The Doula

A DOULA UK PUBLICATION

IN THIS ISSUE

Doula UK
Positive birth.
Supporting families.

AUTUMN 2019 ISSUE 37

In this issue…

Credits & acknowledgments
Cover photo credit: Professor Jacqueline Dunkley-Bent by photographer Joanna Vestey

Magazine team
Thank you to everyone who contributed their time and energy to this edition. Please note that opinions expressed in The Doula are not necessarily those of Doula UK as a whole.

Next edition
If you have any articles, doula stories, experiences or photographs that you would like to share and see published here, please send them to editor@doula.org.uk

Deadline for next issue: 16th December 2019

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Letter from the guest editor

Welcome to the autumn issue of The Doula!

This season's magazine has been such a pleasure to guest edit. Doula UK is striving to be a more inclusive, welcoming space to people who have been marginalised in the birth world. I hope that this is the message which comes through most strongly as you turn the pages. We aim to reflect the rich pool of diversity of our members, the families they work with and the birth community. We are focussed on engaging with a wider range of voices and tackling challenging topics head on. This is part of an ongoing effort to introduce positive change throughout our organisation.

So what next? I'm pleased to announce that we will be working with anti-racism and intersectionality consultant Jamie Schearer - more on this soon. We are also revising our website and policies to reduce gender-specific language. This autumn Doula UK has introduced a bursary to offer free places on our Introductory Workshops for people from under-represented communities.

Last year the MBRRACE-UK report highlighted the disparities in maternal mortality rates. This hit home to me, not only as a doula seeking to support birthing people from all backgrounds, but also as a Black woman and a mother. It is horrifying to think that simply because of my ethnicity I am FIVE TIMES more likely to die in childbirth. As doulas we are in a prime position to help these families who are losing their mothers needlessly. You can read more about the report on page 6.

A few months ago the Young Historians Project contacted us to tell us about their work collating previously unheard stories from African women in our health service. It's a much needed piece of work and I hope that you will engage with it. Our birth story this issue comes from Doula UK member Uduak Udondem, who shares with us the power of maternal knowledge passed down from mother to daughter.

Dr Rocio Alarcon gives us a rare insight into the cultural origins of the Closing the bones ceremony, or 'Hipping' as she prefers to call it. We are challenged to think about who we learn from and to consider the risks of cultural appropriation. Doula UK member Dr Mari Greenfield gives an insight into some of the challenges faced by lesbian and bisexual women during pregnancy and birth.

I'm particularly proud of our cover story this issue which is a wide-ranging interview with Professor Jacqueline Dunkley-Bent, the first ever Chief Midwifery Officer at NHS England. She tells us what she hopes to achieve in this high profile role.

I hope you enjoy reading this magazine. I will be snuggling under a blanket to read it with a mug of peppermint tea! Please use social media to share with us how you carve out time to read The Doula using the hashtags #doulauk and #thedoulamag

Love, Leila x
Guest editor

Leila Baker

Guest Editor

Biog:

Leila has been a Doula UK birth and postnatal doula since 2014. She lives in south east London where she struggles to organise her husband, five children and two cats. She will be using every excuse to hunker down this autumn and continue her third re-watch of Heroes.

Gemma Haywood

Deputy Editor

Biog:

Gemma has worked as a birth and postnatal doula in New York and London, where she currently lives with her husband, two boys and a high maintenance cat. This autumn she's looking forward to exploring the Vagina Museum's *'Muff Busters'* exhibit which opens November 16!

Rachel Ama Vegan Eats giveaway:

This issue we are giving away one copy of Rachel Ama's book Vegan Eats. To enter, send us a photo or video of you creating your personal favourite postnatal recipe to editor@doula.co.uk by 15th December 2019. Entries will be shared on Doula UK social channels!

Doula dilemma

Dilemma:

" I've noticed that some of my clients get treated differently by their midwives and consultants depending on their accent, their ability to speak English, whether they are a single parent, or whether they are a person of colour. A white mother will be given more attention, more time will be spent discussing her options, and there is a whole different level of respect. How can I encourage positive change?"

– Anon

Every issue we publish a dilemma surrounding an aspect of doula work submitted by a reader and we encourage all of you to email us in response with your advice and suggestions as how best to solve it. All emails will be treated with the strictest confidence and any distinguishing details will be amended to protect and retain the anonymity of both the person submitting the question and the people involved in the dilemma.

I have witnessed exactly this. I think it's a society wide problem which is a combination of systemic racism and of people not recognising their racial bias and white privilege (if you are white like me).

I believe that different trusts have different work cultures within their hospitals and birth centres, homebirth teams and health visitors. Language sensitivity and cultural safety may not be updated or practiced in some of them. It can be a challenge to address because people tend to get defensive. Therefore we should aim to be of excellence in communicating. Listening well with intention is a skill I'm practicing and is vital when listening to voices of black people. When people share of their lived experience we must listen. We must witness. Sometimes listening and witnessing is enough.

Sometimes we need to act. I think this will come as we read and learn and most importantly, listen. When acting, it needs to be in a safe way that does not put anyone in danger, especially someone who is already being treated unfairly and is most probably triggered and upset. Doing nothing is not okay. Becoming part of your local Maternity Voices Partnership (MVP) and addressing the issues there can be a useful first step.

Reading up ourselves on racial disparity and learning how to be anti-racist is something anyone and everyone can do. We need to address our own bias, ongoing. Some books I have read that are great are "Why I'm No Longer Talking To White People About Race" by Reni Eddo-Lodge, "Killing the Black Body" by Dorothy E Roberts.

The work is ongoing and we need to source resources and pay as appropriate from learning from teachers online.

We shouldn't ask black people to teach us although there may be black teachers. Pay them if you learn from them, and don't add to their daily microaggressions by tagging and seeking recognition. We should all do this work because we are all in this work.

I also think it's important that doula training courses should incorporate cultural safety. This means addressing issues such as the MBRRACE report from 2018 and looking at what it means to be black and accessing our health care system. Cultural safety should also look into language and LGBTQI+ too, although this is a different topic, it adds to the layers of bias and needs similar attention.

Forever learning.

LD

Thanks for your submission and desire to affect positive change. I live in London and most people here have an accent so I personally can't say that I have experienced this as being an issue.

Prejudice based on accent often goes hand in hand with other prejudices. Some accents are labelled, for example, as romantic whilst others are looked at less favourably. Regardless, if a client does not feel heard or understand the information given by medical professionals this can lead to less engagement with professionals and, in extreme cases, be dangerous if, for example, a professional does not take the time to explain crucial information, if the client does not understand this information or if certain procedures or checks aren't carried out because the professional perhaps finds the client's accent challenging or has prejudices against it. Encouraging your clients to request a translator if helpful is one way that can help if they or you feel that the different treatment they are receiving is based on this.

Sometimes partners are not available for various reasons for example the partner could be working overseas, living abroad, denied or awaiting a visa, in hospital long-term, in prison, have passed on or the woman could be a refugee here on her own. I am also meeting lots of women choosing to parent solo. Whatever the reason, none of these issues are in the remit of a consultant or midwife during antenatal or labour and birth care so if this was questioned in a judgemental way I would certainly question the professional on the relevance of this. If my client did not feel comfortable with the professional I would ask to see someone else and ask if she wants to give feedback or put in a complaint depending on the details of the incident.

Colour and race is a whole different issue.

People can change their accents or have a friend as a birth partner but we take our skin everywhere we go. Unfortunately some people and their beliefs and stereotypes, seem to be just as attached. The result of this being a higher mortality rate for black women and Asian women who are 5X and 2X more likely to die, respectively, during the perinatal period compared to white women (MBRRACE, 2018). The reason for this is simply, racism.

When women ask us to be their doulas they are asking us to be their protectors and advocates. In order to do this effectively in situations where race is a factor, we have to have an awareness, an understanding and information about racism. Some suggestions are below:

- Examine our own prejudices and change these
- Believe women when they tell us of their experiences.
- Talk to clients about race directly and let them know that you will be extra vigilant about this and support them if they (not you or anyone else) feel they are being treated differently because of this
- Educate yourself. Attend training courses on race and cultural awareness run by women of colour.
- Read 'Why I Am No Longer Talking to White People About Race' by Reni Eddo-Lodge. If reading isn't your thing, it's also available as an audio book.
- Speak up and call out racism at work and in your social circles.

To not do anything about inequality, prejudice and racism is to enable it so thanks for writing in and wanting to know how to affect positive change.

TZ

Dilemma for the next issue:

My client has quite an active mind and asks me a lot of questions about feeding, baby sleep, baby care and about her own physical recovery – questions like 'how long should my baby sleep at night?', 'what should we dress our baby in?', 'should I get afterpains every time I feed?'. I try to mostly let her talk and listen, as well as signposting on to guidelines, resources and websites. I always explain that it is her choice how she might want to proceed. However, it seems she doesn't follow up with the information sources I give her and she keeps asking for my personal opinion - and what I might do in her situation. I am finding this tricky to navigate - please can you give me some ideas on how best to support this client?

- Anon

Please email us a dilemma, or your advice to the one published to **editor@doula.org.uk**

Please specify if you wish to include your name or remain anonymous.

MBRRACE-UK report commentary

PROFESSOR MARIAN KNIGHT, UNIVERSITY OF OXFORD

Black women giving birth in the UK have a five times higher risk of dying than white women, and Asian women have a twofold higher risk. But how should we interpret this in our practice and support Black and Asian women to have better outcomes? The underlying reasons for the differences in mortality rates are not fully clear and further research is ongoing. However, some of the findings of the confidential enquiries and previous research do give pointers to areas where we can make a difference.

The first thing to reassure women of, is that the risk of dying in pregnancy in the UK – even for Black and Asian women – is still very low. About 1 in every 2500 Black women die during or shortly after pregnancy and 1 in every 7000 Asian women.

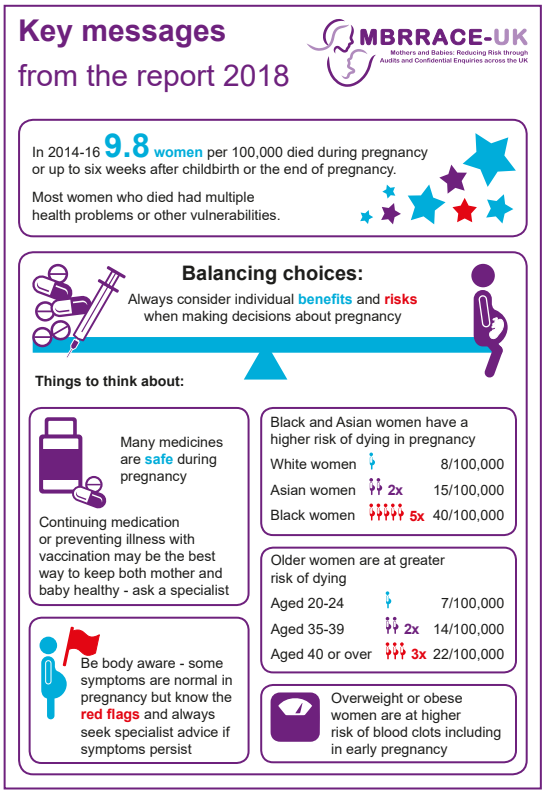
We know that Black and Asian women are at greater risk of some pregnancy complications, such as gestational diabetes, and the occurrence of these conditions appears to account for some of the increased risk. It therefore follows that being aware of the possible symptoms and signs of gestational diabetes, and maintaining blood sugar control, whether by diet or medication, among women known to have gestational diabetes, may be important.

Previous research also suggests that part of the increased risk of maternal death appears to be associated with less use of antenatal care – whether booking late or having fewer visits than recommended. We can only speculate as to whether this means that women who attended fewer visits were less likely to have complications identified, and this eventually contributed to their death, but it does highlight the importance of antenatal visits to detect and treat complications early.

Some women, particularly those for whom language is a barrier, may be unaware of this function of antenatal visits and/or may need help navigating an unfamiliar healthcare system. For many women, including those born and brought up in the UK, pregnancy will be the first time that they have had any major need for healthcare, and advocacy and help to navigate the system can be needed.

We know from both the latest and previous confidential enquiry reports that symptoms of illness are often attributed to normal symptoms of pregnancy. The enquiry has highlighted a number of "red flags" relating to both mental and physical health. By being aware of these, and the need to take action if they occur in the women we support, we can help ensure that women who have unanticipated pregnancy complications are diagnosed and treated early.

Examples of "red flags" in pregnancy include persistent breathlessness when lying flat, chest pain spreading to the back, arm or jaw, and expressing thoughts of violent suicide. Estrangement from the baby postnatally may also be an early indication of possible mental health problems. Particularly in relation to mental health problems, the confidential enquiry has shown that women may consult many different health professionals with their symptoms, yet no-one recognises the overall pattern of their deteriorating health.



Families may find it difficult to distinguish the usual emotional ups and downs of pregnancy and early parenthood from more concerning symptoms, and again as a supporter, being aware of what are normal, and what is more concerning, can be vitally important.

Since these findings were highlighted, a number of women have described experiences of care where they feel their pregnancy care has been compromised due to their ethnicity. It is not clear whether such experiences are widespread or whether they contribute to the higher maternal mortality rate observed among Black and Asian women. It is likely, however, that there are unconscious biases within the way maternity care is provided which may disproportionately impact on women from ethnic minority groups. A lack of consideration of cultural or language barriers are more obvious examples. Less obvious perhaps are difficulties in recognising conditions such as anaemia and mastitis among women with darker skin colour.

We all need to think actively about whether any aspect of the support we provide, or the care being provided by others, is consciously or unconsciously biased against Black or Asian women.

It is clearly of concern that this disparity exists in the modern day UK.

While we cannot fully explain why Black and Asian women are at higher risk of dying during or after pregnancy, supporting women with information about symptoms which are normal for pregnancy and those which are not, help to navigate the maternity healthcare system, and questioning conscious or unconscious biases may start to address it

Marian Knight is Professor of Maternal and Child Population Health at Nuffield Department of Population Health, University of Oxford. Her work with the National Perinatal Epidemiology Unit (NPEU) involves leading the MBRRACE-UK national confidential enquiries into maternal morbidity and mortality.

We asked doulas how they could work to provide a counterbalance to some of the inequalities highlighted in the MBRRACE-UK report:

- **Show a warm welcome –** If a person of colour looks at your website or your social media, will they think that they are a client for you?
- **Be approachable –** As doulas we are in a position to offer continuity of care that the parent may not be receiving anywhere else. We might be the first person they relay a concern to. If you signpost them to their healthcare providers, follow it up with your client to see if they are happy with the response they received
- **Be aware of the position that your client might be in –** Just because you are treating them with the respect they deserve, they might live their whole life in anticipation of negativity
- **Try not to make assumptions –** The client may have been born here or they may not be familiar with their rights within the NHS. They may need assistance with language or they may speak English better than you!
- **Don't be 'colour-blind' –** If you acknowledge in your mind that your client is not white, you can be more mindful of the inequalities they may be facing based on their ethnic origin
- **It's not enough to not be racist –** We need to be anti-racist. Anti-racism includes beliefs, actions, movements, and policies adopted or developed to oppose racism

Uncovering the hidden history of African women and the British health service

SUE LEMOS, YHP MEMBER

The seventieth anniversary of the NHS was approaching as the Young Historians Project (YHP) began brainstorming our next research endeavour, turning our attention to the role of Black women in the history of the British health service. This inspired our current project – 'A Hidden History: African Women and the British health service 1930 – 2000'. The YHP is a non-profit organisation run by young people, aged 16-25, encouraging the development of young historians of African and Caribbean heritage in Britain. We emerged out of the History Matters conference held in April 2015, at the Institute of Historical Research, which was organised to address the lack of history teachers and students of African and Caribbean heritage in Britain. Official statistics indicate that History is the third most unpopular subject among Black undergraduates and in 2016, it was estimated that there were less than 10 Black PhD students studying History.

Since the Heritage Fund awarded us funding in November 2018, we have been working in partnership with the Ghana Nurses Association, Nigeria Nurses Charitable Association and the Black Cultural Archives to illuminate this virtually unstudied history. Historical narratives on Black women's experiences in the healthcare sector have tended to marginalise African women's stories, centring the 'Windrush Generation' and Caribbean women's contributions. In the wake of the Second World War, to address a national labour shortage and support the newly created National Health Service (NHS) in 1948, the British government led a recruitment drive in the colonies to encourage Commonwealth migration to the 'Motherland'. The docking of the Empire Windrush at Tilbury, on 21 June 1948, carrying hundreds of Caribbean passengers, has become a symbolic representation of the genesis of the Black presence in Britain. In light of the prominence of the Windrush era within Black British History, our narrative begins in 1930, with the stories of African women who came to train in Britain before they were called upon to support a fledgling NHS.

During the early to mid-twentieth century doctors, nurses and other medical professionals came to train in Britain because higher education was not yet available in the colonies. From our research we have come across two African princesses – Princess Tsehai Selassie from Ethiopia and the somewhat elusive Nigerian Nurse, Princess Ademola – who lived and worked in Britain during this period. Princess Tsehai, the fourth child of the Emperor of Ethiopia, Haile Selassie and Empress Menen, left for Britain following the annexation of Ethiopia by Mussolini.

She began training as a nurse in 1936 at the Hospital for Sick Children, now known as Great Ormond Street Hospital and worked there during the London Blitz of 1940 – 1941. Sadly, shortly after her return to Ethiopia, Princess Tsehai died in childbirth.

During the Second World War, Princess Ademola, the daughter of the Alake of Abeokuta, trained in midwifery at Guy's Hospital. There is not much known about Nurse Ademola, but we are currently on the hunt for a propaganda film about her, made by the Colonial Film Unit. The Young Historians have however found a series of photographs of her on duty at Guy's Hospital.

Throughout the twentieth century, African women faced various forms of racism in the health profession and in their everyday lives. Before the introduction of the Race Relations Act in 1965 – the first piece of legislation to outlaw racial discrimination in Britain – the rampant racism experienced by Black people in Britain was known as the 'colour-bar'. This was a term used to describe racism in all areas of their life – the refusal of employment, housing, entrance to dancehalls as well as comments, whispers and looks. Through our research, we have learned that there was Black resistance throughout the twentieth century. In the early to mid-twentieth century, the League of Coloured People (LCP) and the West African Students Union (WASU) campaigned against the 'colour-bar'.

To tackle discrimination in housing, members of the LCP opened their homes to African and Caribbean women, while the WASU opened a hostel called Africa House. Within Britain's hospitals, African nurses and midwives encountered much hostility from patients and colleagues alike.

Nurse Ademola
©Imperial War Museum (D16159)

The image on the left contains language which is no longer acceptable. It has been included by the YHP because of its historical relevance to the topic.

The Young Historians Project team

During the recruitment process in the post-war period, African women were often brought in as State Enrolled Nurses instead of the higher level qualification of a State Registered Nurse. This meant they could only carry out certain tasks and would often not be able to take charge of a ward.

The YHP have been uncovering this 'hidden history' through oral history, inter-generational dialogue and archival research. So far, we have drawn on various collections held at the National Archives, Royal College of Nursing, Black Cultural Archives, British Library, BFI Film Archives, British Newspaper Archives and London Metropolitan Archives.

Our team of volunteers have conducted interviews with eleven women who will be featured in our documentary film.

We will also share our research with the public through an exhibition, e-book, a podcast series and a mural at Charing Cross Hospital. We are eager to interview as many African descended women as possible, and so far we have not interviewed any doulas.

We would love the opportunity to represent the experiences and perspectives of African descended doulas within this project. If you are an African woman who worked in healthcare in any capacity between 1930 and 2000 or know anyone who did, then please do get in touch with us. Through excavating this important history, we hope to not only encourage further historical research in this understudied area but also influence the wider public memorialisation of Black women's involvement in the British Health Service.

younghistoriansproject.org

Twitter: ***yhp_uk***
Instagram: ***younghistoriansproject***
Facebook: ***@younghistoriansproject***

To get in touch with the Young Historians Project please email: ***younghistoriansproject@gmail.com***

Neighbourhood Doulas

KAROLINA HARDY & CAROLYN OULADZAHRA

"We need to speak the uncomfortable truth that women — and especially Black women — are too often not listened to or taken seriously by the health care system, and therefore they are denied the dignity that they deserve"

Kamala Harris - parents.com/pregnancy/giving-birth/doula/do-black-women-need-doulas-more-than-anyone

Neighbourhood Doulas is a small grassroots organization that grew out of the friendship, breastfeeding issues and postnatal depression of two mothers living in North Kensington.

Carolyn Ouladzahra and Karolina Hardy met each other when they attended a breastfeeding drop in group with their babies. The drop in was run by a specialist health visitor who was also a breastfeeding support worker and they were eventually trained as breastfeeding peer support workers by the children's center.

'After many hours of volunteering at the drop ins and on postnatal ward at Queens Charlotte's hospital, one of the community midwives suggested that we train as doulas. I called Carolyn and told her that we are going to be doulas. She didn't know what that meant. Neither did I. I said I will google it when I get home.' **Karolina Hardy, Neighbourhood Doulas co-founder**

'We wanted to work as each other's backups, as we both had young children, but… people who could afford doulas privately didn't feel comfortable in having a Muslim doula. We were approached by mothers in our community who needed support but had no money to hire a doula privately and this is how the Neighbourhood Doulas came to be.' **Carolyn Ouladzahra, Neighbourhood Doulas co-founder**

We started to attend births of women in need from North Kensington and soon more women from other parts of London approached us.

"As I stood in front of her, she was wearing just her dress and flip flops, hungry, exhausted, penniless, frightened and so young with her belly protruding new life. She was a trafficked young woman and now lost all her bearings. She spoke little English. I vowed to myself, I will do everything I can to make sure she was not going to go through this alone. I was able to feed her, help her find her way in the legal and housing system with the help of other professionals and organisations, get things for her baby. I was with her when she gave birth to her beautiful baby boy, I helped her establish breastfeeding, which she kept doing for almost two years. I brought her to a wonderful supportive mums' group, where she thrived and helped other mothers. She learned English, felt safe. She is now working and living her life well. Being a doula is amazing but the poverty we see as Neighbourhood Doulas hurts." **Karolina Hardy**

When the Doula UK Access fund was closed, we received some funding from the Westway Trust and were able to help more women.

After that more funding from the Lottery and now funding for the next three years from the Lottery Community Fund has been secured.

Training by Birth Companions helped us get our bearings as a young organization. The organisation has grown since it was established in 2017. The amazing team of 32 doula volunteers have supported approximately 90 women to date. The volunteers that work with Neighbourhood Doulas are from all areas of London, all walks of life and all corners of the world.

Neighbourhood Doulas was set up with the aim to alleviate stress, loneliness and poverty in birthing women who find themselves in difficulties. Most Neighbourhood Doulas clients come from countries outside of the UK from various cultural and racial backgrounds. Many of our clients are women with trauma, sexually abused women, women who have been trafficked, asylum seekers, women with FGM.

'I as a white woman have noticed very early on that women of colour get treated differently to how I get treated. I know the vibration of less-worthiness when I start talking and people realise I am from eastern Europe. I am a well-educated and quite confident woman, but this has taken a toll on me in the 30 years I have lived in the UK. I have observed this with the women we work with time and time again.

I am aware that my presence makes things easier for the woman but still there is often a feeling of disdain from the people we interact with.

Our clients often do not speak English well and are very shy and insecure. Some mothers commented on the fact that when I come with them, the social workers or midwives behave differently than when they meet them on their own.' **Karolina Hardy**

'Neighbourhood Doulas are there to protect the woman's birthing experience and make it less stressful.

We don't want to combat and fight, our aim is to create peace and friendliness around the women we work with. We are very aware that NHS Midwives are currently under a lot of pressure and we have mostly met wonderful midwives.

We know that if a situation which is incorrect arises, we can leave the birthing room and speak to the duty midwife to ask her for a different midwife. We try to diffuse situations of potential conflict by being warm and friendly. We have a lot of empathy for the NHS midwives and how stressful their work is. We are there to form a warm team around the birthing woman. If things escalate however, we do make a formal complaint on behalf of the mother afterwards.'
Carolyn Ouladzahra

'A mother, who wears a hijab, was 42 weeks pregnant and her labour was just starting. The doctors were insisting on an induction which was unnecessary at that point. She declined as she knew she would be in active labour soon, this was her third baby. She was treated as a trouble maker. When she came to the hospital for monitoring, the doctors were very disrespectful.

When her labour began the midwife made no eye contact and no physical contact. She was cold and distant the whole time. After the baby arrived the mother had to have stitches, the new midwife performing the procedure made inappropriate jokes.

I felt helpless and very sad that the birth of her baby had to happen in such an atmosphere. I was sure this was because of her race and religion. They left her to bleed for a long time without examining what was happening. When we wanted to complain about the experience her medical notes were nowhere to be found. We went to a lawyer who was shocked when we told her the details of the story.'
Karolina Hardy

Neighbourhood Doulas volunteer and Doula UK member Hayet Hbabed recounts her experiences:

'Once I was working with a client from Egypt who spoke fluent English. Myself, her mother and sister in law went with her to a west London hospital. We were all wearing Muslim head covering but we all spoke English fluently.

The client had specific needs and was declining vaginal exams due to previous trauma. She also wanted to stay in her bubble and remain in a comfortable position, which the hospital staff were not comfortable with because of the baby's heart rate. Nevertheless, they spoke to us saying "here in the UK we do this and this and this..." like it was an obligation. I also advised the midwife we have a birth plan drawn up by the client that she can read herself to understand how she prepared for labour and birth.

Then she asked if it was in English whereas we were already speaking English for a while. She was rude and her tone of voice and the way she looked at us were not nice. She was also whispering to the other midwife about the fact my client has her pregnancy follow-up done in Egypt until the third trimester...

The second instance was with another Muslim client who had a face covering. I was with her and another birth partner. She was sick in labour and she was left being sick in triage by herself (only one birth partner allowed) for three hours while waiting to be assessed. While vomiting she was looked upon with disgust and she was refused to have us both as support in triage but equally was told there was no midwife or doctor available to assess her. We were left to clean up the vomit ourselves. I can only say by their looks they were not pleased when we asked to be assessed by a female not a male. It is common that women are refused to be seen by a female, the staff claiming there is only a male doctor or midwife on the ward.'

We live in times where the political atmosphere doesn't really improve the understanding various cultures have of each other. As tensions in the world rise, they do play out in the birth rooms also. We at Neighbourhood Doulas can only hope that by offering friendship, warmth and empathy we can improve the atmosphere in which babies arrive on this beautiful planet.

If you would like to volunteer for Neighbourhood Doulas, please write to:

karolina.hardy@neighbourhooddoulas.org

Language for inclusivity – lesbians and bisexual women

DR MARI GREENFIELD, DOULA UK MEMBER

Doula clients include lesbian and bisexual women, and there will be lesbian and bisexual women amongst your fellow doulas. Doulaing rightly centres care on the pregnant person, but we also include the whole family. Lesbian families are often invisible in maternity policies (which may talk about partners and dads as though they were interchangeable), and also in maternity research, where it isn't even yet the norm to ask about sexual orientation as part of equality monitoring.

Anecdotally, lesbian birth mums report experiences of poor care, especially in terms of genital checks after birth, and breastfeeding support. And lesbian co-mothers report feeling excluded by both policies and the care offered. As doulas, when we are invited into such an intimate and vulnerable time in a family's journey, it is important that we make sure that we can offer an inclusive service, which respects different family formations and identities equally. As doulas we also take care of one another, and ensuring you include and respect your lesbian and bisexual doula colleagues is a key part of creating a safe and welcoming doula community. This article gives 9 top tips for ensuring the language we use promotes inclusivity.

1. Don't make assumptions. Sometimes it is obvious that your client or fellow doula is a lesbian – if a client's female partner is present at the interview for example, or if they talk about their wife. But on other occasions, you may not be aware of someone's sexual orientation. Single lesbian and bisexual women in particular often report that maternity services make an assumption that they are heterosexual. 'Coming out' to people repeatedly can be emotionally fraught, because you always have to prepare for a negative reaction. It can also damage a relationship that is just forming, as the person realises that you have fundamentally misunderstood something major about them. As doulas, it is important that we do not add stress to a client by assuming heterosexuality in the absence of them coming out to us.

2. Listen carefully and mirror language. If you are going to avoid assuming someone is heterosexual, you need to listen to what they say about their partner, or their ex, or their baby's conception, and mirror that back. If a lesbian couple have not disclosed how they conceived, do not refer to 'the clinic' or 'the donor', as this may not be accurate.

If someone is talking about a partner and saying 'they', copy that, rather than assuming heterosexuality and saying 'he'. Case study 1 gives an example of how damaging it can be to get this wrong, both for the parents and the baby.

3. If in doubt use gender neutral terms. Phrases such as 'do you have a partner? Will they be at the birth?' are much more inclusive than 'will your husband be at the birth', and signal that you are aware clients may be in a same-sex relationship.

4. Use gender neutral terms on your website, leaflets, posters, or in other promotional material. As above, this avoids anyone feeling excluded by your services before you have even met them. Take a look through all your forms – do they refer to dads, or to partners and/or dads?

Case study 1 - Branwen and Ffion

- Branwen is pregnant.
- Ffion is intending to fully breastfeed, and has followed a lactation protocol.
- They knew antenatally that their baby would need to spend a few days in hospital after the birth.
- But Ffion is only allowed in during visiting hours. They complain about this.
- The NHS replies to their complaint, upholds the policy, and states 'fathers are not allowed on the ward overnight'.

5. Be aware of bi-invisibility. Bisexual people are often categorised by who their current partner is. A woman in a same-sex relationship may be a lesbian, but she may also be a bisexual woman. Equally, a client might have a male partner, but be bisexual. Research shows that invisibility can have a negative effect on self-identity, and that bisexual mothers are especially vulnerable to this (link.springer.com/article/10.1007/s11199-015-0503-z)

6. If you need to know, it is okay to ask. If you aren't sure about something relating to a client's sexual orientation, and you need to know it to provide the best service to them, it's okay to ask. For example, if a baby was conceived through IVF, a client may be offered more scans than usual, and may be offered an earlier induction than a client who conceived using donor sperm not involving IVF. If circumstances arise in which this piece of knowledge might affect how you doula, it is absolutely fine to ask questions. It is often a good idea to briefly explain why you have asked that question too, to avoid the next barrier to inclusion…

7. Don't be nosey. Whilst it is fine to ask questions that you need to know the answer too, it isn't fine to ask about things you don't need to know. Case study 2 demonstrates the impact that this can have.

Case study 2 – Pelagia and Renee

- Lesbian couple, having their first baby.
- During labour a new midwife comes into the room, and asks 'so, how did THIS happen'?
- This is the story they still tell about their birth 15 years later.

8. Ensure your knowledge is up to date. You don't need a detailed knowledge about every possibility to be a great doula for a lesbian couple, but you do need some basic knowledge about conception choices and postnatal choices, such as induced lactation. Basic knowledge of the legal situation for lesbian couples in labour and after birth can also be useful, as it is different to that for heterosexual couples. It can also be useful to have an idea of which books and resources that you might suggest make assumptions of heterosexuality, and which don't. You could also compile a reading list of books about lesbian pregnancies or families that you can share with clients.

9. Avoid using problematic terms. Unintentionally, some birth workers (including doulas) can use terms which cause distress. Below are two examples – there are many more. Think about the language you might use that could be problematic.

Case study 3 – Sophie and Mary

- Medically necessary IVF pregnancy, using Sophie's egg, with Mary carrying the baby.
- But UK surrogacy law is based on genetic fatherhood.
- Lesbian surrogacy is therefore not legal.
- Sophie legally has to be Mary's egg donor, Mary cannot be Sophie's surrogate in law.
- This means that Sophie has to sign all her parental rights away in order for treatment to proceed.

- 'Doula-wife', used to indicate a doula you have a friendship and informal or formal business partnership with. Many lesbian and bisexual women fought for years to have the right to call another woman their wife, putting their jobs, their right to live with their children, and their personal safety on the line. The term wife is therefore very precious to some lesbian and bisexual women, and using it in this way is offensive and appropriative. Using the term wife may also lead others to assume you are a lesbian, and they may then treat whatever you say about lesbian and bisexual women as being an insider view, which can be problematic. Also, even though same-sex marriage is now legal, inequalities with heterosexual marriage still exist. One area of inequality is that a woman cannot divorce her wife for having sex with another woman (only with a man). This inequality arises from a view that sex between women is somehow not real sex, or that sex between women cannot be defined. By using wife to refer to a non-sexual relationship between two women, you are furthering this view.
- 'Real mum', used to ask or define which partner from a lesbian couple gave birth. If two women have chosen to have a baby together, they are both real mums. If you need to define which one gave birth, you can ask that question, or give that information. The idea that someone is only a real mum if they gave birth can be upsetting to lesbian mums who did not give birth, and also to adoptive mums. This idea can also lead to problems for lesbian couples accessing maternity services, as shown in case studies 1 and 3.

Mari is a lesbian birth mum and foster mum, and has been a doula for almost 10 years. She now mentors new doulas, and works as an academic, investigating pregnancy and birth choices, traumatic births and queer pregnancy, birth and parenting at King's College London.

Useful references:

He's not the mother, AIMS article on LGBT birth and language
aims.org.uk/journal/item/hes-not-the-mother

Birth beyond the binary, AIMS article
aims.org.uk/journal/item/non-binary-birth

Mothers and others, academic editorial addressing the invisibility of lesbians and trans men in maternity services
tandfonline.com/doi/full/10.1080/02646838.2019.1649919

'My ambition is that England is the safest place in the world to be pregnant, have a baby and transition to parenthood.'

The Doula interview

Professor Jacqueline Dunkley-Bent

Professor Jacqueline Dunkley-Bent was appointed England's first Chief Midwife in March 2019. She has been tasked with improving care for new and expectant mothers and their children and promoting safer births as part of the NHS Long Term Plan. Jacqueline has previously been the Head of Maternity, Children and Young People at NHS England and is visiting Professor of Midwifery at King's College London and London South Bank University. Her experience has seen her leading and influencing national maternity standards and guidance.

Following the results of the most recent MBRRACE report; are you shocked or surprised by the results?

The recent results from the MBRRACE report on health inequalities in maternity care, especially for those women and families from a Black or Asian background were shocking. Anyone who uses maternity services in England deserves world class care, whatever their background and I have made this one of my priorities as England's first Chief Midwifery Officer.

What do you think needs changing in the system to address these issues?

The one thing that can address this is for women from BAME or deprived backgrounds to receive Continuity of Carer, that means seeing and building a trusting relationship with the same midwife during their pregnancy, birth and postnatally. The NHS Long Term Plan that was published in January 2019 commits to ensuring that 75% of women from a BAME or deprived background receive continuity of carer. This will ensure that the women who will benefit most from this care will see their outcomes improve.

What can be done to change the unconscious bias that seems to have infiltrated the care of BAME women?

We need to make sure that BAME women and families have the opportunity to share their experiences of maternity care with maternity staff and commissioners and co-produce services together through effective Maternity Voices Partnerships. We also need to ensure that there is a genuine offer for maternity care that is personalised to the needs of the woman, and her needs and experiences are listened to, acted upon and that she truly benefits from relational, informational and management continuity. The access to and discussion regarding evidence-based information should be relayed consistently to all women regardless of background and socio-economic status so that they can make their own informed decisions about their care and be supported in those decisions.

As England's first Chief Midwifery Officer, and a woman of colour, do you think your role will bring about change?

My ambition is that England is the safest place in the world to be pregnant, have a baby and transition to parenthood. Quality of care including safety, midwifery leadership including workforce and perceptions of midwifery including the contribution that midwives make to saving lives will be a key focus of my role. All women have the right to receive good maternity care This includes our minority groups such as BAME women, women living in deprivation, lesbian, bisexual and trans people, women from the gypsy and traveller community, sex workers, refugees and asylum seekers. We are working hard to ensure all women and families have positive experiences of NHS maternity care and when needed neonatal care.

'Anyone who uses maternity services in England deserves world class care, whatever their background'

I also want to refresh the role of the midwife and make it clear that midwives have a pivotal role in the health of our nation and can save lives. I am working hard to ensure we fill the 3,600 new midwifery places and promoting midwifery in the NHS as a career choice to children and young people considering their futures. We are also working hard to ensure midwives are well supported with the Professional Midwifery Advocate (PMA) role, which means midwives always have a place to access the support and guidance they need. Finally, we are seeing more midwives working in continuity of carer models and as a result working more autonomously, caring well for each other and the women they support. 2020 is international year of the nurse and midwife and I want to celebrate midwives as well as everyone else who works in maternity to highlight the fantastic work everyone is doing. There are some exciting initiatives next year and I look forward to sharing them with you.

'The one thing that can address this is for women from BAME or deprived backgrounds to receive continuity of carer'

How, as doulas, can we help when we witness prejudice towards our BAME clients in hospital, without causing tension in the room?

I think the best way to deal with this is to be as practical as possible. If you see help provided for another family but not for your client, ask staff if your client can receive that support too. If staff are making assumptions about pain relief and you feel it might be because your client is BAME, encourage the woman you are supporting to voice her needs. Consider joining your local Maternity Voices Partnership to be involved in local improvements to maternity care. You can find your local MVP here nationalmaternityvoices.org.uk.

'encourage the woman you are supporting to voice her needs'

Looking at the state of maternity care across the UK, what gives you most joy and what areas give you most concern?

It is an absolute privilege to lead the midwifery profession in England. What gives me most joy are the tens of thousands of midwives giving women and their families personal and safe care every day while at the same time working to make our service even safer than ever.

What concerns me the most is that we stay on course to meet the 50% reduction in stillbirths by 2025 from the ambition that was set by Government in 2016. Through the full rollout of the Saving Babies Lives Care Bundle (england.nhs.uk/mat-transformation/saving-babies) and the increase in women receiving Continuity of Carer, women and babies should be accessing some of the safest maternity care in the world.

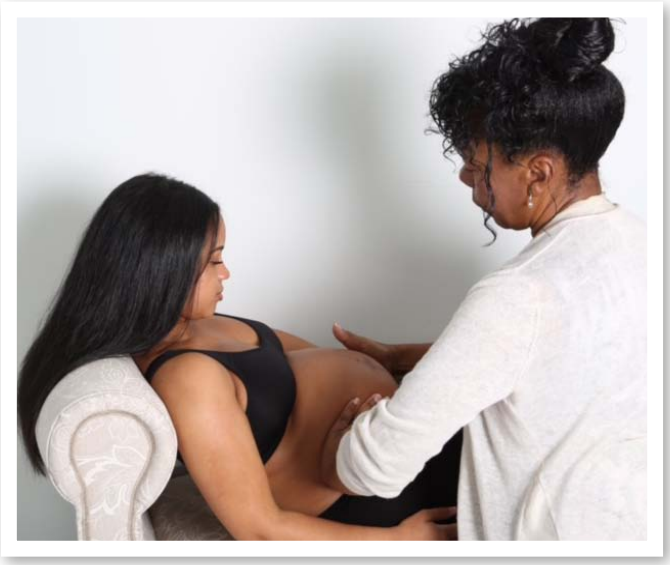
Many Doula UK doulas are involved in their local Maternity Voices Partnership (MVP) as a way to positively influence local maternity policies. Do you think MVPs are an effective force for improving maternity care?

I think MVPs, women and staff working together, are central to improving maternity care. Not just in the representation they give women and their families throughout the maternity system, but also facilitating co-production between the people who use maternity services, staff and commissioners which leads to women-centered, personal and safe care.

Photograph by Benash Nazmeen, midwife

As doulas we have a unique perspective, observing the huge variables in maternity care between different hospitals. Given the overarching responsibility of your new role, is this something that you hope to address?

Unwarranted variation in the provision of maternity care is something that the NHS takes very seriously. The development of the 44 Local Maternity Systems across England has brought together local providers of maternity services.



This means that across each LMS, services are becoming more joined up and women can more easily make choices about where to access antenatal care, which birth setting to plan for and how they will be cared for in the early postnatal period.

'Women's choices should be respected during the maternity journey'

I am one of the national Maternity Safety Champions and we have Maternity Safety Champions at regional and provider level. This network of professionals strives to improve the safety of maternity and neonatal services. We also have a brilliant service user with lived experience of baby loss, and a number of the baby loss charities, helping us at a national level to make safety improvements across our maternity services.

The NICE guidelines and Better Births recommend personalised care and yet, as doulas, we still see women's choices not being respected. Why is there such a disparity between trust guidelines and actual practice?

Women's choices should be respected during the maternity journey. This is more likely to happen when they receive care from a midwife they know.

The more women take responsibility for their bodies, their babies and their births, the more they seek out evidence-based information on which they can make informed choices about their maternity care.

Midwives and obstetricians should be supporting women in the choices they make, ensuring they have been given the benefits, risks and alternative options for each decision a woman needs to make and that she is fully able to make that choice. We also know that women experiencing Continuity of Carer will be better supported overall because of the relationship they will have developed during pregnancy with a known and trusted midwife and if obstetric care is required, also with an obstetrician.

One of the key aspects of the Better Births report from 2016 is the need for more choice and personalisation of maternity services and we are working to ensure that by 2021 all women have their own personalised care and support plan.

Triage has largely become a standard admission area, and yet the majority of these areas have not been designed with the needs of labouring women in mind. Can there be a move towards a more labour-friendly design?

This is a perfect opportunity for Maternity Voices Partnerships to bring together women and staff, using the 15 Steps for Maternity toolkit, to assess any areas used for triage. Triage is meant to be a space where women can be assessed and a plan made with them about the next step, Triage can be assessed as to how welcoming, clean, friendly and calm it feels to be there. In labour for example, we know quiet, calm and dimly lit areas are conducive to women feeling safe and labour progressing smoothly so MVPs can be instrumental in shaping this space.

Marking 18 years of Doula UK

HILARY LEWIN

18 years is a milestone and as any of you who have adult children know, whilst officially adult there is still much work to do...

I am filled with such respect for all those who have shared the care of this now grown baby and it has indeed taken the proverbial village to get to where we are today. I was standing in the right place at the right time when Dr Michel Odent answered my question after one of his talks - 'No, there is no organisation, you should start one. Here is a list of women who have attended my talks and you can use my house to get going…'

I guess this was before data protection and in those days of dial up internet I was the one who made around 150 phone calls to invite women over for that first meeting in his front room. If memory serves, around 40 women showed up that day, a lot of cake got eaten, tea was drunk and plans laid. (This also set the standard for future meetings - doulas know how to make/eat cake…)

Immediately a wealth of knowledge and experience was shared and slotted into place. I got to be Chair, learnt how to send e-mails, stuffed letters in envelopes, as only a minority at that point were online, and generally was part of the beautiful process of women showing up and making things work.

Nicola Wilson regularly provided the venue for our meetings and I remember one blustery autumn when we all got stuck in the mud and had to push each other's cars out of the field.

We wanted to create an organisation to support each other, educate and support families to find the birth they wanted, hold ourselves accountable and create trainings that we might grow into a tribe that could support birthing people across the country.

That has all been achieved and so much more. I know I am not alone when I say I have made lifelong friends with many of the women from that time and continue to meet and befriend women who inspire me beyond belief with what they are striving for and creating today.

Together we have made a network, a community and I have even become a 'doula grandmother' attending a birth 28 years after being at the father's birth. As we supported the birthing mother I looked across her head into his eyes and remembered being in the exact same position as he was born and I looked into his father's eyes.

Doula UK is 18, we have grown our children in this time and our grandchildren. We have lost loved ones along the way too, partners, parents and babies. We have seen women doula each other through death, divorce, loss and of course celebrated each other's growth and success. We have created a community that supports each other as well as the families we touch.

In this time we have seen movements like #Metoo grow, books written, projects created. We have educated people about their fundamental rights, learnt about our own self-care, got out of our comfort zones and learnt about boundaries.

We have learnt that past trauma can affect a birth, that birth can also create trauma for those doing it and those watching it and we are forging solutions for each story as we meet it. Together we have a vast network of knowledge and power. Doula UK is a resource where all this can be shared.

Pregnancy is the intersection for so much learning; first there is the 'how to get pregnant' which is not as straightforward as might be believed, then the 'how to be pregnant' followed by 'how on earth shall I give birth' not to mention the 'how do I actually keep this child alive to 18'.

It takes a village and every village needs it elders, its warriors, its thinkers, mediators, herbs woman, plants woman, builder, inventor and everything else that makes life rich. Doula UK has a place for each one of us.

We are a community of change agents, whether it is one to one with clients, being involved in local groups supporting young families, writing the books that everyone should read, standing up in all manner of settings patiently explaining what is important and why it matters. A doula brings so much more than a helping hand to someone's door which may be why it is so difficult to define what we do.

We are a mighty oak which is growing from a tiny seed and we have to keep planting the acorns so the wild woods are here for the babies that are born tomorrow and the next year and the year after that.

Doula UK has come of age. I am so proud to have been there at the beginning and so in awe of the wonderful container which has grown. Through toddler tantrums, sulky teenage doldrums, baby steps to running free, Doula UK is officially an adult. We still need to support growth but she is up and away and we can all be proud of how she has grown and know that just by being here we are each responsible for her future and the future of birth in the UK.

Happy birthday Doula UK, thank you for all you gave me personally and for everything you have done across the land. I wonder how many thousands of lives we have touched collectively and how many acorns we have planted… Let's not stop here.

Hilary Lewin is one of the founder members of Doula UK and has since gone on to become one of the first UK practioners of Arvigo© Therapy.

She is currently writing a book about the menopause journey which will be out spring 2020 and loves nothing better than bringing her workshops to a kitchen table near you.

hilarylewin.com

Birth story

UDUAK UDONDEM, DOULA UK MEMBER

Becoming a doula really came out of my own birthing experiences, highlighted by the differences between my first birth in a birth centre compared to the homebirths of my second and third babies. For my preparation and labour, I explored alternatives to the traditional antenatal classes led by midwives, which meant working intuitively, choosing the right support people, applying complementary medicine, herbs and the power of breath for labour.

Although this initiated my journey into motherhood in an empowering way, what seeded in me the importance and power of the right kind of support was my mother's presence at my first birth. Her calmness and stillness around the turmoil and craziness of my labour, I still remember now. She was gentle and nurturing; giving me the space to grow into my role mentally along with the physical changes of my body. Her words were not intrusive to me and yet when I asked with concern, worry or fear, her answers were simple and direct which helped and kept me going.

This experience helped me to understand how the presence of a doula is just as powerful as having the right tools.

> " Her calmness and stillness around the turmoil and craziness of my labour, I still remember now. "

My mother became pregnant with me in Ghana; miles away from her mother, family and friends in Nigeria. She befriended a woman shortly after her arrival with my father in Ghana. Her name was Uduak and she supported, cooked and just was there for my mother in her time of need, during her pregnancy, labour and birth. I am very fortunate to be connected with traditional birthing and postpartum stories and knowledge from my mother and elders around me. The support my mother was given during her labour and my birth was a key example of what she received and passed on to me and which I was then able to draw on as I began my journey to become a doula.

I stepped back from work as a birth doula in 2014 to prepare for motherhood for the third time; this time round as a single parent which had its own obstacles from others and myself. I overcame what I thought was fear and judgment that had overshadowed me in not recognising my own power in deciding and wanting to become a mother on my own.

I grew up with many cultural conditions of who and what you should be as a woman and choosing to have a baby alone really helped me give birth to who I am meant to be.

With my knowledge and experience as a birth doula, I intentionally brought many wise, loving and empowering lessons to this pregnancy as well as no expectations at all. I was open to the fact that labour and birth is changeable at any time. Having my third baby at forty, I was considered high risk and was presented with 'possible challenges' such as placenta previa, high blood pressure and birth defects.

I didn't realise how comfortable and confident I was in going with the flow. I chose to have limited interventions with less possible outcome conversations to maintain my confidence and trust in my body's process to labour and birth accordingly.

> " I was learning not to be 'superwoman'. I was learning to be me. "

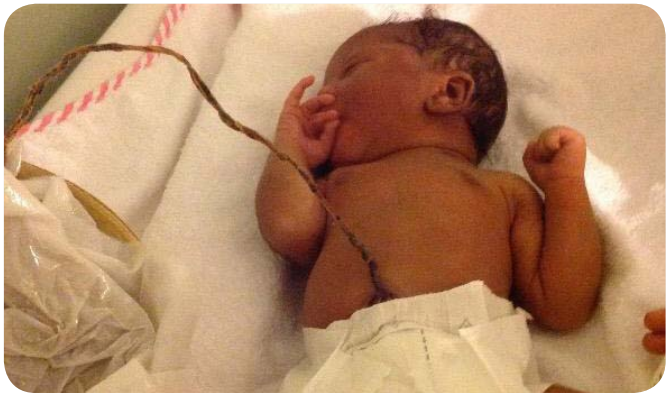
I decided to keep it simple and light. "What will be will be". I was supported, safe and comfortable, with the intent to really enjoy and have fun in my pregnancy.

I went on to have a wonderful homebirth and started my postnatal period with a lotus birth - another way to slow down and connect in a way I hadn't before.

I was learning not be 'superwoman'. I was learning to be me. I began to understand and really appreciate the need for practising self-care in my postnatal period and why it was so important now.

A lotus birth is when you have your baby vaginally, or sometimes also by caesarean, and the placenta is still attached to the baby until it naturally falls off. I thought it would be a beautiful thing to experience; to acknowledge the power and wonder of the placenta.

I didn't tell my family about having a lotus birth because I didn't want their opinions and questions to influence my thoughts. I just wanted to focus on my plan and was lucky to have holistic midwives that supported my wishes.



My daughter was born at home and I birthed my placenta. My midwife put the placenta in a small bowl; they didn't interfere with it, they just left it alone and looked after the needs of my baby and myself.

Hours had passed; family and friends had now left me alone with baby and placenta in bed. Alone, I could now rest. I began to process my whole journey to now and started to connect with the placenta. Sitting in bed and just looking at the placenta, I held it carefully, feeling its energy and processing how wonderful and amazing it was; acknowledging its journey and the role it played over the nine months.

I was so thankful for what it had done for my baby. Everything felt a lot more heightened and I was more sensitive to the gratitude of everything around me.

The process of preserving the placenta was the next stage and it can start with washing the placenta (if you wish to) and using herbs, flowers and salt. When I had the energy, I placed my placenta in a wooden bowl and covered it with rosemary, lavender, rose, calendula and Himalayan salt. I waited patiently until the cord dried and eventually broke and separated. The placenta detached from my daughter after three days - some last for ten days or more. Babies may kick off the cord from their navel as they get more active. My daughter's response to the cord detaching was fine.

A rose bush was the final resting place for my daughter's placenta; nourishing the earth and a place for me and my daughter to be reminded with the blossoming of its flowers each year. You can plant a tree, flower, bush, whatever you feel is right for you.

I applied other elements of postnatal recovery from the very traditional African, to cultural practices such as belly binding and yoni steams, and other elements which worked for me personally. All those things were also key in my recovery.

Experiencing a lotus birth was a really good start to my postnatal period. It helped me feel a lot more grounded in myself, which enhanced my bonding experience with my daughter. There were times when I felt a bit ahead of myself.

I could recognise that this was not right for me at this moment because I had given myself a good foundation of recovery and rest and self-awareness.

I could think okay, this is not normal, I need to slow things down, just focus on what is important – my baby and me.

In my opinion the first two years of having a baby is really your postnatal period - a wonderful time of connecting, nurturing, healing, and rejuvenating. As you go through this timeline, embrace the changes in your mental and physical body as well as the development and growth of your baby. Your hormonal dynamics are changing and a lot of energy is being used up in this process.

It is important that you take the time for yourself to strengthen your bond with your baby, your family and your new journey as a mother; to really understand and learn and process how important you are in this time.

Today, it may not be easy or sustainable for a lot of women to extend their postpartum period for up to two years. Connecting and understanding your body as mother, wife/partner and as yourself takes time.

Whatever time frame you have, with support from family and friends or even a postnatal doula, you can regain your health, wellbeing and embrace the role of new mum to your baby(ies).

I believe experiencing a lotus birth made that possible for me. It's made my experience as a mother this time round different, which I needed. I understand my body when it's not working well and I recognise it in other postnatal women, so it has really helped me in my women's wellness practice as a doula and therapist. I have a deeper understanding and insight into my clients' postnatal recovery, listening to the language and needs of both postnatal and expectant mothers; empowering them on through their journey to wellness and balance.

Uduak Udondem lives in north west London with her three children. Two boys and one girl. Uduak is a birth doula, Arvigo practitioner and pregnancy massage therapist. She is passionate about encouraging women to embrace their changing bodies so they can thrive and heal during those changes.

uduak.co.uk

The ceremony and therapy of the encaderamiento (closing bones or hipping)

DR. ROCÍO ALARCÓN G. (PhD ethnopharmacology; curandera)

In most cultures around the world, motherhood and the postpartum period are important spiritual, social, emotional, transformational events. The significance of these events and the care required has, in each culture, led to the development of a considerable amount of knowledge, customs, rituals and other cultural practices, driven mainly by midwives, who are known by different names according to the community or group where they belong.

Ecuador, located in South America, is one such culture which is home to different ethnic groups and where the practice of encaderamiento has been practiced for centuries. It is considered ceremonial in nature.

The teaching of encaderamiento involves several activities that begin with the transmission of the knowledge of the grandmothers, and the spiritual preparation of the woman who is learning, through practice and oral explanations and then joint practice with them. In my particular case, the ceremonial and practical process has taken me 50 years of training with my ancestors.

Within the lineage and wisdom of my family, those who practiced midwifery and encaderamiento for hundreds of years in Nono (the town of my grandmothers), it was important to understand that the learning of encaderamiento, is not massage only. The practice consists of several ceremonial events for the physical and spiritual bodies. It includes the learning of plants that are required to be used after delivery. These plants have medicinal properties: analgesic, soothing, ritual and symbolic.

Description of the encaderamiento/hipping ceremony

It begins with a phase of purification of both the practitioner and the person to receive the healing and benefits. The person who has gone through the birth requires a full spiritual, emotional cleansing and purification. In this process different plants and resins are used that can aromatize and remove energy forces of different frequencies and that could affect the person during childbirth. The infant is also supported to receive a high frequency energy vibration from both the mother and the person performing the treatment.

Then comes the movement and physical technique of encaderamiento which is called ‘manteo’ and which involves rhythmic movements using a blanket known as a ‘manta’. In my family we use marked rhythms of movement that are numerical: 1.1 or 2.2 etc. This relaxes the person and stimulates the bloodstream to go to the places where the manteo is performed.

'Closing the bones' – a student's experience

EVA BAY GREENSLADE, DOULA UK MEMBER

When I first heard about ‘Closing the Bones’, I booked onto a training course in the UK and loved it - it was a beautiful experience and my body felt like new in the days following the practice. I used the practice treatments on myself as a way to close my body after my four babies but also to seal the idea of becoming pregnant again and to look to the next cycle of my life - it was powerful! I did, however, leave the training with some concerns about what we’d done, what I was missing, what we were learning, and how I could bring it to clients, or if I even should?

I had been learning spiritual healing and trance healing for many years and felt that it was the shamanic and cultural understanding that was likely lacking in the training I did. I knew I wanted to meet the healer who taught the western teachers, to find answers to my questions. I was lucky to meet Dr. Rocío Alarcón from Ecuador, and I was blown away.

The first thing Rocio said was: ‘*Hipping*’ (as she calls it) *‘is a shamanic practise. You are shamans when you do this work, it is ancestral knowledge’*. Rocio spoke of the maternal lineage and how each of us is affected by our maternal lineage. Part of this work is to cut ties and heal ancestral wounds, so a mother can heal and not pass it to her baby, ideally before the mother is even pregnant. Rocio had incredible knowledge of the human body physically and energetically. She showed us how to see the energies in a woman’s body, how to help the body move it around to clear it, then help the body close itself and heal following birth. Rocío was clearly sharing sacred teachings from her grandmothers.

With the help of the hands, certain movements are made in the pelvic area to stimulate the bones and cartilage and ligaments of the pelvic area, to return to their normal position. Then to raise the lower organs - uterus, bladder and cervix. These movements stimulate the muscles surrounding this area to take a firm tone and normal position.

A blanket or girdle is then used to girdle (support) the woman's hips.

There is a period of 40 days after delivery in which to perform this ceremony.

The person who practices it is usually a person who learned from their ancestors whether they are grandmothers, aunts or mothers. In other words, it is a knowledge by ancestral lineage. Within the same family, there is a line of knowledge that is transmitted through practice among related women.

Benefits

This ceremony allows the woman who has given birth to regain communication with and recognition of the pelvic organs, so allowing the woman to adapt to a new condition of life safely and without trauma. It ensures the recovery of muscle and bone strength, that the pelvis takes a normal posture and allows the reconnection of the most important organs in this area. It stimulates the production of what our ancestors called 'divine fluids' (hormones and better milk production for the infant).

Hipping also allows your body to be converted into an energy center that creates security around carrying your child and the process of breastfeeding. It also prepares the body for its sexual life without fear or pain after childbirth.

The future of encaderamiento/hipping

Currently, due to the influence of Western medicine and socio-economic factors such as immigration which see young people seeking out alternative activities or legal status, this practice is being lost. There are simply very few women who practice it and can instruct in this process.

This practice deserves to be reintroduced in different places and communities again, in order to guarantee health and well-being to women who require deeper support in the face of the changes that they must face once a new being comes into the family.

However, it is important for the new generations, who learn in a new system, to respect and recognize that the wisdom and knowledge of our ancestors has been in the making for generations. It is not possible for trainees with a few days experience of workshops to teach and do practices that are not prescribed, or add techniques that could be dangerous. This has a negative impact on the patient, and could damage the delicate building blocks of this health system.

Dr. Rocío Alarcón is an ethnopharmacologist, ethno-botanist, shamanic practitioner, teacher and healer. Rocío has spent over 30 years working with ethnic groups in the tropical rainforest and Andes Mountains of Ecuador and in the Basque Country, Spain. She practices and teaches about shamanic healing ceremonies, using the knowledge that has come from her mother and grandmother's lineage. She offers courses and workshops in Ecuador in the IAMOE centre.

iamoe.org

I knew that this was a lifetime's work, not a series of techniques to learn in a weekend.

I met another beautiful woman, Angelina Martinez, a Partera (midwife) from Mexico. She held unique knowledge of the Cerrada tradition that has passed through her family. After a day-long gathering in London with her I was reminded again that Closing the Bones is a cultural practice, not one we can use lightly or superficially.

The biggest lesson I have learnt since spending some time with these two women is the importance of learning any spiritual, shamanic healing, or treatments from other cultures directly from the source and to keep learning from the source if you want to practice.

A doula with Native American roots said her grandmother says it takes 20 years to learn, 20 years to practise, then after 40 years, 20 years to teach. It makes so much sense.

Without training with an experienced indigenous Curandera, healer or midwife who knows the teachings deeply, we are not learning and understanding properly. We risk practising poorly, we risk damaging women's bodies, and we are dishonouring deep cultural wisdom.

We also risk cultural appropriation, by taking and profiting from sacred knowledge without understanding and acknowledging the culture and lineage from which it came.

I feel an urge to help my colleagues learn well, and protect new mothers from being practised on by people with little experience or full understanding.

We have plenty of wonderful courses in the UK to learn postpartum massage to help women, maybe this is the best route for a western woman to explore before learning Cerrada/Hipping, especially as these courses also teach anatomy, which is vitally important to understand before working on any person's body.

It's important to honour and protect indigenous cultural heritage if we have the privilege of spending time with someone willing to teach their ancestral knowledge. So find an authentic teacher, honour them and credit them for your work with every treatment.

Blessings, Aho

Eva Bay Greenslade,
Doula, shamanic drum practitioner, pagan celebrant

Book and documentary reviews

Book reviews

A Taste of Our Own Medicine by Dr Danett C Bean

This is a neat, concise book covering the concept of postpartum depletion as separate to but connected with postpartum depression. You will learn the main ways to combat or prevent it; as well as who can help and how to engage with different people and resources in the community (including postnatal doulas). It's a simple but heartfelt introduction to the physical, nutritional and energetic depletion many mothers feel postpartum, and the idea of the fourth trimester from the mother's perspective.

The book contains QR codes throughout which link to various downloads and video resources such as interviews with experts on nutrition and chapter summaries, as well as a postnatal care template checklist, all of which help to create a great sense of connection with Dr Danett (as she's affectionately referred to) and everyone sharing their knowledge. It also reinforces the clear, gentle message that this is important, accessible and helpful to all new mothers.

Dr Danett shares her own experience as a mother and draws upon her training in traditional Asian medicine and refers to Ayurvedic nutrition, Qi and energetic care as part of holistic postpartum self-care.

1.

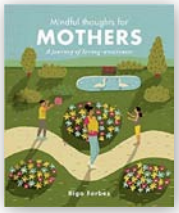
This book would be very useful for mothers feeling the need for help as there is nothing at all overwhelming about it - it's kind, intuitive and all the suggestions are easily achievable, with links to lists, recipes and simple exercises.

Motherwit: An Alabama Midwife's Story by Onnie Lee Logan, as told to Katherine Clark

Logan was born in 1910 into a large rural family in Alabama, only one generation removed from slavery. It is the story of her 40 years spent working as a "granny midwife" (a formally untrained midwife). During this period she helped poor white and Black mothers in the depths of the Great Depression, when doctors were either scarce or unwilling to help.

This oral biography gives us a realistic view of midwifery in the American south, where Logan was originally tolerated by the medical profession, and eventually became a respected and valued part of the establishment. Her faith in God and deep respect for African American folklore and tradition shine through every page. Sometimes the authentic dialect makes this a challenging read, though it captures the personality and character of Logan in a way that makes it well worth the effort of understanding the language.

2.



Mindful Thoughts for Mothers: A Journey of Loving Awareness by Riga Forbes

This book is like a big sister or perhaps more aptly a doula giving you the space and permission to reflect on the challenges of being a mother whilst providing an insight into how you can alleviate stress and cherish the precious moments by being mindful.

Riga Forbes starts by explaining the importance of valuing your own happiness and wellbeing and that by prioritising self-care you will positively impact on the happiness and wellbeing of your child. She then leads us through a pathway of motherhood from the highs of falling in love with your newborn to loneliness, tantrums, work life balance, teenage years and everything in between.

For a practical book it inspires us to be mindful through its lyrical and evocative style. And it's refreshingly un-preachy.

3.

Mindful thoughts for Mothers is a pocket sized gem of a book. It would make a lovely gift for any mother no matter where they are on their unique journey.

Seahorse: The Man Who Gave Birth by Jeanie Finley

Seahorse is an intimate, thought provoking documentary following the story of Freddie McConnell, a transgender man who gives birth. Documentary maker Jeanie Finlay follows Freddie through his attempts to conceive and to carry his own baby. We are given an insight into the huge internal conflicts he faces being pregnant as a trans-man, from the return of a softer shape, wider hips, and more emotional frame of mind as the testosterone wears off; to the later emotional ups and downs of pregnancy, worries about bringing a child into the world in such an unusual way and about being out in public as a trans-man with a growing bump.

"This is a film about me having a baby. But what I feel like I'm going through isn't me having a baby or pregnancy. It's like a much more fundamental sort of total loss of myself."

What is important about this documentary is that it is normalising of the trans experience. As a viewer you will likely come out of this with a much greater insight into some of the challenges that a trans-individual may face. In contrast to the typical commentary which is so often hostile and provocative, Finlay offers a sensitive exploration of the topic which at the same time remains honest and authentic, allowing us a window into some of the difficult conversations with family members along the way.

If we, as doulas, need any more reason to think about how careful use of language can help with client communication and inclusion, it is brought into sharp focus as we see Freddie using a pen to painstakingly correct the non gender neutral language in his hospital pregnancy and birth pack.

In this case it is Freddie's mother who takes the role of birth partner. But from the nascent idea of getting pregnant to the transformational birth experience, this will be a journey familiar to all of us as doulas, who have the privilege of witnessing our clients' growth when they become parents. The final scene is emotional as Freddy cradles his beautiful baby and reflects on how unprepared he had been. The bond between baby and dad, the birthing human, is really powerful.

"I'm a dad, I'm a parent, I gave birth. All those things are true and that's my experience."

NB. If you are wondering about the title – it is the male seahorse that carries the babies until they are ready to be released.

Hazel Nicholls competition winners

The winners of last issue's Hazel Nicholls competition are Doula UK members Jenna Rutherford and Helen Nash. Jenna wins a boob mug and Helen wins the jug!

"My boob journey ended
just six months ago,
and I haven't yet stopped,
to take a breath and go,
WOW, well done, you made it so far,
your boobs are a total star!"

Jenna Rutherford

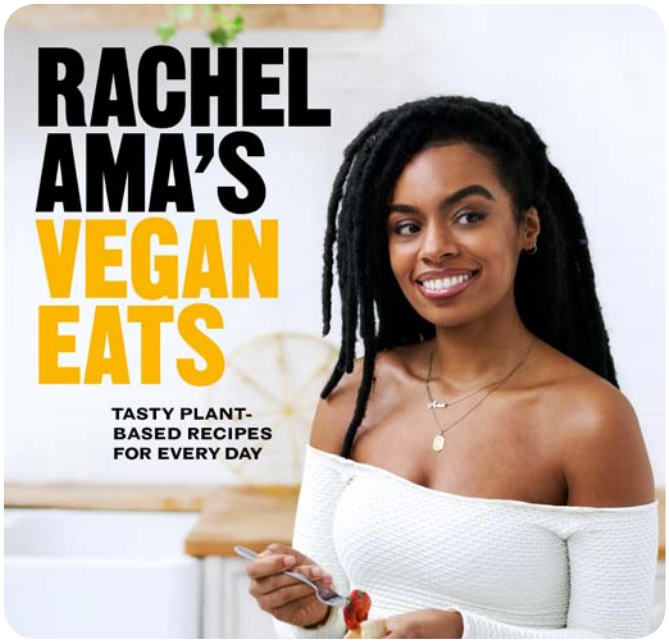
"I grew two humans with my breasts, THESE jugs would be a reminder of their awesomeness and the need to me to look after them."

Helen Nash

Rachel Ama's Vegan Eats recipes

Rachel Ama grew up in north London and launched her vegan YouTube channel in September 2017. She has since amassed a huge following on her social channels. She specialises in simple, affordable and delicious vegan recipes and her first book, Rachel Ama's Vegan Eats, is filled with vibrant, flavour-packed plant-based dishes.

Rachel is an expert on the London vegan scene but she also looks abroad for flavour inspiration, and to both her Caribbean and African roots. Rachel very much made vegan cooking her own and would take staple Caribbean recipes (inspiration from her Sierra Leonean and St Lucian roots) and make vegan alternatives still packed with traditional spices and flavours. Rachel also has a grandma from Wales so was inspired to make some British classics vegan.



Youtube:
youtube.com/channel/UCdkRT_G7eqNTytm52zMw40g

Instagram: @RachelAma_
instagram.com/rachelama_

Serves 4

My mum spent many summers in Sierra Leone,where her dad comes from, and this peanut stew was one of her favourite dishes. She usually had it with chicken, but when I made this plant-based version for her to try, she had the biggest smile on her face. This recipe is a definite winner in our house, perfect for when you want a really heart yand comforting dinner with a nice touch of spice to set your taste buds tingling. My favourite way to eat this is with plantains and coleslaw or a light fresh salad.

Ingredients

- 1–2 tbsp peanut oil
- 500g sweet potatoes, peeled and diced
- 1 × 400g tin of black-eyed peas, drained and rinsed
- ½ fresh red Scotch bonnet chilli, deseeded and kept whole (optional)
- 3 tbsp tomato purée
- 1 × 400g tin of chopped tomatoes
- 500ml vegetable stock
- 125g natural smooth peanut butter
- 200g spinach, chopped
- 1 tbsp fresh lemon juice
- Handful of fresh coriander, roughly chopped
- 2 spring onions, finely chopped
- 1 fresh red chilli, deseeded and finely sliced
- Salt and black pepper

For the paste

- 2 onions, roughly chopped
- 5 garlic cloves, roughly chopped
- Thumb-sized piece of fresh root ginger, peeled and roughly chopped
- 1 tsp paprika
- 2 tsp ground coriander
- 1 tsp ground turmeric
- 2 tsp ground cumin
- 1 tsp ground fenugreek
- ½–1 fresh red Scotch bonnet chilli (to taste), deseeded and roughly chopped
- Pinch of salt

Scotch bonnet chillies can be really hot depending on where they're from and how ripe they are. For a more gentle heat, you can place half a Scotch bonnet – deseeded but not cut up – into the stew to cook, then simply remove it before serving. This way the chilli flavour can infuse the stew but without adding too much heat. This is a great option if you are new to this quite fiery chilli pepper.

Place all the paste ingredients in a food processor and blitz into a coarse paste.

Heat 1 tablespoon of the peanut oil in a large, heavy based saucepan or shallow frying pan. Add the paste and sauté over a medium–low heat for 10 minutes, stirring occasionally and adding a little more oil if the paste starts to stick to the pan.

Add the sweet potatoes, black-eyed peas, Scotch bonnet chilli (if using – see introduction) and tomato purée and mix to combine. Pour in the tinned tomatoes and vegetable stock, add the peanut butter, season with salt and pepper and stir in well. Cover the pan with a lid and bring to the boil, then reduce the heat and simmer for 25 minutes, stirring occasionally.

Remove from the heat and stir in the spinach, leaving it to wilt in the pan for 5 minutes. To finish, add the lemon juice, coriander, spring onions and sliced chillies and check the seasoning, adding more salt and pepper if needed.

Caribbean Jackfruit Fritters

Ingredients

- 1 × 400g tin of jackfruit, drained and rinsed
- 3 tbsp soy sauce (or coconut aminos)
- 2 tbsp nori flakes
- 2 tbsp fresh lemon juice
- 1 onion, finely chopped
- 2 spring onions, finely chopped
- 2 large tomatoes, finely chopped
- 2 mild red chillies, deseeded and finely chopped
- 3 garlic cloves, finely chopped
- 1 tsp dried thyme
- Handful of coriander, finely chopped
- Handful of parsley, finely chopped
- 1 tsp baking powder
- 190g chickpea flour
- 120ml water
- Vegetable oil, for frying
- Salt and black pepper

To Serve

- Sweet chilli sauce
- 1 quantity of Kale and Griddled Pineapple Salad

Makes 8

Using clean hands or a fork, break the jackfruit into small pieces, removing any tough stems, and then place in a bowl with the soy sauce, nori flakes and 1 tablespoon of the lemon juice. Mix well to combine, then cover the bowl with a plate and set aside.

Combine the onion and spring onions in a large bowl with the tomatoes, chillies, garlic, thyme and remaining lemon juice and then add the jackfruit mixture. Add the coriander and parsley and mix well. Sift the baking powder and chickpea flour into a separate bowl, add the water, mix and season with salt and pepper before combining this with the jackfruit and onion mixture. The mixture should be slightly sloppy, so add a little more water if needed. Divide the mixture into eight and shape with your hands into small flat cakes, each about 1cm thick.

Pour a little vegetable oil into a large frying pan set over a medium heat.

Carefully place as many cakes as will fit in a single layer in the pan without touching. Cook for about 5 minutes, until golden brown on the bottom, then turn over and cook for another 5 minutes until crisp and cooked all the way through. Fry the fritters in batches, using a little more oil as needed and keeping them warm on a baking sheet in the oven on a low heat. (Make sure that the oven isn't too hot, or the fritters will dry out.) Serve with sweet chilli sauce and the kale and griddled pineapple salad.

Curry-roasted Cauliflower with Coconut Raita

Ingredients

- 1 cauliflower, broken into small florets and saving the outer leaves
- 1 tsp ground turmeric
- 1 tbsp curry powder
- 2 tbsp coconut oil, melted
- 3 poppadoms, plus extra to serve
- Salt and black pepper
- Mango chutney, to serve

To Serve

- 200g unsweetened vegan coconut yoghurt
- 2 tbsp extra-virgin olive oil
- ¼ courgette, finely grated
- Small handful of mint leaves, roughly chopped, saving some whole leaves to garnish
- Juice and grated zest of 1 lime (saving half the juice for dressing the cauliflower)

Serves 2 as a main or 4 as a side

This curry-roasted cauliflower really is amazing! The combination of the aromatic spices with the soft but slightly crunchy cauliflower and the cooling courgette coconut raita is truly addictive, especially when served with a few crispy poppadoms and some mango chutney for dunking them into. This recipe would also make a fantastic side for a curry or dhal.

Preheat the oven to 200°C fan.

Place the cauliflower florets in a roasting tin with the spices, some salt and pepper and the coconut oil, then mix everything together so that the cauliflower is evenly coated. Roast in the oven for 20 minutes, then remove from the oven and mix in the cauliflower leaves, tearing up any that look too big. Place back in the oven to roast for a further 10 minutes until everything is soft and slightly charred.

Meanwhile, mix together all the raita ingredients in a bowl, season with salt and pepper and set aside.

Remove the cauliflower from the oven, add the lime juice (reserved from making the raita) and crunch the poppadoms on top. Serve with the raita, mango chutney and poppadoms and garnish with the whole mint leaves.

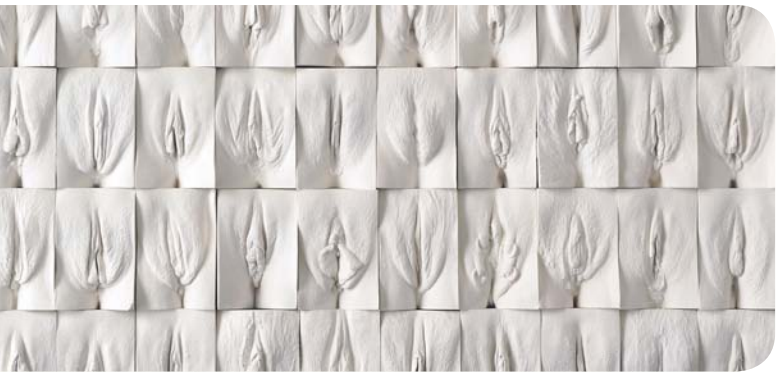
10 minutes with...

FLORENCE SCHECHTER

Florence Schechter is the director of the Vagina Museum. She founded it in 2017 when she discovered there is a penis museum in Iceland but no vagina museum anywhere in the world, so she sought to change that. She has a BSc in biochemistry from the University of Birmingham, UK.

If you could give one piece of advice to a woman worried about the aesthetics of her vagina, what would it be?

Play this game - go have a look at the art piece "Great Wall of Vagina" which is 400 casts of all different kinds of vulvas, and try and find one that looks like yours. You'll probably find at least five. I promise, your vulva is normal and beautiful because all of them are.



What is the most interesting fact you've learnt about the vagina?

During your reproductive years, it has the same pH as wine. I knew there was a reason I loved pinot grigio so much.

If you could feature just one artifact in the Vagina Museum, what would it be?

The Kilpeck Sheela Na Gig:
sheelanagig.org/wordpress/kilpeck

What is the key to feeling body/vagina-positive?

I wish there was one. It's a long road to self-acceptance, and a constant choice to love yourself. Anyone who tells you there is a quick fix to feeling good about yourself is a snake oil salesman.

What are some common misconceptions about female genitalia?

There are hundreds! The myth that it will always hurt the first time you have penetrative sex is one that really frustrates me.

Vagina, vulva, fanny or cunt?

All of them!

If you could make one change to our current sex education system what would it be?

Make it pleasure-inclusive. So often we teach people about the dangers of sex without telling them the reason most people do it...

If you could live anywhere in the world where would it be and why?

Probably London, I love it here.

Tell us about a day that changed your life.

The day I started the Vagina Museum!

Who do you most admire and why?

So many people! Right now, I love Greta Thunberg - I love how she speaks truth to power.

What makes you happy?

Cuddles with dogs.

How would you define feminism in 2019?

Openly inclusive and change making.

If you could grab a quick coffee with your 15-year-old self, what would you chat about?

Probably about how she shouldn't be too disheartened when life doesn't go to plan - better things are on the way.

The Vagina Museum opens in London on 16th November 2019. vaginamuseum.co.uk

"The Great Wall of Vagina is a multi-panelled artwork consisting of plaster casts of four hundred women's genitals. It is intended to grab people's attention, using humour and spectacle, and then educate them about vulvar variation. For many women their genital appearance is a source of anxiety, perhaps not realising that vulvas and labia are as different as faces, and whatever they have down there is normal. This sculpture intends to quell that anxiety and combat the worrying rise of cosmetic labial surgeries. It's time our society grew up around these issues and I'm certain that art has a role to play."

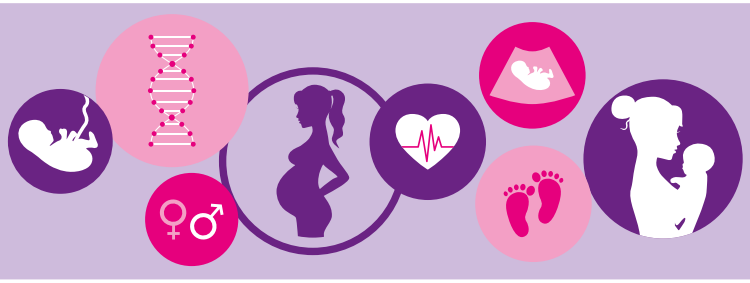
Jamie McCartney

Photo of Florence Schechter:
Credit - Nicole Rixon

Title and Credit :
The Great Wall of Vagina (panel 9 of 10) by artist Jamie McCartney ©Jamie McCartney 2011

greatwallofvagina.co.uk/home

Events calendar



Date	Event	Location	Details
02 Oct	Younique Postnatal Doula Preparation	London	youniquepostnatal.co.uk
04 Oct	Red Tent Doula Preparation	London	redtentdoulas.co.uk
07 Oct	Conscious Birthing Birth Doula Preparation	East Sussex	doulatraining.co.uk
08 Oct	Nurturing Birth Doula Preparation	London	nurturingbirth.co.uk
12 Oct	**Doula UK Introductory Workshop**	**London**	**doula.org.uk**
18 Oct	Red Tent Doula Preparation	Leeds	redtentdoulas.co.uk
21 Oct	BirthBliss Doula Preparation	Liverpool	birthblissdoulacourses.co.uk
23 Oct	Developing Doulas Doula Preparation	Northern Ireland	developingdoulas.co.uk
04 Nov	Developing Doulas Doula Preparation	Godalming	developingdoulas.co.uk
04 Nov	Conscious Birthing Birth Doula Preparation	Glastonbury	doulatraining.co.uk
04 Nov	Conscious Birthing Postnatal Doula Preparation	South London	doulatraining.co.uk
04 Nov	Nurturing Birth Supporting Every Birth	Manchester	nurturingbirth.co.uk
05 Nov	Nurturing Birth Doula Preparation	London	nurturingbirth.co.uk
09 Nov	**Doula UK Introductory Workshop**	**Bristol**	**doula.org.uk**
10 Nov	Younique Postnatal Doula Preparation	West Sussex	youniquepostnatal.co.uk
10 Nov	Birthing Wisdom Introduction to Birth Work	Totnes	birthingwisdom.co.uk
11 Nov	BirthBliss Doula Preparation	London	birthblissdoulacourses.co.uk
18 Nov	Younique Postnatal Twins and more	West Sussex	youniquepostnatal.co.uk
19 Nov	Younique Postnatal Understanding Newborns	West Sussex	youniquepostnatal.co.uk
26 Nov	Nurturing Birth Doula Preparation	Leeds	nurturingbirth.co.uk
30 Nov	**Doula UK Introductory Workshop**	**London**	**doula.org.uk**
02 Dec	BirthBliss Doula Preparation	Watford	birthblissdoulacourses.co.uk
02 Dec	Conscious Birthing Birth Doula Preparation	Manchester	doulatraining.co.uk
06 Dec	Red Tent Doula Preparation	London	redtentdoulas.co.uk
13 Dec	Red Tent Doula Preparation	Edinburgh	redtentdoulas.co.uk
13 Dec	Red Tent Doula Preparation	York	redtentdoulas.co.uk
14 Dec	**Doula UK Introductory Workshop**	**Cheshire**	**doula.org.uk**
06 Jan	Conscious Birthing Birth Doula Preparation	Glastonbury	doulatraining.co.uk
12 Jan	Birthing Wisdom Introduction to Birth Work	Totnes	birthingwisdom.co.uk
14 Jan	Nurturing Birth Doula Preparation	Belfast	nurturingbirth.co.uk
20 Jan	BirthBliss Doula Preparation	London	birthblissdoulacourses.co.uk
23 Jan	Nurturing Birth Supporting Every Birth	London	nurturingbirth.co.uk
24 Jun	Nurturing Birth Doula Retreat Day	London	nurturingbirth.co.uk
01 Feb	Birthing Wisdom Doula Fundamentals	Totnes	birthingwisdom.co.uk
10 Feb	Nurturing Birth Doula Preparation	Brighton	nurturingbirth.co.uk
14 Feb	Every Birth Matters Doula Preparation	Birmingham	everybirthmatters.co.uk
15 Feb	Developing Doulas Doula Preparation	Cambridge	developingdoulas.co.uk
17 Feb	BirthBliss Doula Preparation	Bristol	birthblissdoulacourses.co.uk
09 Mar	BirthBliss Doula Preparation	London	birthblissdoulacourses.co.uk
09 Mar	Nurturing Birth Doula Preparation	London	nurturingbirth.co.uk
30 Mar	Conscious Birthing Birth Doula Preparation	Brighton	doulatraining.co.uk
25 Apr	Nurturing Birth Doula Retreat Day	Bristol	nurturingbirth.co.uk
05 May	Every Birth Matters Doula Preparation	London	everybirthmatters.co.uk
11 May	Conscious Birthing Birth Doula Preparation	Dundee	doulatraining.co.uk
01 Sep	NCT Doula Doula Preparation	Various	www.nct.org.uk

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The down below oil I used from about 34 weeks, I gave birth to a 8lb 1 baby with no tears no stitches and just a few grazes. I am sure it was down to the oil that I did not tear. To me it was 100% worth the money.
Hollie Kenningham

I can recommend the Due Date – pregnancy and massage oil. I have been using it for some time now on our busy labour ward and it is wonderful for back ache labours when baby is in an OP position. Also used during the second stage when baby is putting pressure on the sacral vertebrae when counter pressure relieves the ache. Wonderful scent. Midwife Ann Bentley, R.M.

www.motherlylove.co.uk

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