DOULA CANADA

Advocacy Framework

Position Paper 2022

Submitted To
Shaunacy King
Director, Doula Canada
www.doulatraining.ca

Submitted By
Keira Grant
EDI Lead, Doula Canada
@doulacanada

Table of Contents

What is Advocacy?

“Advocacy” can describe any efforts or actions to change a policy, system, or institution that is in some way harmful to individuals or communities. It can also describe efforts to affect outcomes that are aligned with the needs or interests of particular individuals, groups, or society.

Current examples of advocacy include the efforts of Indigenous communities to expose the atrocities at residential schools and seek truth and reconciliation from the Canadian government.

In the context of perinatal healthcare, advocacy is usually focused on updating practices and policies that are not evidence-based, changing the scope, compensation, or other labour conditions of a health profession or occupation, or health equity and patient rights issues.

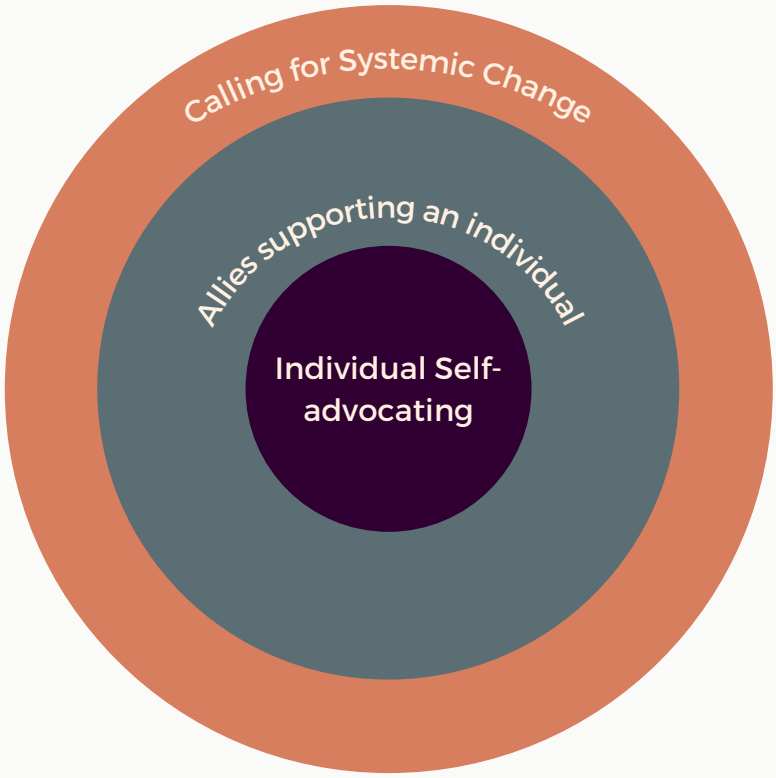
In the context of doula practice, advocacy can operate on three levels: self-advocacy, systemic advocacy, and individual advocacy (Gray & Jackson, 2002, Centre for Excellence in Disabilities).

Advocacy is not without controversy. The line between advocacy and activism is unclear and for many, this has a negative association with confrontation, aggression, and violence (Gray & Jackson, 2002).

For doulas, this controversy has some unique dimensions. One such dimension is that the field is growing, changing, and still seeking legitimization and security within the healthcare system. Another is that the philosophy of doula practice is largely focused on patient empowerment, making the role of systemic and individual advocacy unclear and subjective among doulas.

The goal of this framework is to a) define the three levels of advocacy in the context of doula practice as taught by Doula Canada and b) clearly articulate the nature of individual advocacy in Doula Canada's teaching, and offer practical guidance on how individual advocacy can be enacted.

Three Levels of Advocacy



Defining Self, Systemic, and Individual Advocacy

In Doula Practice

Self-Advocacy Promotion

Self-advocacy refers to an individual's ability to effectively communicate, convey, negotiate or assert his or her own interests, desires, needs, and rights (VanReusen et al., 1994).

Empowering self-advocacy is an integral dimension of doula support. This involves ensuring that clients have enough information to provide informed consent, encouraging clients to speak up for themselves, and creating space for client questions. The politics of encouraging self-advocacy are complicated in doulaing because the doula is an ally, hired support, and someone with more knowledge of perinatal health than the client. Given the inherent power dynamic of possessing greater subject matter expertise, some clients expect the doula to practice in a way that is more directive. The doula may need to self-advocate concerning this and other professional boundaries while finding ways to empower the client to self-advocate.

How It Is Enacted

The Doula-Client Relationship

Ideally, the doula should practice as a knowledgeable peer. To enact the promotion of self-advocacy, doulas must construct their role in a manner that differs from that of physicians or midwives who diagnose and treat as medical authorities. The doula's peer support role is much less specific and largely shaped by the client's self-identified needs. As such the relationship is collaborative and should involve ongoing dialogue regarding the nature of support that is needed and the efficacy of support that has been provided.

Many doulas find that clients provide feedback when the support relationship is over. Similarly, some clients express concern about disappointing the doula when the birth does not go according to plan. Behaviours such as this indicate that a power imbalance has arisen in the doula-client relationship. This can be mitigated by explicitly inviting the client to provide ongoing feedback at the outset of the support relationship.

Communication in the doula-client relationship should promote self-advocacy by using plain language, translating and demystifying medical jargon, and establishing clear boundaries. Doulas also support self-advocacy when they clearly communicate their strengths and weaknesses, as well as their legal obligations and limitations. This might include ensuring that clients are aware of limits to confidentiality, reporting obligations, and transparency regarding the storage and maintenance of documents regarding the client's health.

How It Is Enacted

Informational Support

When enacted effectively, providing patient education, information and resources is a powerful tool for promoting client self-advocacy. Well-informed clients are more confident about their needs and rights, and better positioned to ask meaningful questions and have partnership-based dialogues with their medical team.

Further, the role of promoting self-advocacy is optimized when doulas are informed of the systemic barriers that their clients are apt to encounter and options for removing, disrupting, circumventing, or navigating these barriers. For example, informing racialized clients of the impact of medical racism on a timely and accurate diagnosis of perinatal dermatological conditions can support clients to trust their bodies and ask the right questions of their healthcare providers. Another example is knowing about providers in your community who offer evidence-based care to disabled clients to support clients who have been told that their disability prevents them from a trial of vaginal delivery to speak up or get a second opinion.

Actions

that Promote Self-Advocacy

- Seeking/modeling informed consent
- Using tools like intake forms to facilitate universal discussions regarding trauma, mental health, systemic barriers, etc.
- Clarifying the scope of practice and legal obligations (e.g. child protection reporting requirements, documentation practices)
- Providing evidence-based information
- Being informed of systemic marginalization and implicit bias in healthcare
- Having an understanding of social determinants of health that impact the client
- Establishing a balanced doula-client relationship with clear boundaries
- Using clear language
- Supporting clients to prepare a list of questions for medical providers
- Being aware of the client's mental state concerning self-advocacy capacity
- Having discussions about the client's capacity and desire for self-advocacy during perinatal visits.
- Being knowledgeable regarding appropriate referrals that may benefit clients and direct clients as needed.
- Being trauma-informed and creating space to talk about the impact of personal, vicarious, and intergenerational trauma on the perinatal journey.

Self-Advocacy Promotion

Considerations & Complexities

Empowering self-advocacy effectively requires good judgment and discernment on the doula's part. When clients are in rest and digest mode, a well-informed, empowered client is more likely to be able to self-advocate. Conversely, a client in fight, flight, freeze, or fawn mode is less likely to be able to self-advocate and may want the doula to take a more active role in advocating on the client's behalf. Thus, the doula needs to be attuned to these states in the client and to have had thorough prenatal discussions with the client about the level of individual advocacy that is desired from the doula during labour.

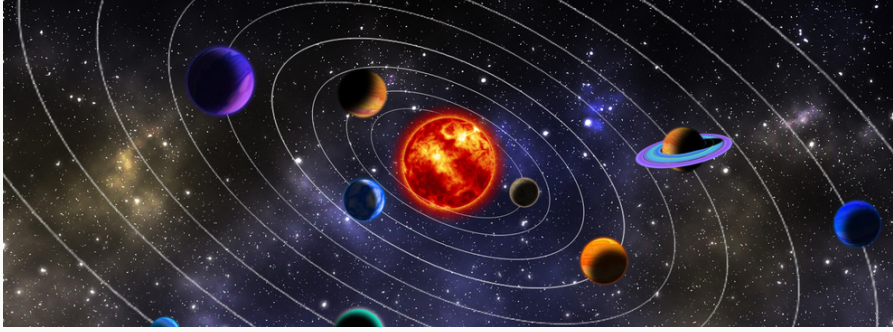
Similarly, perinatal mental illness and/or trauma history may impact the capacity and efficacy of self-advocacy, making perinatal mental health a vital discussion with all clients. Doulas should discuss with clients trauma triggers, signs of mental health concerns, and pathways for accessing support and create an action plan for addressing mental health concerns as a routine aspect of the perinatal planning process.

A person’s beliefs, values, and culture may also influence their ability to self-advocate, their methods of self-advocacy, and the efficacy of self-advocacy efforts. For example, some may believe in trusting the physician as an expert and do not believe they should question or self-advocate.

Moreover, the perceived or actual efficacy of self-advocacy is often lower for marginalized individuals, especially those experiencing multiple forms of marginalization. Multiply marginalized clients often anticipate having greater advocacy needs and greater difficulty advocating for themselves. Thus, multiple marginalized clients are often seeking a doula who will speak up in support of the birth plan during clinical interactions.

Even in instances where the client is expressly seeking for the doula to advocate for them, this must occur at the direction and discretion of the client, therefore the doula functions as a proxy for the client’s self-advocacy.

Systems Advocacy



Broadly put, systemic advocacy is any effort to make changes to written or unwritten rules in a social institution. The focus can be on changing laws, and government structures, or on the policies of hospitals, schools, religious groups, community organizations, corporations, and a variety of other entities. In perinatal healthcare, foci of systemic advocacy include hospitals and other points of care, health ministry laws and policies, insurance systems and coverage, and the practices and curricula of healthcare training and education institutions.

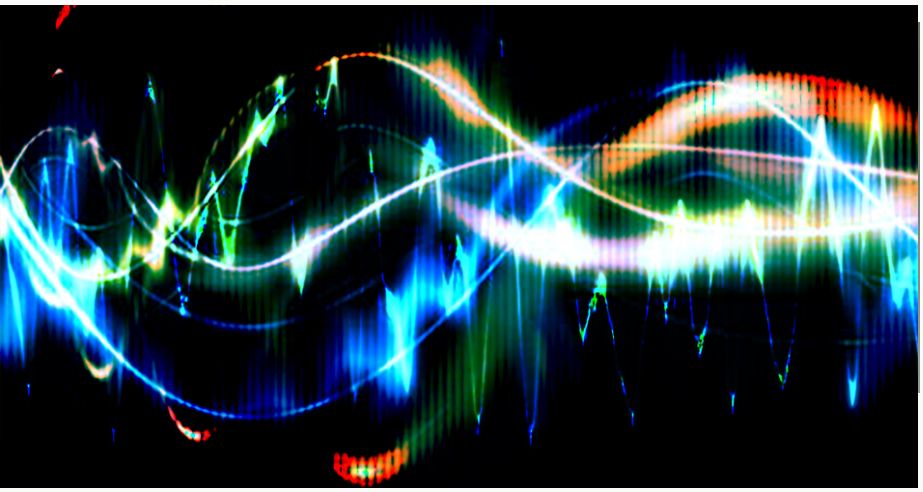
The history and role of systemic advocacy in doulaing are multifaceted. At the profession's inception, clients were almost exclusively affluent and otherwise privileged, with very limited systemic advocacy needs. Currently, doula clients are far more diverse. There is growing recognition that it is often the most marginalized birthers who can benefit most from doula support. As a result, there are increasing options for subsidized or fully-funded support, changing the demographics of the doula client population.

A significant proportion of doulas continue to work with privileged clients who are for the most part well-served by existing healthcare systems. That being said, all people with uteri are marginalized, and many of the actual and anticipated experiences of birth trauma and obstetric violence that doulas are hired to mitigate are pervasive among the birthing population. Examples include c-sections and inductions of questionable medical necessity, episiotomies without informed consent, pressure to introduce formula supplementation in the hospital, constraints on where and with whom one can birth, and a host of other widespread practices. In short, systemic patriarchy within health care puts all birthers at risk of losing autonomy during the medical journey.

How It Is Enacted

In the context of doula practice, systems advocacy can involve calling for changes that make the system more patient-centered and which reduce the impact of systemic inequity (e.g. racism, homophobia, classism, ableism, etc.) in health care. Doulas can enact systems advocacy by joining boards or associations tasked with effecting change, writing to politicians individually or as part of a larger campaign, or forming grassroots, local coalitions to liaise with health institution leaders.

Doula organizations can support and encourage systems advocacy by ensuring that students are made aware of systemic issues, by allying with and spreading awareness of organizations engaged in change-making, and by ensuring that social media content raises awareness and addresses matters that are relevant to the advocacy needs of birthing people and doulas.



Examples

of Doula Systemic Advocacy

- Participating in and amplifying advocacy campaigns that benefit birthers, babies, and doulas.
- Using social media platforms to raise awareness
- Being informed on the views of elected officials on policies related to healthcare and lobbying them to vote in support of birthers, babies, and doulas.
- Joining boards, working groups, or committees of organizations striving for change.

Systems Advocacy

Considerations & Complexities

Changing the systemic dynamics from which these issues arise is in the best interests of birthers and doulas, creating a strong moral imperative to engage in systemic advocacy. However, not all doulas espouse a philosophy of practice that necessitates awareness of systemic issues or effecting change. While engaging in systems advocacy can never be a requirement of individual doulas, training bodies and associations can foster a culture of practice wherein engaging in systems advocacy is normalized and encouraged.

The role of systemic advocacy is further complicated for doulas by the profession's current stage in obtaining recognition and legitimacy. Many policy actors within the healthcare system, including regulated health professionals, are unaware of, confused about, or unsupportive of the doula's role. As a result, many doula associations and training bodies focus their advocacy efforts (if advocacy is undertaken) on seeking professional recognition, legitimacy, funding, insurability, legal protection, and other resources.

The precarious nature of the doula role can create a conflict of interest for individual doulas and organizations with regard to systems advocacy focused on health policy change. As a profession still seeking acceptance, there are valid concerns that this type of advocacy will cause doulas to be seen as "troublemakers", thereby alienating potential allies with more social and political power (e.g regulated health professionals, and hospital administrators). One concern is that doulas could be debarred from access to environments like hospitals or birth centres, thereby depriving birthers of the benefits of continuous labour support.

While these concerns are valid, they speak to some of the very system issues that would behoove doulas and birthers to change. For example, one way in which doulas can and do advocate is for the right of birthers to have the support persons of their choice during labour.

Individual Advocacy

Individual advocacy occurs when a person or group focuses their efforts on one or two individuals navigating a challenge or crisis. Well-known examples include efforts to free political prisoners or grant asylum to individuals at risk of violence.

Individual advocacy can happen informally through the efforts of family, friends, and ad hoc community coalitions. Formal advocacy occurs when agencies advocate on behalf of an individual.

In the doula role, individual advocacy is most frequently undertaken to buttress, complement, or facilitate the client's self-advocacy efforts. The most common circumstance under which the need to advocate for clients arises is during labour and delivery. During prenatal and postpartum support, decision-making might feel less rushed and offer more time and space to promote the client's self-advocacy.

Additionally, as a result of the shifting client demographics noted above, supporting clients with health system navigation is an increasing component of the doula role. This is especially likely to be true if clients are low-income, undocumented, or otherwise socially vulnerable. In circumstances such as this, the doula may have more social privilege than the client and opportunities to use that privilege to the client's advantage. For example, the doula may be aware of resources that the client has not been made aware of and may have better knowledge of the communication strategies needed to secure the resources.

Case Study: Kai& Naima

Doula-Client Relationship

Kai is a birth and postpartum doula with a non-profit collective that supports BIPOC in a large Canadian city. Naima, one of her clients is expecting her 4th child. She is a middle eastern, single mom whose income source is Ontario Works. During her first prenatal visit with Kai, Naima discloses that she experiences chronic back pain that began after the birth of her second child. Her family doctor has prescribed medication and referred her for nerve-blocking injections, but these interventions have provided little relief. The pain has been quite bad during this pregnancy.

Kai asks if Naima has been provided with any education regarding pelvic health and pelvic floor recovery. Naima is unfamiliar with this terminology. Kai briefly explains the pelvic floor, how a weakened pelvic floor can contribute to back pain and options for pelvic floor healing. Knowing that Naima is uninsured, Kai provides information regarding a Rapid Access Back Pain Program initiated by the Ministry of Health in 2019. The program provides free physiotherapy to people with chronic back pain. A family physician needs to make the referral and to do so, they need to be registered with the program. There is no cost to the physician, just some paperwork. Only physicians and primary care Nurse Practitioners can register for the program, so her current midwife is not eligible.

Naima has not disclosed her current pregnancy to her family doctor. She is concerned about explaining all of this to her physician clearly. She notes that her physician has been dismissive of her suggestions in the past. She asks if Kai can send her physician information about the Rapid Access Back Pain Program for her.

What should Kai do in this situation?

Individual Advocacy

Considerations & Complexities

Hospital-based and non-profit doulas are often supporting clients who are navigating multiple other systems, such as immigration, social services, social housing, and criminal justice. As a result, some clients have had to self-advocate throughout their lives and are fatigued from this burden. Under these circumstances, clients may express a desire for the doula to fulfill certain tasks on their behalf. Doulas must have a clear understanding of their role and scope to determine whether or not the request falls within the scope of regulated health professional practice (e.g. the disclosure of personal health information (PHI) is required), or the scope of a social worker (e.g. directly intervening in a child protection matter). Doulas must also consider whether such requests are aligned with their personal and professional boundaries.

Additionally, as doulas have neither the legal protections nor authority of regulated health professionals, in most circumstances, doulas do not have access to effective levers of individual advocacy.

For example, in the scenario described above, Kai is not a legal custodian of health records. Therefore, by sharing the client's personal health information with the physician, Kai is placing herself in a legally uncertain and potentially precarious position (Guide to PHIPA, 2004). Also, since physicians do not see doulas as "colleagues" there is a possibility that the physician will be dismissive of information coming from Kai and damage may be caused to the circle of care surrounding the client. Promoting the client's self-advocacy by further exploring her reasons for being reluctant to present this information to her doctor, and supporting her to develop an effective communication strategy is more aligned with the doula's role, and more likely to yield results for the client.

The "Soft-Advocacy" Framework of Individual Advocacy

And How it is Enacted in Doula Practice

"Soft Advocacy" and Doula Support

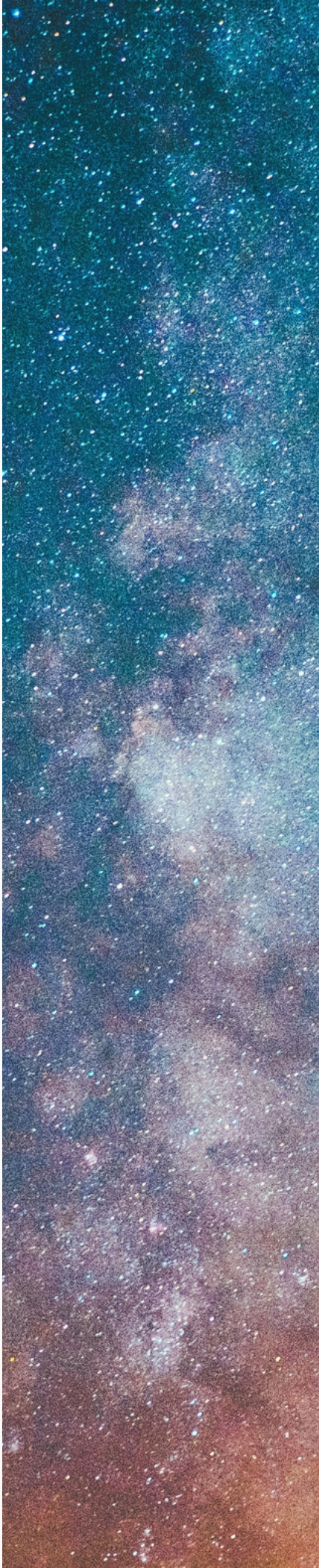
In a 2020 paper based on semi-structured interviews with L&D doulas in the US, S.S. Yam posits a “soft-advocacy” framework to describe individual advocacy as practiced by doulas. Yam asserts that while doulas are not usually able to engage in individual advocacy as it is usually understood, they do routinely use more subtle tactics to advocate for their clients, especially during labour and delivery when the client is most vulnerable. Specifically, Yam identifies three soft advocacy strategies employed by doulas:

1) Creating Deliberative Space
2) Cultural and Knowledge Brokering
3) Physical Touch and Spatial Maneuvers

The following section will briefly describe each of these tactics and how DTC doulas have seen these tactics enacted in the Canadian setting. The case studies provide concrete examples and questions that support reflection on each tactic.

Creating Deliberative Space

People who do not have sufficient time or information to make decisions during labour and delivery are more likely to feel they were coerced by medical staff and are more likely to have a negative experience of childbirth (Oelhafen et. al., 2021). Thus, a significant aspect of the doula’s prenatal role is to ensure that clients have enough information regarding the birth process and medical journey to make decisions as the need arises during labour.



If complications arise during labour and delivery, there is the potential for interventions to transpire that the patient is not consulted on or did not explicitly consent to.

Yam notes that in such situations, doulas often advocate for clients by opening space and time for the client's questions and wishes to be addressed and reflected in decision-making. Examples identified by Yam included asking the client questions about what they documented in the birth plan. For example, if the doula sees the physician about to administer an oxytocin injection to actively manage the expulsion of the placenta the doula may say to the client “Do I remember correctly that you wanted expectant management of the third stage of labour? Meaning that you wanted the placenta to be delivered naturally? It looks like Dr. Smith is about to administer oxytocin so it will be expelled immediately. Is that okay with you?”

While not consistent with traditional definitions of individual advocacy, Yam argues that this fulfills the function of individual advocacy in multiple ways. Firstly, the doula is leveraging their professional experience to observe that the intervention is about to take place, that it is not aligned with the client’s wishes, and that informed consent has not been obtained. The doula is also leveraging strong prenatal discussions with the client to have clarity regarding the client's wishes concerning the proposed intervention. In this instance, the doula needs to say something since the birthing person may not be aware of what intervention is about to happen. However, this approach maintains the integrity of the doula-client relationship by communicating with the client rather than the physician. It also avoids confrontation with the physician while tacitly reminding them of their obligation to obtain informed consent. Additionally, it is aligned with respect for patient autonomy by placing decision-making squarely in the hands of the birthing person.

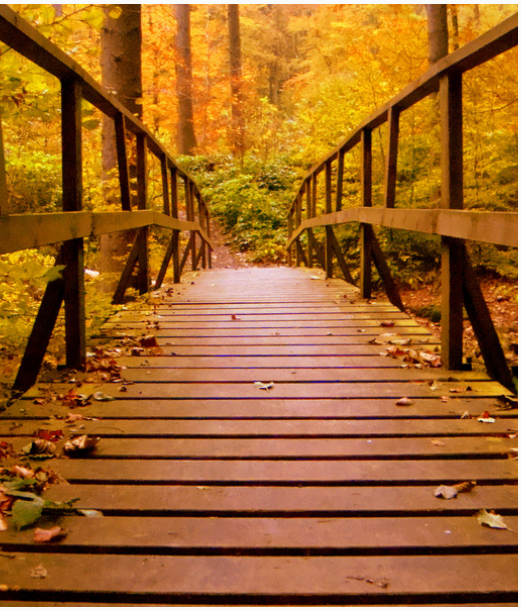
Another tactic Yam identifies in this category is “playing dumb”. One doula in her sample who was highly medically knowledgeable employed this strategy when she could see that clients were confused during interactions with medical staff. She would ask a series of ostensibly naive but specific questions about the clinical scenario, requiring medical staff to provide a detailed explanation of the situation and options in the client’s hearing. She would intentionally leverage medical staff assumptions regarding her lack of clinical knowledge to make this tactic effective.

While there is often an assumption that individual advocacy is confrontational, the examples above demonstrate that there are ways to be vocal without being confrontational, and there are circumstances where speaking up in support of the client’s birth plan is necessary.

Cultural & Knowledge Brokering

Cultural and knowledge brokering are enacted when doulas leverage their enhanced knowledge of perinatal care and cultural medical norms to ensure that clients are well-armed with information in time-sensitive situations. This often manifests as translating medical jargon into plain language, or identifying and removing cultural barriers that the client may not perceive or know how to navigate. Yam identifies a range of tactics used by doulas to facilitate understanding in clinical interactions.

For example, one doula in her sample enacted this by maintaining a discreet running narrative of everything taking place in the labour room, similar to the approach of a sportscaster calling the plays. This ensured that clients understood conversations transpiring between medical staff regarding their care, the purpose of medical instruments, and so on. In this doula's experience, this practice was an enabler of the client's informed consent.



To effectively enact cultural brokering, doulas walk a fine line between not placing the burden of providing cultural awareness education on the client's shoulders, while also not making assumptions about how the client views or engages with their culture. For example, doulas may engage in "soft advocacy" by expressing or demonstrating support for the client's wishes to not engage with certain cultural traditions while the extended family is present.

Central to competency with cultural brokering is asking the client a lot of questions about their experience of a situation and avoiding the natural tendency to make assumptions. As the case study with Hope demonstrates, it is also helpful to know the Canadian healthcare system, and the system and resources available in the jurisdiction where you practice.

Avoiding assumptions is entwined with the practice of "cultural humility". This practice involves making the client's cultural norms, beliefs, and values central in the interaction where these differ from one's own. This is nuanced by the fact that cultural groups are not homogenous or unchanging and each individual engages with and interacts with their culture uniquely.

In circumstances where the doula's culture is the same as the dominant culture where medical care is being provided, while the client's culture differs, this confers a form of power on the doula. The more the client's culture differs from or is viewed as inferior by the dominant culture, the more this power for the doula is amplified. In Hope's case study (page 16), some of this power manifests with Nisha's greater knowledge of hospital systems and resources, and ability to speak English as a first language. When providing support, the doula can leverage this power to the client's advantage by helping them understand and navigate the system, and buttressing the client's self-advocacy efforts.

Information brokering is similar but is more entwined with the doula's enhanced knowledge of medical jargon and perinatal interventions. To a large extent, this role is fulfilled prenatally in the form of prenatal education. Doulas can provide this education in support of self-advocacy by explaining common medical terms that are used in perinatal care while mirroring the client's language conversationally. However, prenatal education cannot prepare the client for every possible clinical situation that may arise during labour and delivery. During this time, the doula can play a critical role in ensuring that the client has sufficient information to provide informed consent.

Enacting this tactic effectively is dependent on the doula not positioning themselves or being perceived by the client as another "expert" member of the medical team. Positioning oneself as a knowledgeable peer allows the doula to act as a bridge to the medical team rather than a member, and maintains the integrity of the support relationship by maintaining the client's autonomy and independence.

Case Study: Hope & Nisha

Cultural & Knowledge Brokering

Hope is an undocumented Ugandan citizen living in Toronto with her two Ugandan-born children, who are also undocumented. She is now pregnant with a third child. Since the father is Canadian and the child will be born in Canada, the third child will be a Canadian citizen.

Hope goes into labour early and begins to bleed heavily. Fearing for her life, she proceeds to the nearest hospital reluctantly. As an undocumented resident, Hope knows she will have to pay for her hospital care out of pocket, a cost she cannot possibly afford.

Hope's child is delivered by emergency c-section and an emergency hysterectomy is also required. At discharge, she discloses to her nurse that she has no family support. The nurse advises hope of a new hospital program that can provide a doula for free. Hope does not know what a "doula" is and is confused by how this care can be free. Nisha arrives to escort Hope home and discuss the plan for her postpartum support. Hope begins to tell Nisha her story and Nisha learns that the baby's father is loosely involved but he has a history of violence and Hope does not feel safe around him.

Hope's discharge instructions are lengthy and there are many medications that she needs to take. Knowing that English is not Hope's first language, Nisha assists Hope by taking notes. Having already learned that Hope is uninsured, Nisha asks the nurse if Hope can be given enough of her prescriptions to get her through the next 24hrs so she has time to coordinate with her pharmacy. The nurse agrees to this request.

During discharge, the nurse provides Hope with a taxi chit for her transportation home. Hope is clearly hesitant to accept the taxi chit. At this juncture, the baby's father arrives, which is a surprise to everyone, including Hope. She is tense, but she returns the taxi chit to the nurse and accepts a ride home from her child's father.

The next day, Hope reaches out to Nisha and asks her to visit because she cannot find the pain medication she was given at discharge. During this visit, Nisha learns that Hope's interaction with her child's father became violent when she returned home and the police had to be called. Hope states that she regrets not taking the taxi home with Nisha instead. She wanted to, but she had calculated the fare and it was more than she could afford. At this point, Nisha explains that the taxi chit would have allowed her to bill the hospital's account with the taxi service, and that "the cab ride would have been free". Hope explains that she was not familiar with a "taxi chit" and did not understand that the cab ride was free. She explains that in her country of origin nothing is free, and she was quite surprised when the hospital gave her free medications at discharge. It would not have occurred to her to ask for this.

Did Nisha employ any soft advocacy tactics while supporting Hope at the hospital? Knowing that the policies of nation-states vary widely regarding what, if any, services are publicly funded, how could Nisha use this information to enact cultural and knowledge brokering going forward?

Physical Touch & Spatial Maneuvers

Tam uses this categorization to refer to any doula tactics that involve physical contact with the client or placement of the doula's body in relation to other individuals who are present. In these instances, the doula is using their physical presence to amplify the client's voice or disrupt obstetric violence.

As the case study on page 18 demonstrates, sometimes just the doula's physical presence beside the client makes the client less susceptible to coercive tactics from medical staff. The use of spatial maneuvers becomes even more explicit when Natasha uses her own physical needs as an opportunity to obtain food for the client and then uses her body to shelter the client from view.

DTC staff and instructors found that they usually used physical touch to model informed consent and compassion in their interactions with the client. This included strategies like asking the client's permission to perform counter-pressure techniques, or asking the client how they feel about the position in which the doula is holding their leg during pushing.

Another common tactic was to gently touch the client to show support and remind them of their presence.

At other times, doulas may use leaning in to straighten out a blanket as an opportunity to have a whispered conversation with the client.

There are countless ways in which physical touch and spatial maneuvers could be enacted. DTC staff and instructors believed that for this tactic to be constructive and ethical it needs to occur:

- With the explicit consent of anyone receiving touch, including attending HCPs.
- With the recognition that touch is triggering for many trauma survivors and that trauma is widespread in the population.
- In alignment with the belief that all individuals have a right to control what happens to their bodies.
- In a manner that does not put the client at risk of harm.
- In a manner that is aligned with liability and medico-legal concerns.

Case Study: Cynthia & Natasha

Physical Touch & Spatial Maneuvers

Andrina is pregnant with her third child and has a clear goal of vaginal delivery after two c-sections (VBA2C). Given her medical history, Andrina's perinatal care physician Dr. Rothstein is not optimistic that she will be able to have a vaginal delivery and has not been supportive of Andrina's VBAC goal. The physician has been pressuring her to schedule a c-section in advance of her due date since her pregnancy was confirmed. Dr. Rothstein has warned her many times of the risk of uterine rupture if she goes into spontaneous labour.

In response to this pressure, Andrina has hired Cynthia to be her doula. Cynthia has been supporting Andrina to prepare for intervention-free labour and to self-advocate during her labour and delivery if she is pressured to move to a c-section.

Andrina goes into labour spontaneously one week after her due date. She goes to the hospital and calls Cynthia to join her. Once Andrina is admitted to the hospital, the medical staff advises her that she cannot eat in case surgery is needed. When Andrina says she is hungry, the medical staff provides her with juice and tea.

A day after she is admitted to the hospital, Andrina is at 4 cm dilation and not effaced. She is quite hungry by that evening when her water breaks. By this time there have been shift changes and the current medical staff is strongly advising her to opt for a c-section. The baby's heart rate is stable and there is no meconium staining in the amniotic fluid. Given this, Andrina chooses to continue to labour with the support of her doula Cynthia.

By the following afternoon, contractions are still more than 5 minutes apart and there has been no change to Andrina's cervix. She is however in a great deal of pain and by this time extremely hungry. Cynthia has now been at Andrina's labour for over 24 hours and needs to call for backup. Since pressure from the medical team to accept interventions, including oxytocin, an epidural, and a c-section, has been growing, Cynthia does not leave Andrina's side until her backup Natasha arrives.

Natasha can see that Andrina is quite weak. Andrina explains that she has not eaten in over 36 hours and that she is desperate for a meal.

Hospital staff are in and out of the room regularly and apply increasing pressure for a c-section. Natasha states that she is hungry and leaves the room to buy some sandwiches at the hospital cafeteria.

When she returns to the labour room, Natasha sets up her chair beside the patient's bed so that she can see the door from the corner of her eye, but such that she is partially blocking the patient from view. Natasha puts out the sandwich on the hospital tray in reach of Andrina and proceeds to start eating one-half of the sandwich herself. Andrina hungrily and gratefully reaches for the other half of the sandwich.

After this light meal, Andrina feels much more energized and is willing to try some yoga and a Miles circuit with Natasha to try to progress labour. Andrina's contractions intensify after that.

Did Cynthia and Natasha use physical touch and spatial maneuvers to support Andrina? If so, how? Did Natasha do the right thing by letting Andrina eat the sandwich? Were there other ways she could have advocated for her client?

Conclusions

Doulas can and do engage in all forms of advocacy, including individual advocacy. Doulas' individual advocacy manifests in a way that defies traditional definitions of this concept. Nevertheless, the outcomes are the same, namely that individuals experiencing unjust, discriminatory, or harmful treatment have effective support to assert their rights, disrupt the status quo, or effect change.

The ethical implications of individual advocacy in doula practice are complex given that supporting individual autonomy is central to the doula's role. The narrative and case studies above demonstrate that there are a myriad of mechanisms by which doulas can enact individual advocacy at the client's behest and as a compliment to their self-advocacy efforts, rather than in place of them.

References

1. Center for Excellence in Disabilities. (n.d.). **Types of Advocacy**. West Virginia University. Retrieved August 23, 2022, from https://cedwvu.org/resources/types-of-advocacy/
2. Gray, B., & Jackson, R. (Eds.). (2002). **Advocacy and learning disability**. Jessica Kingsley.
3. Information & Privacy Commissioner. (2004). **A Guide to the Personal Health Information Protection Act**. 46.
4. Oelhafen, S., Trachsel, M., Monteverde, S., Raio, L., & Cignacco, E. (2021). **Informal coercion during childbirth: Risk factors and prevalence estimates from a nationwide survey of women in Switzerland**. BMC Pregnancy and Childbirth, 21(1), 369. https://doi.org/10.1186/s12884-021-03826-1
5. Reusen, A. K. V., Ryan, G., Reusen, V., & Reusen, V. (1996). **The Self-Advocacy Strategy for Education and Transition Planning**. Intervention in School and Clinic, 32(1), 6.
6. Yam, S. S. (2020). **Complicating Acts of Advocacy**: Reflections Journal, 20, 21.