Doulas as facilitators: the expanded role of doulas into abortion care

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The involvement of a lay support person, known as a doula, in the labour process is a long-standing practice across different cultures and traditions. A great body of literature exists evaluating the effect of a support layperson within the labour process on maternal and neonatal outcomes. This literature demonstrates a positive association between doula support and decreased labour time, oxytocin utilisation, Cesarean section rates and need for epidural/anaesthesia.1 Given the varied benefits afforded to women through doula support at the time of labour, the authors believe that women’s health providers should consider the potential role that continuous lay person support could play at other physically and emotionally challenging moments in women’s lives.

Doulas in abortion care

One such setting in which doula support would be highly beneficial is in abortion care. Abortion is a stressful event regardless of a woman’s circumstances. Unlike pregnancy in which women can accustom themselves for the forthcoming delivery over a period of time, the decision to terminate pregnancy often leaves little time for reflection. Also unlike pregnancy, women often obtain abortion services from medical caregivers with whom they have had no prior relationship. While these and other differences clearly exist between labour and pregnancy termination, many benefits afforded by the presence of a doula during labour would likely translate well into abortion care.

One example of the way in which doula involvement would naturally benefit women during their abortion experience is in the realm of pain control. A national survey of National Abortion Federation members found that 46% of clinics provide local cervical block with or without oral premedication, 33% combine local anaesthesia with intravenous sedation, and 21% use deep sedation or general anaesthesia for first-trimester abortions.2 A recent review of the literature evaluating the adequacy of pain management for first-trimester abortion concluded that many patients who do not receive general anaesthesia find surgical abortion extremely uncomfortable despite any medications that may have been administered.3 In one study that examined the role of a ‘support person’ in the post-anaesthesia recovery room after an abortion, the presence of social support was perceived as overwhelmingly positive to both the patient and support person.4 It is therefore likely that a doula could contribute to pain management in a manner that would augment the various analgesia medications with the exception, of course, of general anaesthesia.

Some doulas practising in maternity care are expanding their services to include abortion support, and several references to the burgeoning abortion doula movement exist in the lay press in print and online media.5–10 These articles chronicle the development of this movement, discuss abortion doulas’ personal experiences, and anecdotally document the positive impact of the abortion doula in the abortion setting. Abortion doulas fall under the larger umbrella of the full spectrum doula, a concept that extends the role of the doula to supporting women throughout the spectrum of their reproductive experiences, including birth, spontaneous abortion, adoption and abortion. The full spectrum doula movement is intimately linked to the reproductive justice movement that places the utmost value on women’s reproductive choices.5

The history of the abortion doula and full spectrum movements dates back to 2007 with the creation of the Doula Project in New York City.6,7 This organisation, which now holds non-profit status, is credited as being the first organisation of its kind that is dedicated to supporting women through
their abortion experiences, births, miscarriage, labour and delivery of intrauterine fetal demise and adoption. The group of all volunteer doulas has paired with a public hospital and clinic to provide these services. As of November 2011, the Doula Project had served over 5000 women. Additional abortion doula groups that are in different stages of development are said to exist in Ohio, Illinois, North Carolina, Washington State, California and Georgia.

**Techniques and skills**

Abortion doulas employ a number of techniques and skills to help women through both first- and second-trimester abortions. Many of these techniques are direct applications of skills used in the maternity care doula setting. Specific techniques include hand-holding, massage, reassurance, providing guidance with breathing, educating women about the nature of the procedure, engaging in conversation or making light-hearted jokes. Personal accounts by abortion doulas stress the importance of listening and being present with women before, during and after their procedures. Abortion doulas report that providers have expressed the value of having such a person in the room during an abortion procedure – women are more relaxed and easier to communicate with, allowing for a less complicated and more efficient procedure. Women have expressed gratitude for a greater sense of physical comfort, control, and safety as a result of doula presence during the abortion procedure.

Despite these positive experiences associated with abortion doulas, this movement is not without controversy within both the doula and pro-choice communities. The community of birth doulas contains a large anti-choice contingency that opposes the appropriation of the term ‘doula’ within the context of abortion. Blog posts and online write-ups about the abortion doula movement are often met with a fierce online debate between pro-choice and anti-choice doulas. Conversely, some in the pro-choice community question the concept of the need for an abortion doula, believing that women are strong enough to undergo an abortion without the need for additional support.

**Concluding remarks**

In laying the groundwork for the inclusion of an abortion doula programme in a high-volume, urban pregnancy termination clinic, we set out to examine what, if any, scientific literature exists on the utilisation of doulas in such a setting. We conducted a review of the literature using a PubMed search with the search terms ‘doula’, ‘labour support’, ‘abortion doula’, ‘doula support’, ‘doula breastfeeding’, ‘doula caesarean’, ‘doula’ and ‘abortion care’. Upon review of 41 scientific articles relating to doulas in PubMed, and 841 secondary references from those articles, we failed to find any mention of the word ‘abortion,’ or any variation of it in these titles.

The complete absence of scientific literature concerning the presence of doulas in the abortion care setting, despite their documented merits in the labour setting, demonstrates a need for greater attention to this service. One abortion doula blog post discussed the challenge in finding providers who recognize the value of abortion doulas in improving the quality of abortion care that they are able to provide. The engagement of the medical community will be instrumental to successfully expanding the role of abortion doula programmes within abortion provision. Furthermore, recognition of the powerful role that abortion doulas could play in improving abortion care for women should provide the impetus to formally study the potential advantages of including doulas in the abortion clinic.

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**References**


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