital. They lament, "We had forgotten who the 'hard-to-reach' actually were" (Meister, Warrick et al., 1992, p.47). This is not unlike the results of the attempted regional program. When the reactions of the health care professionals were underestimated, bridging the gap between community and hospital proved difficult.

Books in the lay press (Klaus, Kennell et al., 1993; Perez and Thelen 1998) and other reports of U.S. doula programs describe tensions between the doulas (often paid) and hospital staff (Elias and Block 1999). The description of a California hospital-based doula program reveals a program evolution not unlike the events leading to the regional labour support program portrayed in this thesis (Dames and White 1998). This program originated
in the office of one physician, and the volunteers were trained by his staff to support patients through labour and birth. However, the program could not withstand the resultant conflicts between hospital obstetric staff and the volunteers. In a new location, the physician recommenced the service, training and paying the labour coaches to support his patients. At the new hospital, the “labor coaches appreciated the nurses’ natural approach to labor” and harmony was achieved (Dames and White 1998, p.7). However, the program was threatened once again, in a forced merger of the hospital with another that had a highly technical focus. This situation presented “an interesting and sometimes difficult blending of two very different staffs and philosophies of birth” (Dames and White 1998, p.7). In response to public pressure to keep the program, the labor coaches have learned to work within the hospital’s system, and the nurses to work with the coaches. Although these hospital doulas are paid, they operate on an on-call basis similar to Calgary’s hospital-based volunteer program.

Another report describes the challenges of implementation of a community-based program that trained local women to provide doula support to teen mothers in three diverse, low-income, and underserved areas of Chicago, The Chicago Doula Project (Glink 1998). This project sought to “understand the process of integrating one model of perinatal support” and to evaluate the model as it was attempted in the various communities’ service structures (Glink 1998, p.45). Although the doulas did accompany their clients to labour in hospital, no mention is made in the report of hospital staff reactions. Rather, the author discusses resistance from the community providers already working in the area, and a second problem, difficulty retaining appropriate doula providers. The former problem was
addressed by further education of each group of workers, highlighting the
benefits of cooperation. Specifying better criteria in selection of community members as
doulas solved the latter. Early reports of the program show increases in the community’s
breastfeeding rates - from less than one percent to over 60 percent, growing acceptance of
prenatal care, and increased demand for the doula supporters (Glink 1998, p.48). This
project’s plans included university-partnered research and ongoing program evaluation and
impact measurement.

The challenges described in the three programs above illustrate important concepts
that were evident in the current research. Combining a community-based program with a
hospital-based program juxtaposes groups of workers who hold sometimes radically
different beliefs, and the process is fraught with challenges. Minimizing or underestimating
the challenges may result in, as in the first attempt at the Calgary VBC program, difficulties
that the program cannot overcome. The work presented in these articles, perhaps
supplemented by further information on the work of both the hospital-based program and
The Chicago Doula Project, could provide lessons on how these challenges were
successfully overcome, and thus be useful to Calgary’s VBC programs.

5.2.3 Nursing & Midwifery

Changing the model of care provided in childbirth is not restricted to a relatively
small effort of volunteers or doulas. In fact, many levels of health care providers in Canada
recognize the need for women to be adequately supported in labour and recommend change
to ensure a level of care of one to one continuous support for all labouring mothers (Society
The question seems less one of the value of the intervention, and more one of who should provide that support, and how can it be effectively implemented.

5.2.3.1 Nursing

Much of the research in this section is a compilation of the work of a University of Toronto researcher, Dr. Ellen Hodnett. As the author of the Cochrane Database Review of “Caregiver Support during Childbirth”, Dr. Hodnett’s position is clear, “every effort should be made to ensure that all labouring women receive continuous support” (Hodnett 2000). Although Hodnett’s focus is provision of support via nurses, including the benefits of and barriers to supportive care in labour by nurses, some of her work has incorporated the labour support techniques used by doulas (Hodnett 1996).

Research in the Canadian setting has shown that labour nurses spend less than ten percent of their work activities in supportive care, and the reports describe the barriers that prevent them from spending more time in this activity (McNiven, Hodnett et al., 1992; Gagnon and Waghorn 1996). Barriers commonly identified are lack of knowledge of supportive techniques, lack of time to implement them when they are known, and lack of belief in the value of provision of continuous supportive care (McNiven, Hodnett et al., 1992; Gagnon and Waghorn 1996; Hodnett 1996). In an effort to promote changes in nursing practice, Hodnett’s research team conducted a randomized control trial in 20 Ontario hospitals to promote research-based nursing practice to improve intrapartum care via a marketing strategy successful in changing practice amongst physicians - the introduction of the new techniques by a peer recognized as an opinion leader (Hodnett, Kaufman et al., 1996).
This strategy proved unsuccessful in facilitating nursing practice change in all but two hospitals. The authors speculate that the strategy itself may not be effective for nurses, and that "complex changes such as these may require more intensive efforts than can be handled by local opinion leaders on an ad hoc basis" (Hodnett, Kaufman et al., 1996, p. 19). A follow-up study investigated the organizational factors that contributed to the successful change in practice in the two hospitals and found that a strongly committed unit manager, and a unit subculture that permitted the changes were key variables (Hodnett 1997). Hodnett reports that nurses who individually try to deviate from the practice norms on the unit are often shunned, which prevents change, for "patients come and go, but nurses must work with the same colleagues for many years" (Hodnett 1997, p. 79).

These findings give insight into the current research. First, evidence of the beliefs in the variation in culture between the labour and delivery units was evident in the themes of stakeholder opinion and, the differences between units was one explanation the interviewees proposed as reasons for the regional VBC program's lack of success. Second, the difficulty of implementing change within the majority of the hospitals in the latter study is noteworthy. In that study, even a directed, concerted, evidence-based research intervention implemented by peers was not effective in making change. It seems unlikely that a small volunteer program like the proposed VBC program could hope to make an immediate change. Awareness of these results may facilitate program implementation and the statement of realistic outcomes for any future attempt at a regional program VBC program. Since the inclusion of the volunteer birth companions may require at least some change in nursing practice, gaining the support of the unit manager may be critical to bringing the
staff on board with the program, and the subculture of the unit must be considered – how likely are the staff to accept or reject the program? In program evaluation it will be important to recognize that success may only be achieved in small increments over time. For these reasons, evaluable program outcomes should include measures of nurse support for the program such as the number of requests made by nurses for volunteers, including nurse evaluation of volunteer matches, and so on. Another key issue is the relative power of the nurses to actually change practices on the unit.

Currently, two hospitals in Calgary have recently participated in a large multicentre randomized control trial run by the Hodnett research team, the Supportive Care in Labor or SCIL trial. In this trial, (n=6900) women in the experimental group received continuous supportive care from a specially trained study nurse. Supportive care was characterized by the nurse’s presence for at least 80% of active labour duration, and relied heavily on the labour support techniques of a well-known doula proponent, Penny Simkin (see, (Simkin 1989)). The outcomes of this trial will have implications for the provision of labour support in nursing (e.g., staffing levels, patient care techniques). Furthermore, if the findings of the SCIL trial result in change of practice in labour support by nurses, it may impact the need for volunteer programs such as the ones considered in this case study.

5.2.3.2 Midwifery

Considerations of midwifery in Canada, and Alberta specifically, may also hold lessons for the volunteer birth companion program, especially with regard to changing practice in the birth setting. A history of midwifery in Canada included in an Ontario task force report records the struggles to legitimize midwifery as a recognized health care
profession in Canada beginning in the early 1900's (1987). Despite evidence of consumer demand (Harvey, Kaufman et al., 1995), and the willingness of Canadian women to accept midwifery care (Wen, Mery et al., 1999), the current state of midwifery in Canada is a hodgepodge of provincial variations. Midwifery implementation ranges from pilot projects in Quebec (Blais, Joubert et al., 2000), to legalized state-provided midwifery care in Ontario and B.C., to the curious state of Alberta midwives - legalized but without an Alberta centre for training, and refused funding under Alberta Health (McKendry and Langford in press).

Midwifery care is based on continuity, not only in labour, but throughout the childbearing cycle, and its most recent development in Calgary was initiated by the volunteer labour of the midwives (Harvey, Kaufman et al., 1995). A randomized control trial conducted within the Nurse-Midwifery Project (Section (3.3)) clearly supported the effectiveness of the pilot program (Harvey, Jarrell et al., 1996). However, it is interesting to note that the researchers found that "cultural differences could exist" among the Calgary trial's hospitals, and that "differences in cultures may result in different intervention rates" (Harvey, Jarrell et al., 1996, p.134). Furthermore, in the project's evaluation it was noted, "One of the keys to the program's success has been the confidence of the obstetricians and family physicians in the six nurse-midwives" (Alberta Management Group 1993, p.28).

In the Quebec Midwifery Pilot Project, a qualitative study identified reasons for the difficulties encountered in the integration of the midwives into the existing health system: (1) lack of knowledge of other health care providers about the practice of midwifery; (2) the legal and organizational structure of the pilot projects; (3) competition over professional
professional cultures (Collin, Blais et al., 2000, p. 117). In the latter category, the authors state that one of the main differences between providers' groups was the way the professionals view risks. Midwives view birth as "a natural event whose outcome depends more on the mother's trust in her own capacities"; whereas, "obstetrician-gynecologists are much more familiar with deliveries that go wrong than are midwives". Thus, non-intervention by midwives is sometimes viewed as incompetence by the physicians (Collin, Blais et al., 2000, p. 118).

In some ways, the doula movement in Calgary may be treading a similar path to professionalism to the one Canadian midwives have walked for decades. Some private doulas in Calgary participate in self-regulation, such as certification through a U.S. organization. However, there is neither formal regulation nor state recognition of labour companions, a state not dissimilar to the ones midwives fought for many years. Benefits of doula regulation include formalization of training, and increased knowledge of the doula role. A governing body that ensures standardized training may alleviate some tensions exhibited in the stakeholder themes of this research, such as lack of understanding of the doula role. Certainly the findings in the midwifery research are similar to those found in this study - cultures vary between workplaces thus affecting practice; increasing the knowledge of health care providers must be considered when introducing a new provider into the system; and, conflicting beliefs about childbirth lead to conflicts in provision of care.
In the current research, some interviewees suggested the growing public awareness of, and reception to, midwifery care may smooth acceptance of the volunteer provision of labour support suggested by the regional VBC program. Yet, others were concerned that the gains in recognition of midwives as legitimate health professionals might be sullied by the reports of doulas that currently practice in ways considered unsafe by health professionals. Yet others suggested that midwifery-doula teams might be one model of care provision for childbirth. In any case, the lessons from midwifery for the regional volunteer birth companion program reinforce that even with evidence of effectiveness, change in hospital practice and culture takes time. Furthermore, one component of successful change is the acquisition of the confidence of the health care professionals already recognized as decision-makers in the system.

5.2.4 The Health Care System & Culture

"...the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the cause of illness; norms governing choice and evaluation of treatment, socially-legitimated statuses, roles, power relationships, interaction settings, and institutions". (Kleinman 1980)

In reviewing the results of this study, Kleinman's work (1980) seemed especially relevant (Kleinman 1980). Kleinman proposes that, as shown in the quotation above, the health care system is not an entity restricted to concrete phenomena such as the patients, practitioners and their tools. Rather, the health care system is also comprised of intra and interpersonal components such as roles, power relationships, and beliefs. The concepts that Kleinman introduces describe the interplay between these components of the health care system (i.e., the roles, beliefs and power relationships) and their effects on the tangible
concepts such as the patients and practitioners. Some issues and the themes of stakeholder opinion described in Chapter 4 illustrate Kleinman's concepts in the current research.

Kleinman argues that to understand a society's system of health care, one must understand how the players think about health care, (i.e., their beliefs about sickness and how to respond to it, and who is viewed as competent to respond to it) (Kleinman 1980, p.26). If one substitutes "birth" for "sickness" in the previous statement, one begins to see the relevance of Kleinman's views to this case study. In order to understand a society's system of care in childbirth, the author would argue, one must understand how the players think about birth, that is, their beliefs about birth, how to respond to it, and who is viewed as competent to respond to it. From the literature reviewed in the previous section, and the research presented in this study, it seems that conflicting beliefs about childbirth in Canada have yielded conflicts in the childbirth setting for mothers, nurses, midwives, physicians and the volunteer or private doulas.

Kleinman states that the biomedical science model that currently dominates medicine in our society tends to "emphasize in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones" (Kleinman 1980, p.32). Indeed, some evidence of this is present in the current work. To the author at least, the solution of the social problem - an unsupported woman in labour - seems somehow more justifiable if the outcomes of the intervention can be strengthened by the inclusion of objective biomedical measures such as length of labour, breastfeeding rates and so on. That is, it seems the VBC program would somehow be more worthwhile if
“medical” outcomes would be improved, and not “just social ones”. Although this is a reflection of the author’s bias, it is evident in much of the other research included in this paper. In the labour support, midwifery or nursing research, for instance, supportive care in labour was justified by the biological outcomes it would improve. It was not sufficient to justify the resource use solely to support an outcome such as “all women wanting extra support were given it”.

Kleinman argues that understanding the health care system players’ beliefs is essential to understanding the therapeutic interventions with which it responds to illness. “Since beliefs about illness are always closely linked to specific therapeutic interventions and thus are systems of knowledge and action, they cannot be understood apart from their use” (Kleinman 1980, p.34). Again, substituting “birth” for “illness” one might apply the same statement to the research mentioned in this paper. In the Quebec midwifery projects, the views of the physicians conflicted with those of the midwives’, leading the physicians to believe the (in)action of the midwives reflected incompetence. In the current research the views of the nurses conflicted with the doulas, leading the nurses to believe the doulas incompetent. Kleinman also states that locality often guides beliefs, and that “greater variation tends to occur between localities than within the same locality” (Kleinman 1980, p.39). The themes of stakeholder opinion regarding site differences, and program differences illustrate this point in the current study.

Kleinman introduces a concept called “clinical reality” to sum the interrelationship of beliefs and actions in the health care system.

“Clinical reality = the beliefs, expectations, norms, behaviors, and communicative transactions associated with sickness, health care seeking, practitioner-patient relationships, therapeutic activities, and evaluation of outcomes.” (Kleinman 1980, p.42)
He then goes on to propose that “neither health care systems nor their clinical reality can be fully appreciated without examining how this biosocial bridge relates culture, as a system of symbolic meanings, norms, and power, to illness and treatment” (Kleinman 1980, p. 43).

Furthermore, we accord health care providers with legitimated power, and this power governs who has the right to make decisions in the health care setting. And, one might add, who will be responsible for the outcomes of those decisions. This power is not equally distributed amongst health care providers, but rests with the professionals who are the most institutionalized (Kleinman 1980, p. 52).

The application of these ideas to the current research is most evident in Kleinman’s description of the outcomes of conflict, that is, power struggles in the health care system when the views of clinical reality clash.

“Professional socialization of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and ‘unscientific’.

Any health-related activities undertaken by patients themselves or by members of the other sectors of the system are dangerous and should not be tolerated. The biological aspects of medical problems are the ‘real’ ones, while the psychosocial and cultural aspects are second order phenomena and are thus less ‘real’ and important.

…the professional sector requires that its form of clinical reality be accepted as the only legitimate clinical reality. Health professionals usually are insensitive to the expectations and beliefs of their patients.

When such arguments surface in the medical profession itself, they are met with considerable resistance.” (Kleinman 1980, pp. 57-58)

Kleinman’s views that the beliefs of health care providers govern their clinical reality fit with the findings of both this study, and other research presented in this work.

Stakeholder opinions in this study revealed many examples of conflicting clinical realities. The clinical reality of the community program conflicted with that of the hospital program,
and the regional program differed again from clinical reality at the other hospital sites. The volunteers or private doulas represented views of childbirth that conflicted with those of the health care providers in this case study. The health care professionals' beliefs about labour support during childbirth were challenged by the presence and activities of some volunteers and private doulas, resulting in precaution and resistance to the program by some health care providers. As the professionals possessed what Kleinman terms "legitimate clinical reality", the balance of power in decision-making rested with them, and a regional program of volunteer labour support in Calgary was not realized.

5.3 Recommendations and Considerations for change

This section presents recommendations and considerations for change that emerged from the cross case comparison of the current programs, the analysis of the themes of stakeholder opinion, and a summary of the relevant literature. The recommendations and suggestions that follow the first are relevant only if the stakeholders decide affirmatively to the first question.

1. Decision-making. After successful defence of this thesis, the results of this research will be made available to each interviewee, some of whom were members of the regional planning committee. The author hopes that the findings of this work will stimulate stakeholders to action, with the purpose of decision-making regarding a regional program of volunteer labour support.

2. Committee Composition. Should the VBC project be revisited, the program may benefit by the inclusion of both clients and lay volunteers as stakeholders on the committee. However, obtaining and facilitating meaningful participation by lay
providers in the decision-making process is a challenge that may not be
easily achieved, and is further considered in the discussion of health policy (Section
(5.1.1)).

3. **Program Problem.** If there is interest in reconsidering the regional program, it is
suggested that a clear statement of the problem the program is meant to solve be a
top priority and focus of the stakeholders’ work. Program-planning should include a
comprehensive needs assessment, and clarification of the resources required and
available to meet the need. The program’s mission, goals, activities of the program
should align with the outcomes as the intended solutions to the problem. A project
timeline, including planned evaluation is also suggested.

4. **Hospital Health Care Providers.** Although the regional planning committee
considered health care provider reaction to the program, their efforts were not able
to overcome the staff reactions at the time the regional program was attempted.
Awareness of the reported issues may invite solutions to alleviate similar reactions,
if the regional program is reconsidered. Lessons learned in other programs (as
described above) may aid the implementation of this program, including
establishment of realistic expectations for program evaluation.

5. **Suggestions arising from cross-case comparison of programs.** The suggestions in
this section are intended to spark discussion and debate in program planning, if the
regional program is reconsidered. If a regional program does not proceed, these
suggestions may be similarly used in the individual programs. Other suggestions are
discussed in the review of findings with respect to the literature.
• Though the programs began in dissimilar circumstances and still maintain some differences, a glance at Table 4.1 seems to underscore their similarities. Focus on a common program problem could allow the differences to be incorporated or alleviated.

• There seems to be goodwill amongst the interviewees to have volunteers matched to women who would otherwise have been alone in labour, or who would be without adequate, reliable support in absence of the volunteer. One consideration is to initially focus only on these women as the program’s clients. Agreement should be reached on client eligibility criteria, in relation to the program problem.

• Interviewees preferred a volunteer-client match made prior to the onset of labour. This change would have the advantage of removing the burden of referral from the hospital staff. If desired by the hospital staff, the option of an on-call-out volunteer list could remain, but be revised such that one phone call to a central number is required, with the telephone responder referring an available, suitable volunteer.

• Is there a need and/or a benefit to increasing the multicultural component of the volunteers? How would this be done? Should men be eligible for volunteer positions?

• The program problem and its potential solutions are influenced by the consideration of resource allocation. Required resources will depend on the problem the program is meant to solve, the proposed level of solution, and the availability of resources. In addition to the current volunteers, regular inclusion of nursing and/or medical students and/or doulas or student midwives who desire to increase their experience with labour and birth may be considered.

• Is this a program that could be expanded into a funded program that recruits and trains community members to provide this role in their own communities as a paid position?

5.4 Strengths and Limitations

The nature of qualitative case-study research is seen as a strength of this research, in that it allowed in-depth description and exploration of the background, current state and context of each case, as well as the contrast and comparison between the cases, and a wide
representation of the views and values of key stakeholders in the specific programs. Furthermore, the flexibility of qualitative work allowed the response to the research question and objectives with a variation of emphasis that would not have been possible if the methods had been restricted by quantitative constraints. For example, if a closed-ended questionnaire had been the sole method of data collection, program model elements may have emerged from the results, but the issues and themes of stakeholder opinion regarding other salient features may not have been discovered. However, an underlying assumption of this work is that those whose opinions reflected the programs agreed to participate, and as such this research is limited by the characteristics of the participants.

A limitation of the work is that only one client was interviewed. This decision was made in the data collection process in consideration of the research question, limited resources, and the data already obtained. As most clients would have a one-time and recent exposure to only one of the existing programs, they would have had little opportunity to observe the issues arising in the data, such as the tension of regionalization or information about the events and activities of the regional planning committee. Thus, interviewees who were likely to have more information because of long time acquaintance or multiple exposures to the program(s) were chosen instead of client interviews. This decision limited the representation of the client mothers' views regarding the programs in the collected data. On the other hand, several participants related to their own birth experiences when discussing the programs being studied or birthing in general.
The participant-observer role of the author in this work is seen to be at once a strength and limitation of this research. The insider affiliation may be viewed as a strength that increased ability to gain access and trust with those who were seen to be key informants of the work. However, being the insider of one program may have hampered the opportunity to obtain information in the second program and/or with members of other identified stakeholder groups. However, as only one contact refused the interview, and most interviews lasted at least one hour, this seems unlikely. Similarly, the author’s previous experience with the programs might be viewed as a limitation that influenced the information gathered and analysis of the data obtained in research process. This is balanced by the advantage that the author’s shared similar experiences allowed a ready understanding of the issues that emerged from the data.

5.5 Significance of Study & Future Research

5.5.1 Relevance to Health Policy

This study has relevance for policy within the CRHA. The evidence in this data regarding the effects of organizational change as it occurred at the time of regionalization was an unanticipated finding. It suggests that employees at many levels of the health care system were, and still are, being affected by this process of change. Previous research studying the effects of the health policy change process within the CRHA proposes ongoing examination of the outcomes of regionalization (Casebeer and Hannah 1996). The current research suggests the beneficial and detrimental effects of change on the CRHA employees are one important aspect of consideration.
Also of relevance to CRHA health policy are questions raised regarding public participation and volunteerism. Must program consumers be included on committees such as the VBC regional planning committee, and if so, what policy governs their influence in the decision-making process? In the case of the volunteer program, would the consumer include the volunteers and the clients? Would the volunteer and/or clients be reimbursed for their time, if other committee members were participating as paid employees? With respect to the volunteer aspect of the programs, what determines adequate and appropriate resource allocation to volunteer programs? What process and indicators would influence the process of change, if the stakeholders desired to expand the volunteer program to a funded pilot project? What governs the decisions to meet health care needs using volunteers rather than paid employees?

Recent Health Canada guidelines include doulas or labour companions among the care providers involved in caring for women in labour and birth (Health Canada 2000, p.1.11). The doula is presented as one option for professional support in labour, to attain the improved health outcomes to mother and baby demonstrated in trials of one to one continuous support (Health Canada 2000, p.5.19). Moreover, a family-centred framework of care is encouraged in the guidelines, with suggestions to facilitate success in the organizational changes required to accommodate this model of care. However, the current research suggests that the role, scope of practice and regulation guiding the labour companions is unclear to health care providers. Examination of the policies that govern women’s rights to choose this model of care in hospital is suggested.
Furthermore, the guidelines state that respect for women and families is illustrated by the organization's willingness to meet the families' wishes for the birth experience, that leadership in change efforts is critical, and that women and their families must be involved "at the ground level of decision making – that is, when planning programs, services and institutions and creating policies" in order to "effect change in the decision-making process at the administrative policy level" (Health Canada 2000, p. 1.13). Thus, as the CRUJA is an organization that espouses the philosophy of family-centred care in labour, the inclusion of women and their families in the decision-making process of planning programs such as the regional volunteer birth companion program is encouraged.

5.5.2 Relevance to Labour Support Literature and Programs

Despite evidence of a growing interest in labour support by lay providers, the literature review that opened this thesis (Section 1.2.3) described only one qualitative research study regarding the provision of social support during labour. The authors of that study called for research regarding "the barriers and facilitators that should be considered for its adoption on a routine basis" (Campero, Garcia et al., 1998). Similarly, although there were a few program description reports, no published research regarding volunteer birth companion programs was found.

The results presented in the current work provide in-depth description of two programs that have provided labour support via volunteers on a routine basis for a number of years in Calgary. Furthermore, the qualitative, comparative case study analysis presents the strengths and weaknesses of the two approaches for service provision in the Calgary context. The description of the activities of the regional planning committee and the
outcome of the attempted regional program presents the barriers and facilitators experienced in this effort. The dissemination of this research, therefore, will allow others to share the lessons learned in this research, responding to a gap in knowledge regarding labour support provision.

Finally, perhaps the most meaningful significance of this study is its relevance to the key stakeholders of Calgary's current volunteer birth companion programs. This research adds to the resources already invested in the separate programs and in the planning of the attempted regional program. In presenting this research back to the interviewees, the author hopes discussion and action will be initiated amongst the stakeholders, facilitating change within Calgary volunteer birth companion programs.

5.6 Conclusion

Using qualitative methods, this multiple case study research project has contrasted and compared two programs providing volunteer labour support to women in Calgary. Thick, rich description of the background and current state of the two programs was succeeded by description of the composition, activities and outcomes of a committee struck to plan and implement a regional program model for labour support provision by volunteers. Themes of stakeholder opinion that emerged in the data yielded two key findings: the regional program model lacked the focus of a stated program problem to orient its goals, activities, and outcomes; and, issues of power and control over decision-making in the birthplace presented challenges the committee and the regional program did not overcome. The relevance of these findings to labour support and health policy was discussed, with recommendations and suggestions for change.
REFERENCES


Perez, P. and D. Thelen (1998). *Doula Programs. How to Start and Run a Private or Hospital-Based Program with Success!* Katy, Texas, Cutting Edge Press.


Rutherford, E. (2001). The Influence of the Agreement Between the Calgary Regional Health Authority and the Salvation Army on Women’s Participation in Health Policy. *Community Health Science, Faculty of Medicine*. Calgary, Alberta, University of Calgary.


APPENDIX I: DOCUMENT LIST

Community-Based Program

1. Sexual and Reproductive Health, Calgary Health Services Prenatal (Best Beginning) Briefing Notes
2. Calgary Health Services, Perinatal Division, Single Women Program
3. Volunteer Role Description, 1993
4. Best Beginning, 1994
7. Volunteer Role Description, 1996
8. Labour Companion Support Group Meeting, April 18, 1996
9. Volunteer Role Description, 1998
10. Volunteer Role Description, 2000
13. Child Birth Educator Volunteer Role Description

Hospital-Based Program

1. What is a doula?
2. Labour Support Course
3. Evaluation of Labour Support Services
4. Volunteer Role Description, 1997
5. Volunteer Role Description, 1999
6. Volunteer Birth Companion Advertising Card

Regional Planning Committee

1. Meeting Summary, Regional Birth Companion Volunteer Program, October 23, 1996
2. Cover letter to Rosemary Burness (October 31, 1996) accompanying Birth Companion Volunteer Survey
3. Birth Companion Volunteer Survey
4. Minutes of the Birth Companion Volunteer Program (Doula), January 28, 1997
5. Needs Assessment Results
6. Comments from Foothills Nurses accompanying needs assessment results
7. Birth Companion (Doula) Program
8. Regional Steering Committee Minutes, March 19, 1997
9. Regional Steering Committee Minutes, July 2, 1997
17. Volunteer Birth Companion Training Program Committee July 6, 1998
APPENDIX II: STAKEHOLDER GROUPS

Original Stakeholder Groups

- Volunteer Coordinators from the community and the hospital sites

- Public Health Nurses who currently refer clients to the community-based program

- Professional Staff representative of the labour and delivery units from all three hospital sites

- CRHA representatives from maternal-child health division

- Volunteers from both programs

- Clients who have participated in the program within the previous month

Additional Stakeholder Groups

- Physicians

- Midwives
Dear:

This letter is to introduce you to a research study about Volunteer Birth Companion (VBC) programs in Calgary. This study is my thesis project as a Master’s student in the Department of Community Health Sciences, in the Faculty of Medicine at the University of Calgary. In this research we hope to discover which program features are considered the most important by the people who are involved with them. You are being asked to participate in this research because you are seen as a person who may have knowledge of one or more of the VBC programs.

Your involvement in the research will consist of an interview that should not take more than an hour. You will also be asked if you have any documents that might be helpful to this work. At the end of data collection you will be offered the opportunity to read and comment on a report about the program discussed in your interview.

The purpose of this research is to provide recommendations on a program model or models, based on the opinions of a wide variety of those who are knowledgeable about the VBC programs in Calgary. For this reason, we hope that you will agree to participate in this study.

This letter will be followed by a telephone call inviting you to an interview at a time and place that is suitable to you.

Thank-you.

Sincerely yours,

Laurie Lagendyk, B.Sc., BSW
Master’s Student
Consent Form

Research Project Title: Volunteer Birth Companion Programs in Calgary: Discovering Stakeholder Views

Investigators: W.E. Thurston, L.E. Lagendyk

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You have been asked to participate in a research study about Calgary’s Volunteer Birth Companion (VBC) programs. This study will discover and describe which of the program features are considered most important by those involved with or affected by these programs. These features will be summarized into a report that will recommend a program model or models.

The information for this study will be gathered by interviewing people who have knowledge about the programs, and by reviewing documents about the programs. You have been asked to participate because you are seen as a person who may have a lot to say about the VBC program(s). However, you may refuse to answer any of the questions and/or refuse discussion on any topic. You may withdraw from the study without penalty at any time.

The collected information for each program will be written into a report. You will have an opportunity to read the report written about the program discussed in your interview. You are welcome to present me with your concerns, comments and opinions about the program report.

After the feedback about each report is received from the participants, a final report will be written. In the final report, the important features identified by those involved in each program will be compared. This comparison will be the basis of the recommendations for the program model or models, along with any suggestions for putting the models in place.

Your interview will be audiotaped, and assigned an identification code. The coded tape will be transcribed (typewritten) for analysis. Stored tapes and interview documents will only have the identification code and no personal identifiers. The master list of names and codes will be kept in a secure area, separate from the interview material. No personal identifiers will be used in the research reports and direct quotations will not contain identifying information unless you give written permission. Gathered information not used in this study may be stored and used for future research. All data will be stored for 7 years as per University of Calgary regulations.
It is important for you to know that I have volunteered as a birth companion, and that I am already familiar with some of the people in both programs. I have not worked as a VBC for over a year.

The risk of harm in this research is slight. In the event that you suffer injury as a result of participating in the research, no compensation (or treatment) will be provided for you by the University of Calgary, the Calgary Regional Health Authority, Dr. W.E. Thurston or Laurie Lędędyk. You still have all your legal rights. Nothing said here about treatment or compensation in any way alters your right to recover damages.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Dr. W.E. Thurston at 220-6940 or
Laurie Lędędyk at 289-6363.

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

Participant’s Signature

Date

Investigator and/or Delegate’s Signature

Date

Witness’ Signature

Date

A copy of this consent form has been given to you to keep for your records and reference.
Interview Guide

Laurie’s preamble:

“I’m interested to learn more about the volunteer birth companion programs that exist in Calgary. As you’ve read in the consent form, the purpose of my research is to discover what features of the programs are considered important by the people who are involved with them, or the people who are affected by the programs.

The information from my interviews and other research about this program will be gathered together into a report. You will have an opportunity to read that report and give me feedback about it. Then, the reports for each program will be used to make recommendations about the design of the programs, pulling together as much of the information as I can.

You’ve been asked to help with this research because you are seen as a person who probably has a lot of knowledge (or a lot to say) about the program. That’s the kind of person I’m looking for. Although I think it’s important to include your information in the report, I will not use anything to identify you in that report. And if I want to use a direct quotation of yours, I’ll ask your permission in writing first. Is that all OK?

Before we begin, I like to tell people that I have a list of topics that I want to be sure we cover in our interview. Sometimes as we talk about one thing, we cover another topic on the list. So besides taping the interview you’ll see me writing notes to myself from time to time.”

QUESTION GUIDE:

Will you tell me what you know about the doula program as it stands today?
For instance, what kind of clients does it serve?
Probes: how are clients identified?
How many?
What are the volunteers like?
What service is provided?

What would you say is the program’s purpose?
Probes: What are they trying to do?

Do you know anything about how the program got started? Can you tell me about it?

How did you come to be involved with the program? How are you involved today?

What do you know about the resources for each program? How are they supplied?

What are the best features/strengths/things you like about the doula program(s)?

What would you change about the program? What would you like to see happen next with the doula program? If it was the best possible program, what would it look like?

Probe: participation in design and monitoring, who and how?

You may know/I think you know/do you know/that another program with volunteer birth companions exists in Calgary, and that a region-wide program has been looked at in the past. What do you think about that? What are the pros and cons? Are there benefits to that/barriers?

What about expansion of the program? To other hospital sites?

What would you like to see done with the information from this research? What is the best possible outcome this research could have?

Do you know of any documents that I might use to help me in my research?

Probe: examples appropriate to interviewee.

Is there anyone that you think is important for me to talk to in order to gain the whole picture about the VBC/doula program?

Thank-you. (Reminder that the report will be available. Obtain address to send thank-you note/program report.)
June 14, 2001

Dear [Name],

Some time ago you were interviewed for the research study about Volunteer Birth Companion programs in Calgary. This letter is to thank you for taking part in that work. Each person interviewed for the study added information about the program features they considered most important. This first report contains a description of the two programs and the Regional Planning Committee.

Enclosed with this letter is the first report of the research. You are being asked to read and comment on this report. Please feel free to write on it and send it back to me in the enclosed, stamped envelope. To be considered in the thesis, comments should be returned to me by June 25, 2001. If you would rather speak to me in person, or email me, you will find this information on each page.

I asked each interviewee what I should do with the results of this study. I received many excellent suggestions on ways to let others know about the results. After I am finished the thesis, I plan to follow up on some of these.

Thank you for taking the time to review this paper. Your opinions were an important contribution to the study, and are valued now, as I complete this stage of the work.

Sincerely yours,

W.E. Thurston,  
Associate Professor

Laurie Legendyk,  
Master’s Student
APPENDIX VII

About the research:

The data for this research was obtained from multiple sources: documents like committee meeting minutes, my own experiences with the programs, and 16 interviews. Like yours, each interview was taped, then transcribed. I went over each interview transcript, listening again to the tape, and making corrections when necessary.

Using a computer program, I coded the interview data so that similar pieces of information from each interview were grouped together. For instance, if an interviewee spoke about what the volunteers of the program were like, it was coded under "Volunteer characteristics." This made it easier to view at a glance what everyone said about the volunteers, and to compare what was said about the volunteers in each program. You will see examples of this on the next pages.

The information from documents was sorted by program. This data helped me discover details like when the program got started, or who sat on the committees, and what the committee discussed. Combining information from the documents with the interview data helped to clarify things.

I concentrated on information that people talked about the most, or talked about with the most emphasis. Data from documents was included in the same way. When points of view were different, I tried to represent both, but the interpretation is ultimately mine.

These are the first results of the research work. They are not complete. The final stage of the work will be to compare the two programs, taking into consideration the work of the regional planning committee. It is from these comparisons that recommendations about the future of the programs will be made.

I hope you enjoy reading the first results, and that you'll give me feedback about them. The work has included the opinions of a wide variety of people interested in the programs. I sincerely hope the finished product will be useful in making decisions about the programs in the future.

Laurie Lagowicz
Home Phone: 1-89-636
laurel@smtp.com
Please return by June 33, 1993.
COMMUNITY-BASED PROGRAM

Origins and History

This program grew out of the Calgary Health Services (CHS) program, Best Beginning, in the early 90’s. At first it served only Best Beginning clients, and had less than 10 volunteers. The role of the volunteer was to provide social support to women referred by public health nurses. Volunteers were usually interested in careers like nursing or midwifery. After they were accepted into the program, volunteers attended a series of CHS prenatal education classes as their training. Most of the pregnant mothers they supported were very young, perhaps had a low income, and usually lacked someone to accompany them to prenatal classes or through childbirth. The volunteers could provide support in any of these areas, and usually were matched with the mother in pregnancy, before labour began. Volunteers and mothers kept in contact by phone calls, or meetings, and a pager when the due date approached. Once labour began, the volunteer stayed with the mother, until the baby was born in hospital. If both the volunteer and the mother wanted it, one post partum visit took place.

Today’s Program – Purpose, Clients, Volunteers & Activities

Although this program has changed in some ways since its beginning, its purpose seems to be about the same: to provide social support to women in need through pregnancy, labour and childbirth. No longer only for Best Beginning clients, the mothers may be referred to match with a volunteer because of language or cultural barriers, or because she lacks dependable support from a partner, family or friends. Today’s clients are generally older, with more women of other cultures being matched with volunteers. The volunteers are always women who have a strong interest in childbirth and providing support to women. Many of the volunteers are well educated and/or have much life experience. Interviewees describe them using words like “open”, and “understanding”. The volunteers do not represent the multicultural mix of their clients. Volunteer training has expanded to include a 12-hour labour support training course, and attendance at birth with an experienced volunteer. The group meets regularly to share their experiences, discuss group business, and for continuing education. The volunteers themselves suggested and worked on many of these changes. The group usually has 10 volunteers and includes about 5 of the original members, and some of the hospital-based volunteers. Up to 40 clients are matched each year. The program is minimally funded through Volunteer Resources.
HOSPITAL-BASED PROGRAM

Origins and History

This program was started at the Peter Lougheed Centre in 1995, in response to a growing interest in labour support via doulas. About a dozen volunteers were chosen and completed a 14-hour course, using doula-training methods developed in the U.S. Many of the first volunteers were women who had already shown an interest in hospital volunteer work. The clients were women who arrived on the labour and delivery unit who might benefit from having a volunteer with them. These mothers might be dealing with cultural or language differences, or a long or difficult labour. The nurse would explain the program to the mother, and an on-call volunteer would be brought in to support her through the rest of labour and birth. Sometimes volunteers would visit the woman after the birth, bringing the birth story to share with the mother. Volunteers found that, rather than being available only by phone, if they came into the unit on their on-call days, they were more likely to be used. Many of the earliest volunteers have now left this program.

Today’s Program – Purpose, Clients, Volunteers & Activities

The hospital-based volunteer birth companion (doula) program provides support to any labouring woman who may benefit by additional support through labour and birth. The request for the services of a volunteer doula can be made by a nurse on the unit, or by the mother herself. A volunteer request might be made for much the same reasons as when the program began – cultural or language difficulties, youthful mother, or the labouring mother arrives on the unit with no support or inadequate support. As in the original program, the volunteer remains with the mother until birth, sometimes with one postpartum visit. Volunteers still find their best chance of being assigned to a mother is by being an active presence on the labour and delivery unit. As the original group of trained volunteers grew smaller, there was insufficient funding to train new volunteers. In order to allow the program to continue, a decision was made to admit new volunteers if they had obtained certified doula training privately. The current group of volunteers are keen to help women through labour and birth, which also helps them gain birth experience. Although some of these volunteers also work as private doulas, many times they work without pay. Interviewees use words like “professional” and “experienced” when they talk about these volunteers. Although they do not reflect the multicultural nature of their clients, at least some of these volunteers speak a second language. Most of the volunteers meet regularly at the association for private doulas. As a result, volunteer group meetings have decreased. The program carries up to a dozen volunteers. Hospital staff call for a volunteer about once a month, but if the volunteers are proactive by being present on the unit, up to 50 matches are made in a year.
THE REGIONAL PLANNING COMMITTEE

In 1994 in Calgary, the formation of the CRHA stimulated change throughout the health care system. Committees were formed to make decisions about how best to streamline and coordinate all programs and services offered in the CRHA. This affected both the community and hospital volunteer labour support programs, who had already discussed combined training. From the viewpoint of the CRHA Maternal/Newborn design committee, the community-based and hospital-based programs seemed to provide similar services. A committee was formed in 1996 to discuss the possibility of a regional program of volunteer labour support.

Minutes of the regional planning committee (RPC) were found for six meetings between October, 1996 and June, 1998. Between 12 and 18 people attended each of these meetings. Various sub-committees contributed to the committee’s function in areas such as program design and volunteer training.

Common points of committee discussion or committee activities included:

- The use of the name "doula". The committee agreed on the term "volunteer birth companion" (VBC) instead.
- The preparation and distribution of a survey to determine the need for a program.
- The planning of the details of a regional program of volunteer birth support, including a statement of mission and goals; volunteer standards, scope of practice, training and experience; and, a code of ethics.
- The preparation of a fourteen hour training program. This was delivered as a pilot program to some of the community program volunteers.
- Introduction of the regional program to hospital staff through in-services; introduction of some volunteers to Rockyview through a tour; and, to Peter Lougheed through the pilot training program.
- The ongoing discussion of hospital staff reaction to the volunteer program.
- Program funding and ownership was discussed in the latter committee meetings, including a proposal for a full-time administrator of the proposed regional VBC program.