The Case for
A Volunteer Doula Project in Leith

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Glossary

Doula: A trained and experienced partner who accompanies a woman through pregnancy, childbirth and the first weeks of life.

Introduction:

The Scottish Government has made reduction of teenage pregnancy a priority. The national Respect and Responsibility framework has supported the development of initiatives such as the C:Card service, sexual health drop-in services and the SHARE programme with the aim of supporting sexual health education, reducing barriers to services and helping young people make informed decisions. Although reduction of teenage pregnancy is important, little has been put in place in Scotland to support young women and their families when a pregnancy occurs.

The rates of teenage pregnancy in Scotland are higher than those in most other western European countries (ISD Scotland 2008), and within Edinburgh, the area of North Edinburgh and Leith has the highest rate of teenage pregnancies (2001-2003) (Scottish Neighbourhood Statistics 2003).
It is important to remember that these statistics only chart an event (pregnancy) and that there are many factors that may place these young women and their babies at risk for example higher risk of poor antenatal care and postnatal depression (Women's Health 2008). In addition, many young pregnant women may experience lack of support and social isolation from peers and family, as well as financial and educational pressures and negative societal attitudes (Women's Health 2008). Risks extend to children born to women in vulnerable groups as they experience a "a higher risk of death or morbidity and face problems with pre-term labour, intrauterine growth restriction, low birth weight, low levels of breastfeeding and higher levels of neonatal complications" (CEMACH 2005, in Goodwin 2008, p.6).

Addressing health inequalities is a priority for the Scottish Government as a whole and, specifically, for the NHS. The Equally Well Implementation Plan (2008) has recommended several strategies that address inequalities within antenatal care and into the early years. These include improving the capacity of antenatal services to address the needs of women in high risk groups, improving breastfeeding rates in deprived areas and among disadvantaged groups and developing holistic support services for families with very young children at risk of poor health and other poor outcomes (p.27).

Tackling health inequalities also extends to the principles embedded in the Maternity Services Strategy which aims to address the needs of vulnerable and disadvantaged women and to reduce barriers to care (NHS Lothian 2009)

Young pregnant women require care that reflects their often complex needs. Doula care is an innovative and cost-effective intervention that has the potential to support this group and in so doing, can help to narrow health inequalities.

Doula Care Defined

The word Doula is derived from an ancient Greek word meaning "handmaiden" or "servant". Within this context a "doula" has been redefined as "a trained and experienced partner who accompanies a woman through pregnancy, childbirth and the first three weeks of family life" (Goodwin 2008, p.3). It is important to stress that a doula does not take the place of medical care. A doula's speciality is to provide emotional and physical support throughout pregnancy and birth. In the later stages of pregnancy, a doula will help a mother and partner design a birth plan, discuss hopes, expectations and fears about the upcoming birth and support the woman and her partner through this process. In labour, the doula is normally called very early on in the process thereby helping the woman and her partner through the various stages of labour with emotional and physical support. It is imperative that this care is consistent and continues throughout the labour. This can be a long process, sometimes exceeding 12 hours. After the birth, the doula often stays for the first few hours to provide extra support. Some doulas have specialist knowledge of breastfeeding and can help mothers to trouble-shoot any breastfeeding issues that arise. Doulas may visit the mother and baby during the first six weeks after birth and refer them on to other services as and when those are needed.

Overview

Over the past 15 years, there has been increased recognition of doula care as a safe and effective way of supporting women and their partners through the antenatal, labour and post-partum period. Although the practice of privately hiring doulas is becoming more common, it has been acknowledged that the cost of this valuable service may be a significant barrier for pregnant women. As a result, the creation of volunteer doula programmes in which women are trained as doulas and volunteer their services, has grown in popularity, primarily in North America. Recently, this model has been replicated in Hull, England, and has received national recognition, culminating in support from the Department of Health for the roll-out of the programme throughout England.

This report will investigate how doula care can address the specific needs of vulnerable pregnant women, especially young women. A short literature review will examine the growing evidence base supporting the incorporation of doula care into the maternity setting and the structure of the Goodwin Volunteer Doula Project in Hull and conclude with recommendations on how to adapt them to the needs of young pregnant women in Leith.

Doula Care: the evidence base

The needs of women in labour span many domains -emotional, physical and medical. There is a growing evidence-base that clearly outlines the positive outcomes of constant care during labour. Although this may be seen as an aspect of midwifery care, providing constant physical and emotional care may not always be a reality for midwives who must also balance medical care and hospital protocol. The House of Commons Health Committee on Health Inequalities (2009) has recognised that "the declining numbers of midwives coupled with increasing numbers of birth means that midwives' workloads are increasing" (p.89) This may restrict the opportunity to provide constant physical and emotional care throughout labour and require midwives to prioritise care for women in high-risk medical situations (House of Commons Health Committee 2009).
This review will examine the evidence surrounding the outcomes of constant care during labour, how doula care can contribute to these outcomes and how doula care can be used to specifically reduce health inequalities.

Overview
In order to gain a broader understanding of the issues surrounding labour support and to establish a firm evidence base, three systematic reviews were consulted. These reviews looked at a total of 31 studies examining the effect of consistent physical and emotional support to labouring women. Most reviews assessed random control trials (RCTs) that compared the physical and emotional outcomes of constant physical emotional support, predominantly provided by a doula, compared with limited or intermittent labour support.

Each systematic review has shown a marked decrease in most obstetric interventions such as caesarean sections, forceps and vacuum delivery, oxytocin induction and use of epidural anaesthesia when consistent care was apart of the labour process (see Appendix A).

Doula care and reducing health inequalities

The Greater Glasgow and Clyde Inequalities Sensitive Practice Initiative (2009) recently released a qualitative study examining the experiences of vulnerable childbearing women. These women reported feelings of vulnerability, feeling like an "outsider" and difficulty communicating their wishes. They expressed a need to become involved in their care and become part of the decision making process as opposed to being recipients of care. In order to respond to the needs of vulnerable women this report advocated services that would respond to their specific and complex needs. It emphasised quality interpersonal communication and relationship building as the way to achieve this.

In Hull, Green (2008) conducted a qualitative study involving 39 women who had participated in the Goodwin Volunteer Doula project either as expectant mothers or volunteer doulas. The expectant mothers highly valued "having someone there" who was on their "side". They often reported developing a supportive relationship with their doula and feelings of personal empowerment. The report concluded that the programme was a beneficial service to both childbearing women and volunteers doulas and suggests that this program has the potential to complement current maternity services (p.33).
In the quest to justify doula care, Green warns against a wholly scientific approach which examines the merits of care solely on medical outcomes and argues that the "demonstrable promotion of a confident birth despite complexities" should be the focus of assessment (p.32). Indeed "softer" outcomes such as increased self-esteem, less emotional distress, increased breastfeeding rates and shorter labours are less frequently studied although equally important (See Appendix B). All reports looking at these outcomes have indicated a positive correlation with doula support. No adverse effects of doula care were reported.

Examination of Systematic Reviews

All of the research reviewed has shown a decrease in the medical interventions with constant care throughout active labour (see appendix A), but the extent of that decrease varies.

Zhang et al's. (1996) systematic review studied the results of doula support with young, first-time mothers with an average age of 20. This review looked at four studies involving 1,349 women. When outcomes such as spontaneous vaginal labour without interventions, such as oxytocin augmentation, instrumental or caesarean section delivery, were examined, those with doula support were twice as likely to have a spontaneous delivery as the control group with no doula support. Overall, those with doula support spent 2.8 hours less in active labour than the control group. In terms of psycho-social outcomes, those women who received doula support felt more satisfied with their birth experience and had an easier time bonding with their infant. Following the birth, those women with doula support reported breastfeeding initiation rates higher than those without doula support.

Scott et al (1999), conducted a systematic review that looked at 11 RCTs, involving a total of 4,391 women. These studies examined the outcomes of constant versus intermittent care by either medical professionals, doulas or lay female attendants. The authors concluded that intermittent care in any form had no significant effects on medical outcomes or interventions. However with continuous support, medical interventions such as epidural

analgesia, oxytocin augmentation, forceps and caesarean section delivery were significantly reduced.

The Cochrane Review has also reviewed the outcomes of constant support throughout labour however concluded “labour support appeared to be more effective when it was provided by women who were not part of the hospital staff”(p.1). This finding was echoed in Manning-Orenstein’s 1998 study which compared emotional outcomes of women who hired doulas with those of women who were trained in Lamaze, finding the former to be less emotionally distressed and to exhibit higher self-esteem.

Further studies

Individual studies provide insight into how doula support has impacted on maternity care in the hospital setting. McGrath and Kennell’s (2008) study examined the effects of doula care on caesarean section rates for middle-class couples. Overall the caesarean section rate was 13.4% for the doula supported couples as opposed to 25.0% for those couples without doula support. In addition, those women who were induced in labour and had doula support were significantly less likely to have a caesarean section (12.5%) than those women who were induced but did not have a doula present (58.8%).

Klaus (1993) cites a US study that has shown that doula support to reduces the need for a caesarean section by 50%, reduces the need for epidural analgesia by 60% and cuts the duration of labour by 25% (cited in Goodwin 2008, p.6)

These results are similar to those in a 2004 doula survey conducted by Doula UK with 74 birth doulas who collectively attended 282 births.

Intervention	Doula UK	National Average
Caesarean Section rate	10%	20%
Epidural Anaesthesia	15%	33%
Instrumental Delivery	7%	11%

National average taken from NHS maternity statistics, England: 2002-03 by the Department of Health

Each systematic review and individual report studied recognised that continuous care during labour; in most cases provided by a doula (lay or professional), significantly reduces the need for medical interventions, although the degree to which these interventions can be reduced varies.

Limitations

Although the importance of providing constant care throughout has been demonstrated, the definition of “doula” has varied throughout the studies consulted and as a result, “lay” doula support (support from friends or family with no formal training), has been difficult to measure against the support provided by professionally trained doulas

Some studies have chosen to examine the effects of support provided by “female companions” and had a more flexible definition of doula support (Klaus et al. 1986, Campbell et al. 2007). Although reduction in medical interventions has been the overall outcome, the role the women played in this capacity may be less consistent than a doula who completes formal training.

As the education of doulas is frequently becoming a requirement to practice and be recognised professionally, the role of the doula is much more comprehensive encompassing a broad knowledge base, reflective practice and code of ethics (Scottish Doula Network 2008, DONA 2009, Doula UK 2009,). The role of the trained doula is not solely limited to constant physical and emotional support throughout labour, although this is an important aspect. Continuity of care, development of a trusting relationship and tailoring of care to specific needs are core aspects of this role. As the need to address health inequalities grows, offering free or subsidised doula care has been recognised as an effective way to address these inequalities (Goodwin Development Trust 2008, Health Connect One 2009, Single Parents Centre Volunteer Doula Program 2005)

As there have been no adverse effects to doula care established, (Hodnett et al. 2008, Scott et al. 2000, Zhang et al. 2006), it is expected that trained doulas will not only improve the outcomes for mothers and babies but provide a consistency of knowledge and experience.

Conclusion

The benefits of doula support can not be underestimated.
This review has shown that professional and consistent doula care is an effective way to reduce health inequalities by:

- Providing personalised, one-to-one care that addresses the specific needs of childbearing women.
- Providing support and advocacy, which has been shown to increase self-esteem and feelings of empowerment.
- Allowing childbearing women to participate more fully in the provision of their care.

In addition to narrowing the health inequalities gap, medically, doula care has been shown to:

- Significantly reduce the need for caesarean section, forceps delivery/vacuum suction, epidural anaesthesia, and oxytocin induction.
- Significantly increase breastfeeding rates.
- Significantly reduce the amount of time a woman is in active labour.

Example of Excellence

Hiring doulas privately is a practice more common to North America and has been growing in popularity over the last 15 years. In most cases, doulas are paid professionals who have completed a combination of formal training and mentorship and are often members of a Doula association (for example DONA International, Doula UK or the Scottish Doula Network).
As the positive outcomes related to doula support began to be supported by a firm evidence base, the popularity of doula support has increased. As this is a service that is generally contracted privately, it has become clear that the advantages of doula support is generally available only to those who can afford it. This has prompted a response within the voluntary sector and hospital boards to recruit women to become volunteer doulas, thereby reducing the economic barrier related to this service. Most of these programmes are located in North America.
Recently, a volunteer doula programme has been successfully replicated in Hull, England. This is the first of its kind in the UK and since its inception three years ago, has expanded throughout the city and has achieved national recognition.

The following is a summary of this project and an examination of its structure, successes and challenges.

History of the Goodwin Volunteer Doula Project

The Goodwin Development Trust is a Hull-based organisation that specialises in developing community projects, managing these projects and developing frameworks to be developed nationally.
Heather Barnes, manager of the Goodwin Volunteer Doula Project, is a professionally trained Doula, aromatherapist and infant massage instructor with a strong background in project management. She recognised a need for a service that provided labour support for women where paid Doula services would otherwise be a barrier. In collaboration with Goodwin Development Trust, Ms. Barnes developed a sustainable, nationally recognised programme that works throughout the city of Hull.
Through partnerships within Hull NHS, maternity services, local voluntary agencies and sure start children's centres, the Goodwin Doula program operates out of a main office and two satellite offices in the city. This project has been in operation for three years and has trained 64 volunteer doulas and runs with a core of 5 paid staff. Since its beginning in 2005, the project has received 250 referrals and supported 190 women. Fifty percent of the service users are immigrant women. Translation services form a large part of the programme.

Goodwin's Management Structure

Within the Goodwin Development Trust, the Volunteer Doula Programme operates under a board of trustees and receives direction from the senior management team.
The programme itself operates with 5 paid staff which comprise of one project manager, three project development workers and one administrator. It has an operating cost of approximately £142,000/year.

Programme Structure

As the strength of the project is very much dependent on the commitment and skills of its volunteers, a crucial component of the programme lies in its selection of these women.
Volunteer intake occurs twice a year and involves a detailed application form, participation in an information night and personal interviews. Last year, the project received over 150 requests for applications. Of these,15 women for each intake were chosen.
The training course is taught over a 6 week period, and is an accredited programme by the National Open College Network (NOCN). Each participant chooses at which level to complete the course: either at level 2 (GCSE equivalent) or Level 3 (A Level equivalent). Completion of either level will allow the volunteer to work with the programme however level 3 requires more written and group work throughout the course. Each participant is assessed by the project manager an internal and external evaluator. Although successful completion of the course is needed to participate as a volunteer, those who do not meet the required standards will be supported until successful completion is achieved.

The topics covered in the 6 week course includes:

- A 2 day breastfeeding course
- Cultural Diversity
- The Father's Role
- Ante and Postnatal Care
- Child Protection Level 1
- Domestic Abuse Awareness
- Health and Safety
- Multi-agency Working
- 2 day "Preparing for Birth" course
- Smoking Cessation in Pregnancy

Training also includes a visit to the local maternity hospital.

Each month, additional training sessions are offered. Past topics have included:

- Natal Hypnotherapy
- Self-defence
- Drug Awareness
- Aromatherapy
- Sexual Health

When a match has been made, each volunteer Doula is supported by the local project development worker on a continuous basis. It is a requirement that each Doula phone-in to the head office to indicate when their visits are beginning and ending to ensure maximum safety of all participants. Each volunteer is given a personal alarm and mobile phones are a requirement. An initiation and exit interview is conducted by the project development worker for both the volunteer Doula and pregnant woman to ensure a desired match. This also ensures that the service is evaluated consistently.

Opportunities for participants

The Doula project specifically targets immigrant and vulnerable women within the Hull area. In many ways, the project serves as a referral point for women and their families after the postpartum period, ensuring that issues uncovered within their time in the programme are followed-up and support continues in other forms.

Recruitment for the project both for participants and volunteer doulas relies heavily on the partnerships developed throughout the community and referrals from these agencies. The profile of this project has been raised through the media in various ways, for example newspapers and official website.

As a participant in the project, women who are supported by the volunteer doulas will:

- Have an initial interview with a project worker outlining the project and determining the participant's specific needs
- Meet their volunteer Doula with the project worker to ensure an adequate match
- Be supported throughout pregnancy (usually from 7 months onwards) with meetings twice a month then every week closer to the due date
- Be supported through development of her birth plan
- Have the Doula present throughout labour, birth and first few hours postpartum
- Have post-partum support up to 6 weeks after birth
- Receive breastfeeding support
- Receive a "birth story" account from their doula
- Have an exit interview with Project Development worker to evaluate their experience and provide feedback for the project.

Funding

Primary funding for this project is provided by Hull City Council through the Early Years and Childcare Grant (England).

Challenges and Lessons Learned

As previously mentioned, volunteer selection is one of the most crucial aspects of this programme. It must be kept in mind that professional doulas often charge between £300-£800 per client. This cost does not only reflect the amount of time needed per client but also the need to be available at all times, especially during labour where time the commitment could exceed 12 hours. Therefore, the level of commitment and professionalism needed for this role far exceeds that which is usually required within a volunteer setting and the appropriate selection of volunteers is vital. Volunteers must be aware that they may be required to stay with a labouring woman for many hours at a time and often at very short notice. In terms of the Hull programme, the demographic that this project deals with requires volunteers to have an understanding of alcohol and drug misuse, domestic abuse issues and child protection protocols. The safety of the volunteers is crucial and therefore must be a priority for the paid employees. This is ensured by having each volunteer Doula call in to the main office when a visit begins and ends as well as notifying the project when they are attending a birth.

In terms of the volunteer intake, a large percentage of the women volunteering to become Doulas have a keen interest in training to be midwives in the future or continuing on to train medically. Although having future goals is positive, it must be stressed that the role of a Doula is not a medical one and therefore the ethos surrounding care is different from those in the medical profession. It is important that this is fully understood by the volunteer.

When exploring the challenges and lessons learned, issues surrounding professional boundaries have been a reoccurring topic. First, it has been important to define the boundaries for the volunteer doulas. As the majority of the clients enter the programme with varied and complex issues, it is important for the doulas to know what issues are and are not appropriate to deal with and to what level they are expected to engage in these issues. Although an important aspect of the programme is signposting and referrals for the client, the Doula must be comfortable with recognising the issues present but not taking on the responsibility of dealing with them.
In turn, paid employees also must be aware of their role and the boundaries that lie within that role. They may have more of an active role in referral,

however, must also be careful not to over step their boundaries. In this respect, some of the project workers have a strong background in social care, family support or counselling, however do not work within that role.

When selecting volunteer doulas, the project strives to choose volunteers from a variety of backgrounds, education levels and life situations. Although this is important for diversity and amicable matches between clients and volunteers, project workers must be able to support each volunteer to their required level.

Moving Forward

The success of a volunteer doula project will largely depend on the strength of the support of its partners and a strong belief in its ethos. Therefore, it is important that buy-in is achieved in both the public and voluntary sectors. Following the feasibility study, it is recommended that a working group is formed comprising of voluntary agency representation, NHS staff (midwives, general practitioners, public health/health promotion specialist) and interested community members.

Plans to replicate the Hull programme in Leeds are currently being discussed. In order to achieve "buy-in", the following posts were recently present for a meeting that assessed the feasibility of a volunteer project in that area:

- Head of Midwifery (local maternity hospital)
- Head of service development PCT (NHS)
- Children's centre improvement manager
- C+YP social care commissioning manager
- Head of children and strategic partnerships – project implementation
- Commissioning manager for maternity services

Establishing a Volunteer Doula Project in Leith

Following a meeting with The Junction's board of directors about the possibility of starting this project, it was clear that efforts must be concentrated on looking for future partnerships within the Leith community. Although the idea of the project was supported by the board on the whole, the scale of the project was recognised as a barrier to taking full responsibility for it.

Preliminary contacts have been made between The Junction and The Birth Resource Centre. The BRC is very supportive of this project although is currently going through a staff and manager change, therefore links will have to be re-established in the future. Other possible partnerships to explore would be: Home Start, Stepping Stones, YMCA, National Childbirth Trust, local GP clinics and any other local agencies working with vulnerable families and pregnant women.

It must be stressed that although NHS collaboration is imperative for this project's success, the strength of the project rests in the fact that it operates within the voluntary sector. The partnerships, signposting, advocacy and independence of the project will thrive within the voluntary sector ethos. The population that will access this service are clients who would regularly access other services within the voluntary sector. It is also questionable whether the NHS will regard this service as one that rests within its remit.

It is expected that a working group will be established that can take these ideas forward. If this happens the following areas of exploration are recommended as a starting point:

- The location of the volunteer project
- Establishing project partners
- Ascertaining client target group
- Finding funding opportunities and achieving sustainability
- Partnership working between voluntary agencies, the NHS and Scottish Government
- Mission statement and timeline for project development
- Continued partnership building with the Goodwin Doula Project, Scottish Doula Network and The National Childbirth Trust

Conclusion

This report has provided a strong evidence base that clearly outlines the benefits of a voluntary doula project in Leith. The outcomes of a volunteer doula project underpinned by its firm evidence base provides an easy fit into many current government targets and policies, for example, HEAT breastfeeding targets, the Equally Well strategy, Better Health, Better Care and current NHS maternity targets.

Although the difficulties in establishing a new project within this financial climate can not be underestimated, the proactive policies from the Scottish Government to support innovative projects that holistically address health inequalities provides encouragement that this is a project that could thrive in Leith.

Appendix A

Effect of Constant and Doula Care on Medical Interventions

Medical Intervention	Cited
Decreased Caesarean Section Rates	McGrath & Kennell, 2008 Hodnett et al. 2008 (SR) Keenan 2000 Scott et al. 1999 (SR) Kennell et al. 1991 Zhang et al. 1996 (SR) Klaus et al. 1986 Trueba et al. 2000.
Decreased need for forceps and vacuum delivery	Scott et al. 1999 (SR) Kennell et al. 1991 Zhang et al. 1996 (SR) Hodnett et al. 2008 (SR)
Decreased need for oxytocin induction	Scott et al. 1999 (SR) Kennell et al. 1991 Zhang et al. 1996 (SR) Hodnett et al. 2008 (SR) Klaus et al. 1986
Decreased need for Epidural Analgesia	McGrath & Kennell, 2008 Hodnett et al. 2008 (SR) Keenan 2000 Scott et al. 1999 (SR) Kennell et al. 1991 Zhang et al. 1996 (SR)

SR= Systematic Review

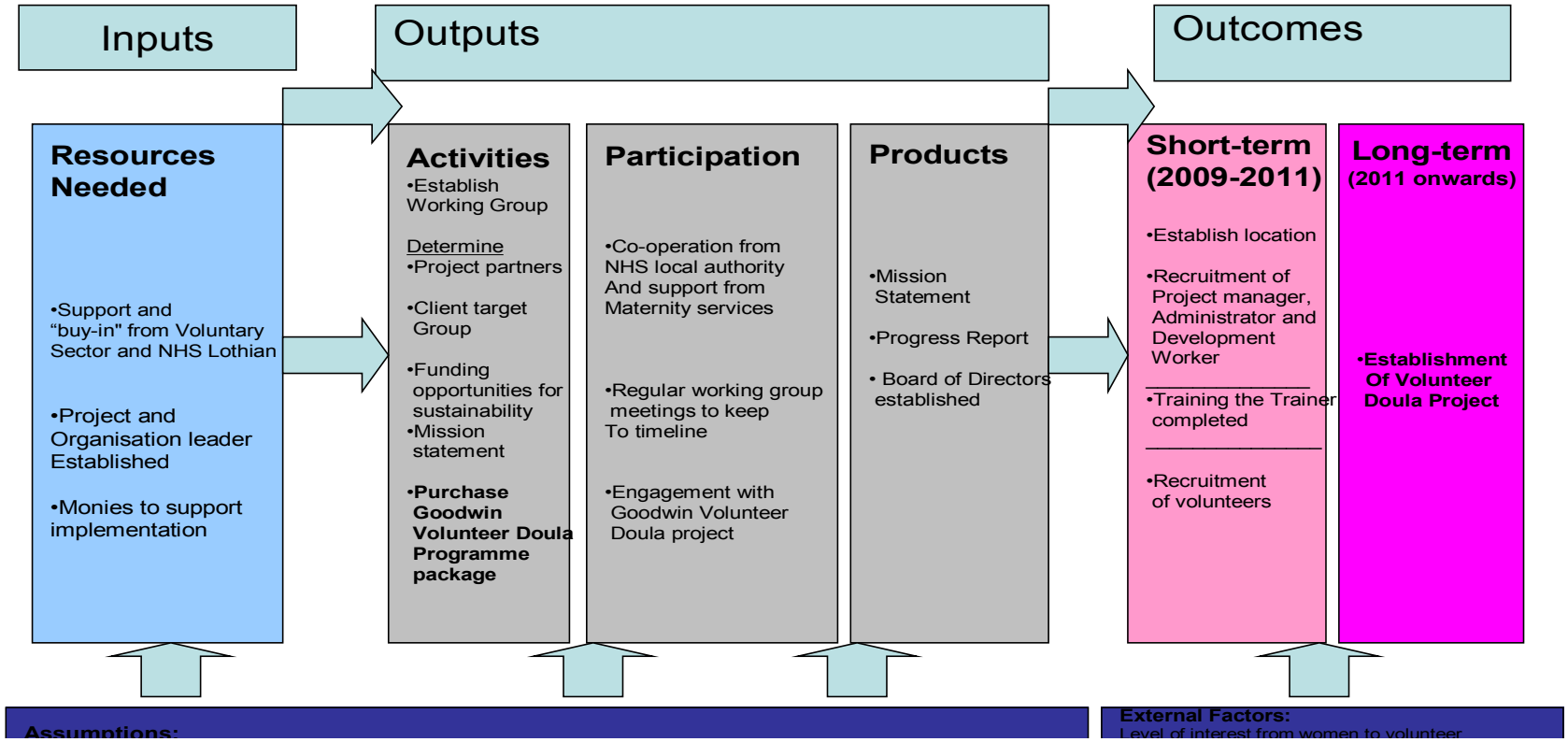
Appendix B

Effect of Doula Care on Psycho-social Outcomes

Outcome	Cited
Higher self-esteem and less emotional Distress.	Manning-Orenstein 1998 Scott et al. 1999 (SR) Hodnett et al. 2008 (SR) Trueba et al. 2000.
Higher rates of exclusive breastfeeding initiation	Scott et al. 1999 (SR) Langer et al. 1998
Positive prenatal expectations, positive perceptions of their infants, support from others, and self-worth	Campbell et al. 2007 (SR) Sosa et al. 1980
Shorter Labours	Scott et al. 1999 (SR) Langer et al. 1998 Kennell et al. 1991 Hodnett et al. 2008. (SR) Keenan 2000 Klaus et al. 1986 Zhang et al. 1996 (SR)

SR= Systematic Review

Volunteer Doula Project- Logic Model



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Notes of Thanks

The author would like to thank:

Sam Anderson, Audrey Morrison, Rachael Wilkins, the team and board of directors at The Junction: Young People, Health and Well-being for their support in the creation of this report.

Heather Barnes for her wealth of information and encouragement

And Mark Taplin

Front Cover image: www.mayanhealers.com/doula_care

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