AIMS For a better birth...

'NHS doulas'

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Adela Stockton looks at the issues around doulas working within the mainstream services

I must confess to being purist, some might say idealist even, when it comes to doulas. For me, it's about The Relationship between the doula and the mother or couple, and equally, about the opportunity for women to take back responsibility (or power) for their own birthing experience.

The fact that the mother selects and enlists her doula on her own terms, based on a shared sense of ease with and trust in one another, means that the doula is utterly hers. Their relationship has time to develop and grow during their prenatal meetings, when so much of the groundwork in preparation for birth takes place; in this way, the doula comes to understand how it is that this woman wishes to be supported, begins to know what it is that this father requires to feel comfortable in his role during labour and birth or early parenting. Once labour commences, the doula is then able to 'be' with the mother or couple from a place of mutual understanding, when often there is little to 'do', and after their baby is born, as Lao Tsu's ancient proverb states, the new parents can indeed proudly declare: 'We did it ourselves!'[1]

It makes little sense to me therefore, for a doula not to have met the mother she is going to support until labour has already started, and it seems peripheral to the point of the doula if she is allocated to parents by the midwife in-charge at their point of entry to the birthing unit. As the research suggests, continuous support is more effective when it is not provided by those associated with the hospital.[2] Such may be the case, however, for the 'NHS doula', sometimes known as a 'Birth Buddy', who increasingly can be found working shifts on a voluntary basis in maternity units, from Aberdeen to London, around the UK. Mostly, NHS doula projects have developed out of local women's initiatives to support birthing women in their community on a voluntary basis, which have then duly been incorporated by the Primary Care Trusts (PCT). At least one project is awaiting formal evaluation due in early 2012, some are in the pipeline while others already appear to be well embedded.

Despite the currently more widespread recognition of the benefits of her role, if there has been one ongoing grumble about doulas, it has been regarding the issue of accessibility. It has been suggested that the doula is only for women or families who can afford to pay,[3] despite the fact that there has been a consistent effort among the doula community to counteract this. National network Doula UK[4] has a Doula Access Fund in place for example, and some doulas offer their services on a voluntary (although still independent) basis, such as Birth Companions[5] who support women in prison. In the past, a small number of doulas have worked through Surestart or other such government schemes, on a self-employed contract. It might be considered therefore, that the introduction of a 'NHS doula' would be welcomed, a

means whereby any woman who wants one can access a doula, during labour at least, if not postpartum too.

But what about The Relationship? What about the balance of power between service user and provider? What about the working boundaries of the doula role?

In some areas, it seems that the primary aim for providing NHS doulas is to offer psychosocial support to mothers from more vulnerable groups, such as substance abusers or asylum seekers, or those from deprived communities. The idea being that the doulas do meet with the mothers during pregnancy to develop a relationship and there is an element of choice on the woman's behalf in who she accepts to support her. In other locations however, it appears that the doula is considered more as 'an extra pair of hands' in the birthing unit for whoever needs them, whether mother, couple or indeed, midwife. It may be that the doula and midwife are mutually supportive as they work side by side, but I wonder how far this set-up is conducive to the doula's primary role which is to build a relationship with and empower the mother? Furthermore, according to the Nursing and Midwifery Council,[6] it is in fact unlawful for a doula to 'assist...the medical practitioner or registered midwife...in childbirth'. And while doulas strive at all times (or should do) to maintain a positive interaction with the attending staff, if the doula is present essentially for the benefit of the midwife, where does this leave her in terms of allegiance to and advocate for the mother?

This question is even more pertinent when the NHS doula has been 'trained' by the Primary Care Trust (PCT), by tutors/facilitators who are not themselves working doulas. The discussion around how far a doula needs to be formally prepared may be ongoing, and the above scenario does not apply to all NHS doula schemes. Some 'training' programmes do have experienced doula input, such as Goodwin Doulas and the Homerton Hospital Birth Buddies, or alternatively, apparently require the new doula to have under taken a Doula UK approved course in order to apply for the project, such as in Aberdeen. The concern of Doula UK about those who have not undertaken any such preparation however, is that these doulas may lack the background philosophy of a doula centred approach, of 'being' rather than 'doing', as well as a real understanding of the level of privacy required to support 'undisturbed', physiological birth, thereby potentially compromising the essence of the doula role.[7]

The other longstanding apprehension about doulas is the sensitive issue of how their presence might potentially affect midwifery recruitment, even, the role of the midwife itself. As research midwife Mary Ross-Davie laments, there have always been concerns that doulas may be used 'to prop up an already underfunded system constantly seeking cheaper options'.[8] While the doula remains an independent worker, employed by the women and their partners, whether on a fee paying or expenses only basis, I wonder how likely this is to happen. In order to protect the integrity of the doula role, it seems essential that the mother and father remain in control of who they enlist, which effectively removes doulas from the equation regarding the statutory employment of midwives. So whether doula services installed as part of the statutory maternity care system will contribute to the already dangerous shortage of midwives, remains to be seen. As we know, it is not the midwives who set the rules, rather the politically

driven PCTs.

The emergence of the NHS doula sits most uncomfortably with me in several ways therefore. While I am wholly in favour of women and families being able to access the kind of suppor t that is right for them during childbirth, I am concerned that the allocation of on-duty doulas risks undermining the mother (and father's) autonomy, that the doula role itself will be compromised and yes, that midwives will be displaced. All of which seems utterly counterproductive towards appropriately and sensitively supporting birthing families and improving the normal birth rate.

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