NATURAL CHILDBIRTH MOVEMENT IN HUNGARY

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Abstract. As the behavior science, preventive approach and health-oriented worldview gradually permeate the whole of medicine, transformations in obstetrics are occurring slowly all around the world. The technocratic character of the medical approach to obstetrics strives to keep the intrinsically natural process under total control of medicine, which has provoked the emergence of the critical movement known as the natural birth movement. However, this generic term is only used theoretically in Hungary because the movement is yet to develop a single base that would bring together its separate units. One of the

most important units of the natural birth movement is the doulas community which, after twenty years of differentiation, is seeking possibilities for cooperation, joint action and representation of natural childbirth. In this article, I would like to discuss this process, which reaches beyond its own frameworks - since it affects not merely the quality of obstetrics but also modern and post-modern definitions of health and disease, the system of power, gender roles, distribution of knowledge, the relationship between nature and technology, as well as the long-term problem of the quality of life within the society - significant questions not only for Hungary.

The cultural history of birth and childbirth is usually reduced to the history of birth medicalization, and Hungary is no exception. Ethnographers and anthropologists provide a number of descriptions of the characteristics of premodern childbirth culture, in which they present a series of preventive magic procedures that regulate the behavior of the pregnant woman (and sometimes of the wider environment) for the protection of the fetus. The researchers show the birth system's socio-cultural embeddedness and the roles of the participants, especially the midwife (e.g. Bloch – Parry 1982, Kapros 1990, Gélis 1991, Kóbor 1992, Deáky 1996, Benedek 1998, Balázs 1999, 2012, Kókai 2002, Csonka-Takács 2006, Gryneaus 2012, Kisdi 2018). The history of the professionalization of the midwife praxis leads to the medicalization of childbirth, when the experiential knowledge has been overwritten by the studied knowledge according to the training prescribed in the regulations[1], and the midwife[2] increasingly gets under the supervision of the doctor who takes control of the birth. During this progress childbirth removed from the social status into the scope of medicine as a potentially dangerous process, and because of the routine use of preventive interventions (as continuous monitoring, bounded to the bed, restriction of freedom of movement, shaving, enema, artificial rupture of membranes, inducing and acceleration of birth, analgesia, episiotomy) also the problem-free natural childbirth has become a medical event indeed. As a critique of this medicalization, the natural childbirth movement emerged in the first half of the 20th century, based on post-material values emerging in Western states in these times and then completed in the 1960s, which sought to assert human aspects beside material values.

In the study below I would like to present the history, framework and message of the natural childbirth movement, with special regard to Hungary. In my analysis I pay special attention to the doula movement, which is part of the natural childbirth movement, through which I try to present the socially critical attitude that characterizes the natural childbirth movement, the dilemmas which

frame its institutionalization, although I do not want to suggest that characteristics of the doula movement could be generalized to the natural childbirth movement as a whole. The aspirations of doulas show a specific set of solutions and problems based on their special goals, yet they characterize explicitly the attempts to resolve the dichotomy of the lay and professional, the individual and community, the traditional and modern or the natural and the cultural.

Theoretical framework of the natural childbirth movement

The natural childbirth movement is a postmodern phenomenon that refers to childbirth without ’unnecessary’ interventions. Of course, it is a multifactorial question of what constitutes unnecessary intervention, but it basically means routine preventive interventions that have been classified as ’non-recommended’ procedures according to WHO recommendations.[3] In contrast, in hospital practice and in everyday speech, natural childbirth is understood to mean simply vaginal childbirth, so the two meanings of the term do not overlap. The natural childbirth movement is a broad form of social organization whose participants struggle in different ways, with different emphases, but fundamentally for the humanization of childbirth, which primarily means supporting natural processes if the health of the mother and fetus allows it. As a condition for the humanization of childbirth, the outcome document of a conference held in Brazil in 2000 (’International Conference on Humanized Childbirth’), signed by 2,000 participants, is a typical example of it. „Humanized childbirth means: 1. the parent woman is in the focus, there is no external control and no decisions are made over her head, 2. perinatal care is basically primary care provided in the community (i. e. outside the hospital) and not in the hospital, 3. this requires midwives, independent midwives and doctors to work together in a coordinated way as peers, 4. the use of obstetric technology and medicines in perinatal care must be based on scientific evidences” (Wagner 2010: 209–210).[4]

The movement most often refers to the recommendations of maternity care formulated by the WHO since 1985 defining the goals to be achieved. The first recommendation indicated the highest possible frequency of interventions with specific percentages, but today the WHO thinks more in trends and aspirations, emphasizing that the category of normal childbirth is not universal: „In spite of the considerable debates and research that have been ongoing for several years, the concept of ’normality’ in labor and childbirth is not universal or standardized. There has been a substantial increase over the last two decades in the application of a range of labor practices to initiate, accelerate, terminate, regulate or monitor the physiological process of labor, with the aim of improving outcomes for women and babies. This increasing medicalization of childbirth processes tends to undermine the woman’s own capability to give

birth and negatively impacts her childbirth experience. In addition, the increasing use of labor interventions in the absence of clear indications continues to widen the health equity gap between high- and low-resource settings. This guideline addresses these issues by identifying the most common practices used throughout labor to establish norms of good practice for the conduct of uncomplicated labor and childbirth. It elevates the concept of experience of care as a critical aspect of ensuring high-quality labor and childbirth care and improved woman-centered outcomes, and not just complementary to provision of routine clinical practices. It is relevant to all healthy pregnant women and their babies, and takes into account that childbirth is a physiological process that can be accomplished without complications for the majority of women and babies".[5]

By natural childbirth movement, then, we mean a socially critical movement that, through its interpretation of the quality of childbirth, highlights the woman from her subordinate patient role, thereby undermining established power relations. By interpreting childbirth as a natural process, the movement wants to liberate nature and woman at the same time, so the natural childbirth movement can also be interpreted as an ecofeminist movement, although the global goal of the movement is to serve the interests of all mankind.

As a social critical movement the natural childbirth movement is part of a postmodern childbirth culture that grew out of modern childbirth culture, but also draws on the experience of premodern childbirth culture. So before we get into our central topic, I would like to clarify these concepts.

The childbirth culture that preceded or hasn't adopted the medical approaches yet can be called a *premodern childbirth culture*, which considers childbirth a social event. But it is important to keep in mind that the culture of birth is very diverse and its systems are very complex. To cover a wide variety of solutions to this diverse topic with a single term is only acceptable if we would like to present the essence and social embeddedness of change.

With similar proviso, we can call the second major segment of childbirth cultures a *modern childbirth culture*, which is also not homogeneous, but much more standardized than the premodern one. This second type refers to the officially recognized Western medicine, and within it, obstetrics, which, according to the biomedical paradigm, considers childbirth a health event. In modern childbirth culture safety is the most emphasized value that is sought by a multitude of preventive interventions and the use of modern technology. Anthropologist Davis-Floyd (2003) calls the view of modern childbirth culture that considers technology-based solutions to be used whenever it is possible a *technocratic need*. The medical literature accounts for a drastic reduction in maternal and perinatal mortality as a result of medicalization,[6] but the phenomenon was obviously fundamentally influenced by multifaceted lifestyle

changes, shift in social and family structures, changes in eating habits, infrastructure development and access to information, and an improvement in general health and hygiene.

We can call *postmodern childbirth culture* the theory and practice that seeks to transcend the medicalized modern childbirth culture (but evolves from it and incorporates the necessary elements), which carries the ambivalence that characterizes the relationship between the modern and postmodern in other areas (Hassan 2002: 51). The postmodern childbirth culture which is rooted in new researches of the perinatal sciences is based on a holistic view, such as the premodern childbirth culture. The practice of postmodern childbirth culture can be found partly in extra-institutional births (such as home birth, midwifery practices, birthing centers), partly in the work of doulas, partly in hospital midwives who prefer the holistic view, and partly – in Hungary and, more rarely, in Central and Eastern European countries – in the individual initiatives by certain hospital obstetricians. In postmodern childbirth culture the birth safety is to be primarily achieved through the emotional and practical support of natural childbirth and not through technology. So there is a strong emphasis on continuous, non-interventional support of childbirth.

In the recent decades, reformer hospital practices which have emerged primarily in Western Europe and in the northern states, have incorporated the principles and practices of postmodern childbirth culture into their own systems. The anthropologist Robbie Davis-Floyd called it a *humanistic childbirth culture* (2003).

It is particularly important to emphasize that a given childbirth culture is not possible to grasp in a particular area or historical time, but in an attitude that related to conceptions of the birth's nature and order, of the fetus and of the role of women in labor and assistants.[7].

Towards humanizing childbirth

The natural childbirth movement, of course, did not emerge from nothing. It was based in part on the holistic approach of premodern childbirth culture, and in part on new psychological methods aimed primarily at reducing labor pain, but in a fundamentally natural way. An early example of this is the psycho-prophylaxis developed by Velvovsky, Nikolaev and Platonov in the 1940s, which was based essentially on Pavlov's theory. According to this, the development of a positive psychological situation results in new, positive conditional reflexes that lead to pain reduction (Tiba 1988). In the Western countries, the English obstetrician Grantly Dick-Read spread the method of psycho-prophylaxis, but as early as 1933 he wrote his work Natural Childbirth,

introducing the concept of natural childbirth, according to which the woman, by controlling the process of childbirth, is less likely to need pain relief. Both concepts were built on the conscious role of the woman, considered the transfer of knowledge important, and expected a continuous supportive attitude from the helping professionals. Their work culminated in the work of Ferdinand Lamaze, who, based on psycho-prophylaxis, also involved fathers as supporters of childbirth, but to be the real developer of ’father present at birth’ is considered by Robert Bradley (1974). Bradley stated that the doctor has no place in the maternity ward unless some complication arises. He stressed that the newborn is able to be born on its own, and the woman mostly knows and feels what she needs to do. This approach has been a starting point for the natural childbirth movement ever since. As he had designated the father as a supporter of childbirth he reinterpreted it as a social event.

Although the omission of analgesics necessarily served the interests of newborn, it was not yet conscious. Focusing specifically on the newborn, the French obstetrician, Frederick Leboyer was the first who proposed a procedure that would maximally adapt the obstetric practice to the needs of the newborn, because he found the standard procedure drastic, insensitive, and unnecessarily painful (he recommended dull lights, increased warmth, slow movement, only cutting the umbilical cord when it is no longer pulsating, warm bath instead of washing the newborn under tap water, wrapping the baby in a warm blanket instead of dressing in tight dress, omitting or postponing unnecessary measurements and interventions, postponing the necessary examinations, immediately placing the newborn on the mother's chest and immediate support for breastfeeding). In his opinion, a doctor is only needed for a physiological childbirth if there is indeed a complication because "childbirth is the woman’s secret garden. The man has nothing to gain there. I don't."[8] Leboyer can also only imagine the presence of fathers as mental supporters who take care of the safety of the parent woman at the door.[9]

Similarly, Michel Odent, an obstetrician, thinks that the presence in the birth of the father or any actor who receives a share of the woman's attention increases brain neocortical activity, which in turn reduces oxytocin production and inhibits the natural process of labor (Odent 2001). Odent founded the Primal Health Research Center in London, which examines the links between perinatal events and subsequent health status.[10] In his books, he argues for the importance of pre- and perinatal experiences in the development of human adaptation skills (1986, 2001). Odent is associated with the introduction of water birth in the hospital. He played a leading role in advocating the construction of family-style maternity rooms and in emphasizing the importance of working with doulas.

The scientific basis for supported, natural, possibly non-interventional childbirth is thus mainly tied to male psychologists and obstetricians whose ideas

contradicted the principles of modern childbirth culture and who are still seen by the movement as the base of its legitimacy. However, the transmitters of the principles, the members of the natural childbirth movement, the leading researchers in the investigations that has multiplied since the 1990s, are mostly women, as also the parent women of course are women. This explains why the movement is considered a feminist movement, even though their goal is to protect the interests of the newborn, so they are by no means limited to the interests of women.

Research on the postmodern childbirth culture in Hungary

In Hungary, the history and characteristics of alternative childbirth culture[11] were first written by psychologists (Varga – Suhai-Hodász 2002), as the perinatal sciences are usually led and coordinated also by psychologists. Within sociology, an academic research led by Ágnes Losonczi (1986, 1991, 1999) started back in the 1980s, but no real run-up to the sociological study of postmodern childbirth culture took place. The study of modern and postmodern childbirth culture did not become popular in Hungary even within anthropological circles, so I found few handrails when I started to explore the topic in the mid-2010s. First, I examined the socio-historical and social dimensions of home birth, which served as the topic of my dissertation. Then I dealt with changes in childbirth cultures and later my attention turned to doulas, who apparently form the bridge between professional birth assistance and lay interpretive systems. In 2017, my university research team conducted 49 in-depth interviews with doulas. We did not have any database for this, so we contacted other doulas with the help of the leaders and representatives of the four existing Hungarian doula organizations. The contact was preceded by four expert interviews which we conducted with these helpers and which served as a starting point for creating a series of questions for interviews with the doulas. In parallel, a questionnaire distributed on discussion boards and websites visited (also) by doulas was completed by a total of 95 doulas.

In the second phase of the research (2018) we visited mothers who gave birth with a doula. A total of 83 interviews were conducted. The processing of this material is still in progress.

In the meantime, and since then, I have been striving to monitor online and offline the activities of the doula movement, which is quite differentiated and diversified, to participate in events that are of great importance in the life of the doula movement, and to keep in touch with the movement's leading individuals. I am in a rather fortunate position because self-representation is also extremely important for doulas in terms of social acceptance, but the doula reflections of

my writings directly influence the possibility of further cooperation, so I have to pay particular attention to this in my interpretations.

A third and a fourth phase of research are also planned, but the epidemic situation has prevented continuation for the time being. In the fourth stage, we would like to ask about the experiences and opinions of midwives, and then – the most difficult group to reach – we are interested in the point of view of obstetricians. The doulas report significant rejection but we would like to get more background information before approaching this group.

Natural childbirth movement in Hungary

Two branches of the natural childbirth movement are receiving more social attention in Hungary today: one is the home birth movement and the other is the doula movement that has grown out of it. However, there are further organizations that, as civic movements, struggle to humanize childbirth with advocacy (e.g. EMMA Association), professional policy (Different State in Obstetrics! Movement[12]), or mother-centered emphases (Semmelweis Movement), but in these organizations there are also many doulas and they have a close collaborations with professionals on home birth. The natural childbirth movement in Hungary began with home birth in the late 1990s, but today it is a national-wide, socially active movement. Its organizations played a major role in the professional debates on the regulation of home birth and in the establishing of the obstetric principles[13] adopted last year. Although the latter is still far from being put into practice, and some members of the movement do not consider the proposals for change to be drastic enough, they nevertheless consider their introduction to be of great importance.

Home birth in Hungary

As the doula movement grew out of home birth in Hungary, and the scandal surrounding home birth spread around the world press, it is worth covering it very briefly. The key figure of the Hungarian home birth is Dr. Ágnes Geréb, a female obstetrician-gynecologist and psychologist who left the hospital after 17 years of clinical practice because of numerous clashes with management on professional issues related to childbirth support. Long before the introduction of ’father present in childbirth’ in Hungary, she allowed the fathers to enter the maternity ward, allowed mothers to go into labor and give birth in a position they find appropriate and did not perform the routine interventions if it was possible, and she was therefore always punished by the management of the hospital. When she encountered the phenomenon of home birth during a journey in the USA, she realized that the childbirth principles in which she believed

were already implemented there, so she contacted international organizations and professionals who supported natural childbirth, and in the 1990s she tried to build the conditions for home birth in Hungary more or less based on Western patterns. She ran into walls from the obstetrics profession, hospitals and the state bureaucracy for a long time, but changes in expectations on childbirth among citizens and three deaths related to home birth[14] finally led the state to take action and in 2011 regulated the conditions of home birth. The details of the regulation have been debated ever since with several amendments but no one disputes the significance of the act. Meanwhile, the lawsuit against Ágnes Geréb ended in the conviction of the doctor due to the three deaths, but presumably as a result of international and Hungarian, primarily civil, and secondarily medical protests, Ágnes Geréb eventually received a presidential mercy. According to the accusation, the doctor's professional misconduct contributed to the death of the three children, but according to the defense and several international professional organizations, Ágnes Geréb did not make a professional misconduct. I am not prepared to take a position on the issue but in my book on home birth (2013) I have explicitly described the details of the lawsuit. Today, although it is possible for both midwives and obstetricians to ’lead’ a home birth under certain strict conditions, because of the invariably condemning attitude of the medical profession only a few midwives have used this option so far, mainly those who already have worked in home birth previously, and not a single doctor. In Hungary, about 0.1 percent of births are planned and take place outside the hospital (at home or in maternity home).[15] In home birth, the doulas were present from the very beginning, acting as an aide to the midwife. These were at first women who gave birth at home and wanted to further take part in the humanization of childbirth. They later created the first doula training course.

The scientific legitimation of the role of doulas

But who exactly are doulas? A doula is a non-medical helper, who is able to provide continuous physical and psychological support of labor, complemented by childbirth preparation and confinement assistance as needed. In Hungary, it is up to the mother's needs whether she uses the help of a doula during the period of pregnancy, in preparation for childbirth or only asks to be accompanied in childbirth by a doula, or perhaps still needs support after childbirth by her. Doulas typically consider the support of the whole process to be effective and they emphasize the importance of childbirth preparation, the expansion of the pregnant woman's knowledge about her body and events of pregnancy, childbirth and breastfeeding and the deepening of her self-confidence and awareness. Leaving the atmosphere of home birth that was considered ’natural’ from the very first, they now accompany mainly hospital births, saying there is a greater need for them. During childbirth, they help the mother who gives birth to

the child with so-called ’comfort services’: they give her food and drink, boil water, foment, massage, mediate between the mother and the hospital staff, explain, translate medical terms and slang. However, doulas find that their most important task is the presence, an emotionally supportive, ongoing presence that hospital staff are unable to provide due to a lack of capacity (and often attitude). At the same time, they also help the present father by acting as a channel of communication and background support in a medium unknown to him.

In order to place themselves in the network of helpers surrounding the parent woman, doulas emphatically define their functioning as a social activity. This separates them from health tasks and responsibilities, but at the same time they operate in the field of health care, which inevitably creates a situation of conflict – so health professionals cannot interpret their presence in the labor room. At the same time, research supporting the importance of their work is very important to them, but their content is mostly health-related – at least only theese have credit within the ranks of medicine, where they paradoxically want to prevail.

The results of childbirth studies of the recent decades (in genetics, epigenetics, neuroendocrinology, neonatology, neuropsychology, perinatal psychology, psychoanalysis, anthropology), confirm, that after a problem-free pregnancy, the best perinatal outcome can be achieved with as little intervention as possible (Lothian 2004, Gaskin 2008, Varga 2015, Gizzo et al. 2014, Odent 2014, Buckley 2015). The key to this is the continuous, non-interventional support (Kennell – Klaus – McGrath 1991, Scott – Klaus – Klaus 1999, Scott – Berkowitz – Klaus – 1999, Redshaw – Heikkila 2010, Hodnett et al. 2013, Bohren et al. 2017), which is also the most powerful experience for a woman in labor (Berg et al. 1996, Waldenström et al. 1996, Lavender 1999, Baker et al. 2005, Larkin – Begley – Devane 2009, Dixon 2013, Gibson 2014). Research has shown that childbirth with a person who is constantly present and provides mental and physical support in a meaningful way, have a shorter labor time, are less likely to require pharmacological pain relief. Episiotomy, use of obstetric forceps and vacuum, use of artificial oxytocin or cesarean delivery are less needed (Camann 2000, Meyer et al 2001, Simkin – O’Hara 2002, Scott et al 1999, Gilliland 2002, Stein et al 2004, Hodnett et al. 2013, Bohren et al. 2017), furthermore the mothers are calmer and more balanced in the first days after childbirth and behave more gently with newborn and have fewer breastfeeding problems (Klaus - Kennel - Klaus 1993).

As hospital staff are not able to provide a continuous supportive presence due to institutional structure and general congestion in health care, doulas want to play this role. As studies show, the continuous, supportive presence appears as a positive factor partly due to its psychological effects (encouragement, increasing self-confidence, ensuring a social atmosphere), partly due to physical support and communication. According to a meta-analysis by Bohren et al. (2017) the

support by a doula also improves the outcomes of childbirth because it increases the self-esteem and self-confidence of the parent woman.

These phenomena are explained by the function and equilibrium of hormones naturally produced during labor and childbirth (e. g., oxytocin, beta-endorphin, stress hormones, prolactin), which can only be produced and have an optimal effect if the childbirth proceeds on its own, at its own pace, without interventions, so without increased distress (Odent 2014, Bell – Ericson – Carter 2014, Buckley 2015). Thus, if the woman in labor feels 'well', 'safe', 'loved', natural oxytocin production will be stronger, but stress hormone levels rises less, birth is easier, less intervention is needed and early bonding becomes easier too (Lederman et al. 1987, Taylor et al. 2000, Lothian 2004, Levine et al. 2007, Varga et al. 2011, Olff et al. 2013, Benfield et al. 2014, Kenkel et al. 2014, Odent 2014, Alves et al. 2015, Feldman 2015, Varga 2015, Buckley 2015). And the method and quality of birth seems to have long-term effects on health and quality of life (Jansen et al. 2007, Torkan et al. 2009, Hyde et al. 2012, Dahlen et al. 2014, Prick et al. 2015, Mosca et al. 2016, Dietert 2016, Stavros et al. 2017).

Significant studies, meta-analyses from the Cochrane database[16] and relevant articles in midwifery and medical journals – in translated and summarized form – usually reach doulas through information channels that operate partly online and partly offline within the natural childbirth movement with the participation of professionals (psychologists, midwives, biologists, obstetricians, jurists, social scientists, etc.), who are sometimes doulas themselves. This need, opportunity and ability for legitimacy explains the scientific tone of doulas' self-interpretation.

Accordingly, the long-term goal of doulas is to change the obstetric protocol that the movement believes is not based on psychological support for childbirth, but on preventive interventions and intensive delivery management.

Doula movement internationally and in Hungary

The doula movement grew out of the natural childbirth movement, which originated in the U.S. around the 1960s, and doulas already played a major role in this. It so happened that in 1966, in her dissertation on breastfeeding, an anthropologist, Dana Raphael[17] (a colleague of Margaret Mead, with whom she founded the Human Lactation Center in 1975), referred to the Greek word doula (slave) for women who in traditional cultures help mothers during the postpartum period (today they are called postpartum doulas). Later the meaning of the term doula was expanded to include women who in that time were already trying to support, help and advice other women during pregnancy-childbirth-

postpartum period by criticizing technocratic practice. The first doula organization (as a non-governmental organization) was established in the United States in 1992 (Doulas of North America, DONA) and the Doula UK in England in 2001 (these are the largest). In Eastern Europe the natural childbirth movement was formed after the change of regime – on a different way from country to country and relying on different social bases. In Hungary the first doulas became doula on a universal basis: those who gave birth at home and wanted to remain close to giving birth began to support the preparation and childbirth of other women, but at home. From 2000, they also started training doulas within the Alternatal Foundation (which organized home births) on how to give the most optimal support for other women in hospital birth, and then in 2001, eleven doulas founded the Association of Hungarian Doulas (MODULE). After some joint training, they split up, and the first doula organization became independent. They worked partly as doulas, partly they trained additional doulas in a three-day residential training (which has now been expanded to 2x3 days). The curriculum is self-knowledge and knowledge about physical and mental events of childbirth, and the instructors include midwife, perinatal specialist, lactation counselor, body awareness instructor, but the doula's principle is that doulas should be taught by doulas, and the emphasis is not on the knowledge what are acquired but on the supportive attitude, since the doula has no explicit 'task' in childbirth. The Module sought to build relationships with hospitals, but on an informal rather than formal basis. Due to theoretical and organizational issues within the Module, the president resigned in 2007 and established the Békés Doula-coterie, who organizes a highly precise but more time-consuming course on similar topics (2 days of self-knowledge training, four days of professional training and optionally an additional 150 hours „doula workshop"). The leader of the Békés Doula-coterie tries to ensure their access to the hospitals by concluding written agreements and to make her organization transparent, but it still based on personal sympathy where the Békés Doulas are allowed to go. The next stage in the history of Hungarian doulas was the appearance of the American DONA in Hungary, thanks to a doula who trained both the Module and the Békés Doula-course, then went to the USA, completed the DONA training, and then obtained a DONA training paper, so she has been leading training in Hungary according to DONA's international standards since 2010. The training is very similar to the other two trainings (although she mostly held the sessions alone), but perhaps she puts even more emphasis on self-knowledge. At the end of the last year, however, this doula decided to break up with the DONA, returning on its own, because for example she underestimated the training time required by DONA (it was 3 days, and she is now extending this to 22 days with additional training opportunities). It is also important that within the framework of DONA she held several trainings in various Eastern European countries. There is also a fourth training place, the Sarasvati Foundation, founded by a yoga instructor, who is also a doula, but they train

doulas only in a very small number, and there is no lasting doula-coterie around them. Thus, the different doula-coteries grew out of each other, and today – albeit with an emphasis on Budapest, the capital – they have achieved national coverage. The most of the doulas are related to one of the doula-coteries, but there are some (about 20 %) who function as independent doula. Rarely there are women who have not completed any of the doula courses, and also call themselves in a hospital as doula, but they are also invisible to other doulas and there are different perceptions of them. For many, it is a problem because their behavior as a doula is uncontrollable, but others find nothing objectionable in it, saying that every woman is a doula by virtue of being a woman – it is taken for granted by one of the key figures in the natural childbirth movement, the previously mentioned Michel Odent (who – as a man[18] and as an obstetrician gynecologist also leads a doula course in London).

The co-operation between the doula organizations is on a low level: this is partly due to the fact that in each organization the organizational and administrative tasks are concentrated in the hands of one doula, it is difficult to divide the tasks (because participation in the operation of the organization is voluntary), so the cultivation of external relations is lost, on the other hand the theoretical division regarding the nature, possibilities and future of birth support and doulas cannot be denied either.

It is worth mentioning that the majority of midwives who accompany home births in Hungary today with a qualification and license in accordance with the legal requirements have also started their careers in natural childbirth as a doula.

Today in Hungary around 150 women act as a doula (although more than 1,100 women earned a doula rating), but their activity is very different. As well as the number of births they attend each year, because they work as a doula in addition to their other civic occupations.[19] Only two of these women live off their doula duties.

Dilemmas of self-representation and community building within the doula movement

Referring to Clifford Geertz, we can assume that communities are created and function in the process of creation of meanings. The first doula-coteries were formed in the process of reinterpretation of the nature of childbirth, the social role of women, the relationship between mother and fetus, the paternity and the effective way of maternity support. Later the events of the differentiation and slow institutionalization of doulas also drew attention to the doulas themselves. The purpose of doulas is to attract the attention of the user side first (mothers, families), of the health sector (midwives, doctors), but constantly emphasizing

that this is in the interest of newborns and ultimately of society. This global definition of goals and the need for local action have made self-reflection unavoidable, which has been embodied in more and more precisely organized meetings between the doula-coteries in recent years. Of course, the desire for self-determination is also an old phenomenon among doulas, it is a subject of continuous discourse online and offline in closed groups, a prominent topic on the websites of individual doulas and doula circles, and it is also a focal point on the occasions of press releases, but the clash of fundamental differences of approach has taken place only in a latent way so far.

It is obvious that, as it is usual in the case of new social movements, we cannot encounter communities in the ’traditional’ concept among doulas either. Their social formations are interpretive communities because the network of doulas is created and included in the network of natural childbirth movements by a given interpretation of childbirth and birth in a given space and time. So they are characterized by networking, which started from an originally centrifugal growth. The creation of new directions is always based on individual initiative, on an innovative or different approach to existing concepts, and over time the training announced by the initiator has extracted its basis. In most cases, however, the connection to a doula-coterie is not a conscious choice of values (because they do not know all the doula-coteries previously), but later it means a strong engagement for many. Basically, the characteristics of a doula organization depends on the personality of the leader — who is not necessarily the official leader. The differences are primarily to be found in the conception of what it means to be a doula and the ways how doulas are organized, not in the way how the mother should be supported.

They talk about community, a ’real community’, but in practice it means Wellman’s personal networking community (1999), in which members’ individual strategies are organized along common values and common goals into a common social field where the main integrating force is not the personal acquaintance between members, but solidarity. At the moment, members of doula-coteries know little about each other, often do not know who belongs to which coteries, and in fact, some are just urging at least, those who live close to each other should make contact so they would not be so polarized. The currently working doula-coteries are not equally integrated either: there are places where communication is extremely loose, and there are places where the leader calls the doulas she has trained as her own ’daughters’, and this classifying term really suggests that here the organized interaction is continuous, in fact a kind of feedback monitoring. The goal of the current process is to create a network of group networks.

As medicalization is becoming more and more intense in Hungary in parallel with the humanization efforts of childbirth, doulas are finding it increasingly

difficult to enter hospitals – whether they can accompany childbirth within a hospital depends on the personal permission of the head of the obstetrics department or the current obstetrician. There is no uniform regulation for this. Younger doulas do not perceive change, but older ones talk about ever-narrowing opportunities. Therefore, joint action is seen by them as an increasingly urgent task, but it brings to light the difficulties of operating as a community.

It may seem, then, that this is in fact a process of institutionalization, but most of the doulas do not desire institutionalization, but an experience of existence in a community in which reciprocity and solidarity are emphasized. Moreover, many are explicitly afraid of institutionalization, saying it deprives the movement of its main characteristics, its ability to adapt quickly, the virtue of variability, diversity and spontaneity.

The dilemma, then, arises from the fact that the majority does not want to give up their individual strategies at all, and they are confident that they can act uniformly in their diversity (even this was the motto of the last – and first nationwide – doula meeting: ’We look for similarity in our diversity’). It is instructive to examine the issues along which the dilemmas of community building are articulated.

The first and the most important question is, what does it mean to be a doula? There is a broad consensus that to be a doula is rather a profession, a mission or a lifestyle than a business or an occupation, yet there is a debate about how could be achieved a standalone profession code within the TEÁOR system (Uniform Classification of Occupations in Hungary), but by not classifying it as a health care job, as an auxiliary to the work of midwife, as it works now, but as a self-employed activity (namely a social activity). So at the same time they are trying to avoid the interpretation of doula-role as an occupation, but they are fighting for an independent profession code, because this makes them ’understandable’ for society.

To be a doula as a lifestyle mostly means helping, and they often emphasize that the doula role is interpreted for them not only in the interrelationships of childbirth system, but in their entire way of life, so the supportive attitude stems from their personality. However, they believe that the mother should be supported in what she needs, which is the right way for her individually, and not in a pre-determined way, so the creation of a common framework for action is highly controversial. However, the ongoing community building process also names this issue as a central problem. Joint action is only possible if there is a common code of ethics and rules of functioning besides the own set of rules of each doula-coteries, that sets out the theoretical and practical framework for the operation of the doula. None of them question whether this is necessary if they want to win the cooperation of hospitals, and even the most receptive

obstetricians ask them to do so, furthermore this is the most controversial issue, since ‘common’ would essentially mean compromise against the ‘individual or unique’, which signifies an additional basic motif of doulas.

Striving for the co-operation of individual strategies means seeking a common framework for doula identity. According to Manuel Castells (1997: 6-7), identity is the process of constructing meaning by social actors, and meaning is what the social actor symbolically identifies with the purpose of his or her action. The problem of self-determination has accumulated within the framework of the ’project identity’ program, which is also characteristic of proactive social movements in general. It is therefore a question of humanizing the way of childbirth is not only to represent the interests of a narrow circle, but also to radically ’naturalize’ the beginning of life (which means maximum support for the normal course of childbirth), the ability of the newborn to adapt, the mother-child, father-child relationships, and, in the long run, to improve the well-being of society, which requires new interpretations of roles, power relations and values at many points. The framework of the desired community can in principle be built on the goals and norms assigned this framework, but a high degree of respect for individual preferences, values and strategies makes any different values acceptable if it serves the interests of the fetus or the newborn or mother. And whereas the development of the doula identity is based on learning to accept and serve needs based on different norms, so they do not want to implement their own principles of normal childbirth on the way enforcing their knowledge about normal birth, its support and the interests of newborn in each case, but in a long-term way they intend to draw society’s attention towards a postmodern childbirth culture. And this is only possible if there is a unified, or at least seemingly unified group behind the principles. However, the controversy surrounding the name of this group already indicates the cognitive conflict that results from the collision of basic identity elements.

At the last doula meeting, which was proclaimed by one of the doula-coteries as a national meeting for all doulas (which in advance questioned the strongly emphasized egalitarianism), the organizers strengthened continuously and consciously the unification, mixing, rapprochement, cognition, the experience of ‘common’ with both verbal and use of spatial tools, which, they hope will deepen the desire for community, and which, however, does not end with intent but prompts action for a common goal. Among doulas, all attempts at community building are highly emotionally charged, so that this emotional-based community will extract the actors who take on the task of developing common theoretical and practical minimums (the most important are code of ethics, code of conduct, rules of functioning and cultivating of external relations). Since doulas do everything on a voluntary basis – except of the work with the mother[20] – the belonging to the community and serving a common cause seems to be one of the most important motivation.

The doula movement as a social critique

Community perception also has a temporal factor because in addition to the concept of lock-time and abstract timelessness (which are the subjects of criticism),[21] they think in a third time paradigm, ’evolutionary time’, which refers to the sustainability and continuity of the relationship between humans or human and nature. This evolutionary time means that our lives must be measured by the lives of our descendants, and our lives cannot be ripped out from the process of lives arising from each other, so the lifestyles and choices of our ancestors affect our lives, the same way our choices about childbirth affect our descendants’ life in many aspects (e. g. their health, the ability to love, adapt or bond, etc.) These interpretations are about the long-term effects of childbirth and birth quality, and primarily reflect on epigenetic relationships.[22] Beyond the horizontal solidarity this conception creates an additional intergenerational solidarity, that includes the doulas, mothers, children of the past and the future, but more emphatically also the family to an extended concept of community. While in the past (10-15 years ago) doulas spoke mainly about the support of women and mothers, and tried to pass on their knowledge in women's circles, today they talk specifically and emphatically about supporting families, where the support of the father and the unity of the family play an important role.

The involvement of doulas reinforces the fundamental principle of the natural childbirth movement that childbirth is a female affair. With the modernization the empirical knowledge of childbirth was removed from the knowledge-base of women, and the expertise of midwives was subordinated to medical science. As the obstetrician-gynecologist profession is strongly masculine in Hungary[23] and in many other parts of the world, the female perspective has been eliminated, which considers childbirth as an intimate, feminine, emotionally based, social event rather than a standardized physical event. According to critiques of postmodern childbirth culture the surgical approach of modern childbirth doesn’t consider female experience and intuitive behavior to be legitimate, but for the postmodern midwife and the doula helping her, this is the starting point for attending childbirth. The theorists of alternative birth movement say that after an uneventful pregnancy the medical presence at birth is in most cases unnecessary and disproportionately expensive. The need to reintroduce the assistance of childbirth to the hands of midwifes has naturally led to a status hack and even a bread war, especially in countries where gratuity (or "parasolvency") is a common practice and where there is a low level of transparency (for example in Hungary).[24] However, the goal of enforcing a female perspective is not in itself to empower women, but, through stronger female participation, to ensure that the interpretation of birth and childbirth in

addition to rationality considered masculine is given an emotional character that is considered a feminine trait.

On the issue of the power over childbirth the natural childbirth movement is characterized by a kind of naturalistic approach, according to which childbirth is not controlled by the doctor or by the woman in labor herself, but is influenced by forces that are more powerful, unknown and stronger than human. That might be a biological code (Bálint 1991), hormones, the fetus, nature itself, God, or even some kind of spiritual power. There is a strong emphasis in the movement on the view that human is not a being who rules nature, but acts as part of it. Therefore, childbirth, which in its original form will never be perfectly controllable, can only be interpreted as a natural process. This idea appeared exclusively in postmodern childbirth culture, as both premodern and modern childbirth culture seek to dominate and oversee the childbirth process with their own technology (magic or high-tech). Nevertheless, despite the innovative idea, postmodern childbirth culture also socializes childbirth simply by incorporating it into its own norms and proposing as its technique the preferred non-interventional method.

Because doulas can and are prepared to support women primarily in the process of natural childbirth (so these women are conscious in connection with childbirth and they want to have a normal birth), the doulas' activity by itself is a critique of modern, technocratic childbirth, whose preventive procedures are technical, but some theorists say they are as ritual as the preventive rites of premodern childbirth culture (Martin 1987, Davis-Floyd 2003, Kitzinger 2005). Enema, shaving, episiotomy, pharmacological acceleration of birth, pain relief, anesthesia, the routine of taking care of the newborn, and artificial nutrition of the baby often serve to strengthen the modern notion of birth order and nutrition rather than to facilitate childbirth and the emergence of early bonding. According to Davis-Floyd (2003: 2) the rites of the technocratic birth model make us feel that we can transform unpredictable and uncontrollable natural processes into a relatively predictable and controllable phenomenon that reinforces technocratic society's belief in supernatural technological superiority.

Summary

The natural childbirth movement as a postmodern childbirth culture, fundamentally seeks to transcend modern childbirth culture, namely with a change in attitude. However, this intention is by no means limited to the issue of childbirth. While the stated goal is to improve the quality of childbirth, the path that leads to the goal also raises a number of other social issues. The problem of power and the social role of the woman are related: the power over birth and the recognized knowledge of childbirth was taken over from the woman by man in

the process of medicalization, so the desire to return control over childbirth to women's hands is incompatible with the accepted ways of technocratic childbirth management. The resulting conflict has, over time, escalated into a cognitive conflict (Brehmer 1976: 985-1003) in which the disputing parties are able to substantiate their truth with scientific evidence (i. e., they have the same sources, but select them differently) and because of their practices they have quite different experiences. The movement seeks to achieve a stronger representation of women in childbirth primarily by increasing the competencies of midwives and, on the other hand, by making accepted the hospital presence of doulas. However, an important goal of the movement is to strengthen the type of autonomous, decisive and decision-making type of woman who can stand up for her child's and her own rights and interests in the maternity ward, which basically means that her feelings, intentions and preferences are not subordinated to the technocratic machinery. According to the basic goals of the movement, this endeavor primarily serves the interests of the newborn and ultimately the quality of life of society. The natural childbirth movement considers childbirth as a holistic whole, in which the interests of mother and fetus do not separate, and – taking into account the long-term effects of the quality of childbirth – it also seeks to reform the way of newborn's reception. Although opinions are divided on the presence of fathers in the maternity ward, the movement is fundamentally seeking to strengthen the type of 'involving father' by extending their attention also to fathers in terms of conscious preparation for childbirth and the postpartum period. Doulas play a significant role in achieving the above goals, seeking to support women in conscious pregnancy, childbirth and postpartum period as a non-medical but specifically a social supporter, and targeted research suggests they can play an important role in improving perinatal outcomes. The organization of their communities, which operates on a voluntary basis and within the civil sphere, reflects the dilemmas that characterize the natural childbirth movement. Representing the nature of childbirth, which is thought by them to be non-standardizable (as modern childbirth culture does), makes it important to represent diversity, which, however, makes the process of institutionalization difficult. At the moment we can witness the strong diversity of both modern and postmodern childbirth culture, which means the emergence of many different versions of the humanistic childbirth model between the two poles of the technocratic and holistic childbirth model, but it is not yet clear how it can be reconciled in practice and what theoretical framework can be put in place for high technological possibilities and the increased demand for natural childbirth.

Notes

[1] In Hungary, the midwife regulation of Queen Maria Theresa (1770) marks the beginning of medicalization in maternity ward.

[2] The Hungarian language distinguishes the medical-minded midwife (*szülésznő*: caregiver in delivery), who always works in a hospital, from a psychologist-minded midwife (*bába*: attendant in birth) accompanying both hospital and home births.

[3] https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=6933E13DCC8BA0E6D2AE22E13B4021C9?sequence=1 (download time: 13.11.20)

[4] Marsden Wagner, the interpreter of the conference, an obstetrician, perinatologist and public health expert was director of the WHO Mother-Child Section from 1990 to 2005. Therefore, his statements serve as an important source of legitimacy for the natural childbirth movement.

[5] https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=6933E13DCC8BA0E6D2AE22E13B4021C9?sequence=1

[6] As stated in the resolution of the Hungarian Professional College of Obstetrics and Gynecology on home birth in 1999: 'The tremendous achievements of the Hungarian obstetrician in reducing maternal mortality and morbidity were related and are relating for institutional births, intensive detection, preventive approach, conscientious procedures of obstetricians performed with the utmost care and diligence, strict adherence to professional rules.' Resolution of the Professional College of Obstetrics and Gynecology of 26 February 1999 on 'Planned home birth'. Magyar Nőorvosok Lapja (Journal of Hungarian Gynecologists), 1999, Vol. 62, p. 233, or Martini 2002.

[7] The Hungarian Ethnographer Eszter Csonka-Takács, for example, writes about the change in the culture of childbirth in Gyimesközéplok, Transylvania in 2006: „The change is more of a practical, technical nature: there is a difference between the place of delivery, the method of care and the person assisting in childbirth. All this was transferred from the family sphere to the official scene. At the same time, however, the community way of thinking about childbirth, the traditional system of habits and beliefs, and the behavior of mothers did not change fundamentally. Childbirth is still seen as a natural process that, until it starts, cannot overwhelm family everyday life, the division of labor, or relieve a woman of her responsibilities " (Csonka-Takács 2006: 33).

[8] Interview with Leboyer (http://www.kismama.hu/babavaras/gyonged_szuletes/2909/ Time of download: 11.02.20.)

[9] ’Forgive me for saying this – you are smiling, you are seeing the shock and doubt on my face – when a husband speaks to a woman in labor, confuses her, distracts her from who is most important in those hours: her baby. In the moment when something breaks the relationship between the mother and fetus, the fetus is lost! If the mother pays attention outward, her husband’s words, she is unable to look inward, to her child at the same time. And never, for a moment, should the newborn be left alone.’ (Interview with Frederick Leboyer: http://pro-bio.hu/index.php?option=com_content&task=view&id=81&Itemid=36 (Time of download: 12.11.20.)

[10] www.primalhealthresearch.org

[11] Alternative childbirth is essentially what the natural childbirth movement is struggling for and what I call postmodern childbirth culture. The term alternative refers to the theory and practice that emerges in parallel with a medicated childbirth culture, but can create misleading associations if a practice that supports the natural course of childbirth is called an alternative solution. The term postmodern childbirth culture, in my view, more accurately covers its relationship to modern childbirth culture.

[12] The name of the movement cannot be translated into English because it is based on a pun in Hungarian. In Hungarian, ’different state’ (in the form of ’differentstate’) means also ’pregnancy’ (in a folk version), and the name of the movement is understood in a prompt mode (let there be different (better) states in obstetrics!)

[13] Ministry of Human Resources Health Professional Guidelines on Family-Friendly Maternity and Newborn Care. Magyar Közlöny (Hungarian Gazette) 2019, Vol. 20, p. 2193-2212.

[14] Three deaths are linked to Ágnes Geréb. In March 2000, a baby born at home had to be resuscitated, which was successful, but the newborn suffered such permanent brain damage that he died a year later. The second death occurred in late 2003, when the second of twin newborns died sixth months after the birth. Twin births are usually indicated as a risk factor in home births, but according to Ágnes Geréb, knowing all the risk factors, the risk was as small as possible in their case, because the heads of both fetuses had in front, both developed in separate membranes and the placenta was separated too. The first baby was born properly but the heart sounds of the second newborn deteriorated rapidly, he became purple and breatheless. Although resuscitated, the baby died half a year later. The third tragedy occurred in September 2007, when the fetus’ head came out at dawn at the end of an uncomplicated birth, but the shoulder of the fetus got stuck in the birth canal. Although the mother was already in the hospital 12 minutes later and the fetus was rescued with a barrier incision, the baby’s life could no longer be saved.

[15] Kisdi 2013. Before regulating home birth, I requested from the Central Statistics Office the data that could be assumed to be a pre-planned home birth. I asked for screening the live birth forms, where the birth took place outside the institution but a health professional was present (there is no option to mark homebirth or birthing home on the data collection form). Currently operating midwifery services have only partially made available to me their data, so I cannot provide real numbers for recent years.

[16] Established in 1995, the Cochrane Databesed of Systematic Reviews (CDSR) was based on Iain Chalmers' work Effective Care in Pregnancy and Childbirth (Chalmers 1989), a systematic database of randomized trials of obstetric interventions. This established the Cochrane Pregnancy and Childbirth Database in 1993, and then expanded in 1995 to the Cochrane Database of Systematic Reviews. (https://community.cochrane.org/handbook-sri/chapter-1-introduction/11-cochrane/112-brief-history-cochrane)

[17] The book published on the basis of her dissertation: Raphael 1973

[18] There were two male doulas in Hungary, both of whom were connected to the natural childbirth movement through their wives, but did not act as doulas for long. Their evaluation by the doulas was not clearly positive. A male obstetrician also completed one of the doula courses to get acquainted with the attitude and experiential material that doulas have. He is also a supporter of natural childbirth.

[19] In my sample, the occupation means in many cases intellectual status, as 77.89% of the respondents have a degree, two of them have PhD degrees (ethnography, neurobiology), and another 6,31 % studied in higher education at the time of the survey. By education most have a health degree (biologist, doctor, pharmacist, mental hygienist, special education teacher, midwife), to a lesser extent commercial and economic, approximately the same proportion of humanities and social sciences (including psychologists), followed by educators and those with engineering degrees. Many are (have been) in postgraduate training, but these are mostly training that can be integrated into the practice of doula work.

[20] The remuneration of doulas is mostly uniform, fixed in advance, and depends on the type of services. However, there is also the phenomenon of social doula service, which partly means offers to those in need, partly free hospital on-call attendance, partly free training in deprived communities in Hungary (primarily among the Roma).

[21] Although the time factor (reconciling work, family and doula tasks) is also a constant problem for doulas, the tightening of life processes by time limits is most clearly criticized in the case of childbirth. According to the approach of the

natural childbirth movement, birth cannot be adjusted to the time represented by the clock – a culturally defined framework – because in their opinion, individual births should only be adjusted to their own rhythm, which takes into account individual characteristics. The notion of timelessness in the case of childbirth refers to a perception that does not take into account the intergenerational effects of childbirth and birth.

[22] One of the prominent Hungarian psychologist researchers of epigenetic, transgenerational effects (head of one of the Hungarian university departments of psychology) herself is actively involved in the natural childbirth movement. Her writings, lectures and activist actions are well known among doulas, in the latter often working together with doulas.

[23] Today, 87.78% of obstetricians in Hungary are men, and the former members of the Hungarian Medical College of Obstetrics and Gynecology used to be exclusively men. The members of the current College of Obstetricians and Gynecologists and Assisted Reproduction are men only and the authors of obstetric textbooks are also exclusively men. In 2014, there were 181 female obstetricians and gynecologists for 1,301 male obstetricians and gynecologists (Hungarian Statistical Office, Yearbook of Health Statistics 2014: 86-97)

[24] Between the submission of the manuscript and the publication of this article, the Hungarian government enacted a law prohibiting parasolvency. The consequences of this move for the transformation of the obstetric system are not yet known.

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