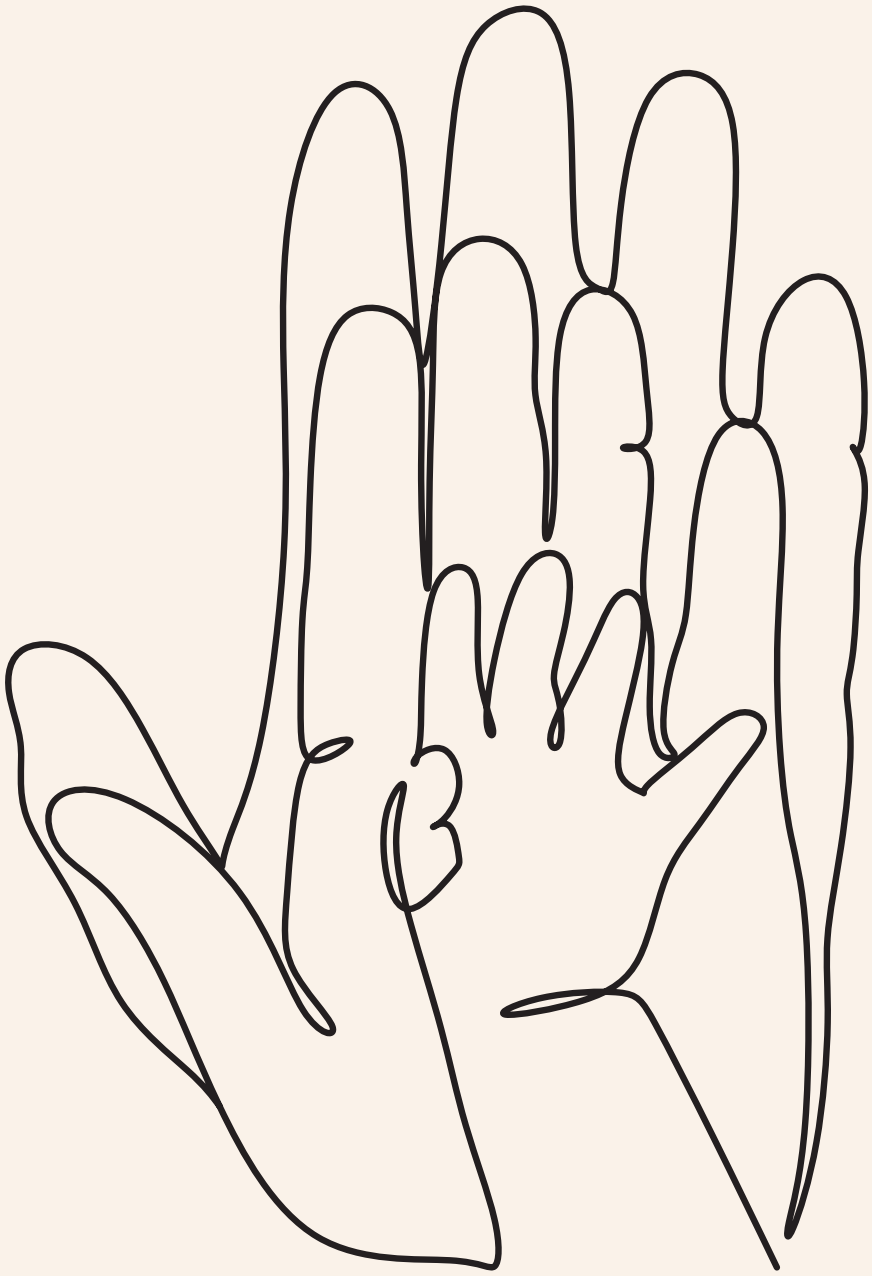


ADVOCACY

A Toolkit for Perinatal Professionals

DOULA CANADA

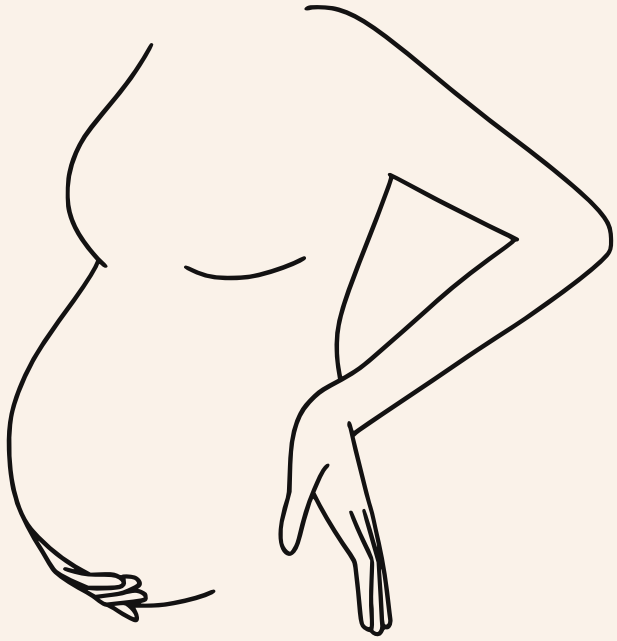
WWW.DOULATRAINING.CA

Welcome

At Doula Training Canada we are committed to providing doulas with the learning and framework to enact advocacy for themselves, their clients, and the community.

This toolkit is meant as an introduction to advocacy and a guide for doulas in how to offer advocacy that supports their role.

In this toolkit you will find practical strategies for supporting clients and communities through teaching self advocacy and advocating for clients.



Who is Doula Canada?

Doula Canada provides opportunities for doulas and childbirth educators to professionally develop their skills and confidence as reproductive support persons.... around the world!

Established in 2001, Doula Canada has a long history of offering quality training with a personal approach. “Certification with confidence” and evidence-based approaches to resource and skill development are two mandates of our organization.

Our Mission

Doula Canada aims to improve reproductive health through the development of client-directed care and a focus on community support models. Our focus is not simply on the reproductive experiences of labour, birth, and postpartum, but on all reproductive journey’s our clients may experience.

We work towards achieving our goals by:

- Focusing on evidence-based information and highlighting where more research must be done
- Mentorship and learning support that positions community at its centre
- Collaboration with other organizations, non-profits, professional bodies, and other stakeholders in reproductive support matters
- Community building through fundraising, emphasis on affirmative practice, and a focus on trauma-informed care models
- Professional development on topics related to reproductive support, health, and advocacy
- Communication and development of learning opportunities that are accessible and dedicated to quality

Our Vision

To build a dynamic community for the continuing education and inspiration of professional reproductive support persons.

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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.

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.

Gray, B., & Jackson, R. (Eds.). (2002). Advocacy and learning disability. Jessica Kingsley. Information & Privacy Commissioner. (2004). A Guide to the Personal Health Information Protection Act. 46.

THREE LEVELS OF 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 clients have enough information to provide informed consent, encouraging them to speak up for themselves, and creating space for client questions.

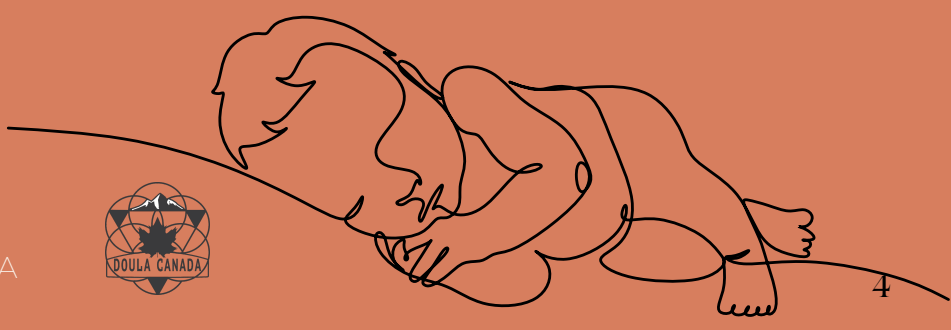
Systems Advocacy

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.

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.



ADVOCACY IN ACTION:

How do we DOula that?

In the context of the doula-client relationship communication and information support should promote **self-advocacy** by:

- 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.

ADVOCACY IN ACTION

Practice the skills:

Case Study: Rose

Rose's first birth was traumatic. Her obstetrician was arrogant and disrespectful and performed an episiotomy without her consent. According to him, her baby was too big to be delivered without this intervention, but the baby was under 7 pounds so Rose questions this information. A resident did a poor job of suturing the episiotomy and as a result, Rose experienced lasting pain and other symptoms of pelvic floor dysfunction.

Now pregnant with her second, Rose is determined to have a positive birth experience this time. She has researched everything there is to know about childbirth and is now looking for a doula to support her labour and delivery. Rose lives in a rural community and home birth with a midwife is not an option. All birthers where she lives must go to the hospital. Given that there are very few OBs in her catchment, there is no guarantee that the OB who delivered her first child will not be involved in her care again.

Rose is determined to birth at home and not have contact with this doctor again. She is looking for a doula who will support her in having an unassisted home birth. Only the doula and her partner would be present. A local midwife is managing her prenatal care, but she does not intend to call the midwife when she goes into labour. She plans to notify the midwife after the baby is born and claim she gave birth precipitously so that the baby can receive newborn care.

Rose explains this to you at a consultation. What should you do?

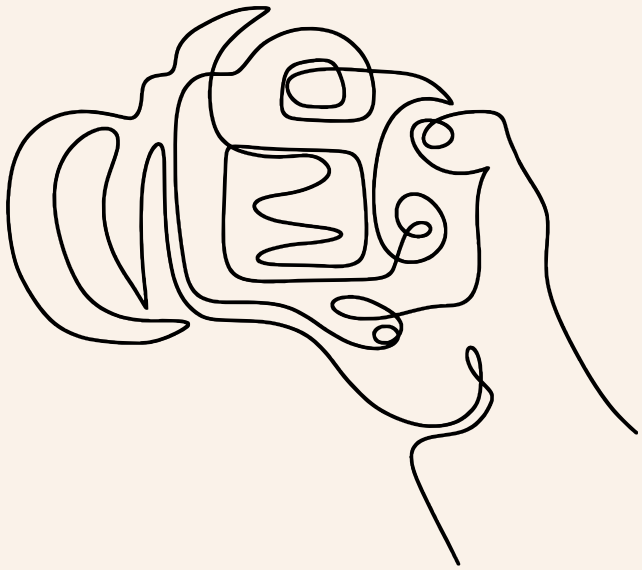
ADVOCACY IN ACTION:

How do we DOula that?

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.

Systems advocacy can look like:

- 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.



CONSIDERATIONS AND COMPLEXITIES IN ADVOCACY PRACTICE:

In Self-Advocacy

Empowering self-advocacy effectively requires a doula to be able to determine where their client is at in the moment. Being attuned to the client includes thorough prenatal sessions in which a discussion about the client's needs around advocacy is discussed.

Understanding that a client'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.

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.

In Systems Advocacy

The role of systemic advocacy is further complicated for doulas by the profession's current stage in obtaining recognition and legitimacy. Many policy makers within the healthcare system are unaware of, confused about, or unsupportive of the doula's role

The nature of the doula role can create a conflict of interest for individual doulas with regard to systems advocacy focused on health policy change. 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. One concern is that doulas could be barred 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.

ADVOCACY IN ACTION:

How do we DOula that?

In the doula role, **individual advocacy** is most frequently undertaken to support, 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.

Individual advocacy can look like:

- Supporting clients with health system navigation
- Understanding the role of social privilege and using it to support clients
- Awareness of resources and the pathways to access them

CONSIDERATIONS AND 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.

ADVOCACY IN ACTION

Practice the skills:

Case Study: Kai

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 5th child. She is a Black, 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 clearly to her physician. 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?

"SOFT ADVOCACY" FRAMEWORK

Yam, S. S. (2020). Complicating Acts of Advocacy: Reflections Journal, 20, 21.

In a 2020 paper, 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:

Creating Deliberative Space

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 and in postpartum.

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.

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.

Physical Touch & Spatial Maneuvers

Yam 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.

SOFT ADVOCACY IN ACTION:

How do we DOula that?

Creating Deliberate Space can look like:

- Opening space and time for the client's questions and wishes to be addressed and reflected in decision-making.

  For Example: *asking the client questions about what they documented in the birth plan. 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?"*

- " Playing Dumb"

  For Example: *When you see that a client is confused during interactions with medical staff. You can ask a series of ostensibly naïve 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. In this way you are intentionally leveraging medical staff assumptions regarding your lack of clinical knowledge to make this tactic effective.*

SOFT ADVOCACY IN ACTION:

How do we DOula that?

Cultural and Knowledge Brokering can look like:

- Translating medical jargon into plain language

  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. (Yam 2020)*

- Making the client's cultural norms, beliefs, and values central in the interaction where these differ from one's own.

  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.*

- Information brokering

  For Example: *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. 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.*

ADVOCACY IN ACTION

Practice the skills:

Case Study: Hope

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 has placenta previa and goes into spontaneous labour in advance of her scheduled c-section. Hope 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 third child is delivered by emergency c-section. As a result of hemorrhaging, an emergency hysterectomy is also required. When it is time for Hope to be discharged, she discloses to her nurse that she does not have family support and no one who can escort her home from the hospital, or assist her during her post-surgical recovery. The nurse seeks Hope's permission to seek support from a local non-profit doula collective that supports BIPOC. Hope does not know what a "doula" is and is confused by how this care can be free. Skeptically, she allows the nurse to hire a doula from the collective. 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.

Given the complexity of Hope's medical situation, her 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.

ADVOCACY IN ACTION

Practice the skills:

Case Study: Hope continued:

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?

SOFT ADVOCACY IN ACTION:

How do we DOula that?

Physical Touch and Spatial Maneuvers can look like:

- used physical touch to model informed consent and compassion in their interactions with the client.

  For Example: *This includes 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.*

- The doulas use of their body in the space

  For Example: *doulas may use leaning in to straighten out a blanket as an opportunity to have a whispered conversation with the client. In circumstances where clients were experiencing more overt aggression from their care providers, doulas have physically moved their clients out of harm's way or used their hands to block an unwanted intervention.*

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 Health Care Practitioners
- With 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
- 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.

ADVOCACY IN ACTION

Practice the skills:

Case Study: Andrina

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.

ADVOCACY IN ACTION

Practice the skills:

Case Study: Andrina continued

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?

BIRTH WORK THE INTERSECTION OF ADVOCACY, EQUITY & CAREGIVING

As birth workers, we hold a unique and important role as community workers. This is reflected in the individualized care and relationships built between the client and the doula. The work can vary from long-term to short-term, virtual or in-person, and it can be hands-on or hands-off, etc. etc.
While there are certain things that are outside of the scope of a doula's work (performing physical exams or medical procedures, for example), there is flexibility in how you show up for your clients.

As birth workers, we specialize in connecting our clients to any needed community services prenatally or postpartum. Services can include postpartum support groups, infant supplies, bodywork (pelvic floor therapy, massage therapy, acupuncture), and lactation support to name a few. When people have a positive birth experience and know where to get support during the immediate postpartum stage, their journey into parenting begins with a stronger foundation.

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

With a trusting relationship and our connections throughout the community, doulas help open the door to the full spectrum of reproductive care — leading to quality improvement of physical and mental health outcomes for pregnant individuals and better outcomes for infants.

RESOURCES FOR FURTHER EXPLORATION

The Radical Doula Guide is a political primer for full-spectrum pregnancy and childbirth support written by Miriam Zoila Pérez. The 52-page guide is a resource for doulas that addresses the political context of supporting people during pregnancy and childbirth. Check out this podcast and TED talk, too.

Radical Doulas Make "Caring a Political Act": Full-spectrum Birthwork as Reproductive Justice Activism dissertation by JaDee Yvonne Carathers.

Evidence-Based Birth statistics about how the presence of a doula, or continuous support person, can positively impact a person's birth experience and outcome. (We eagerly anticipate future research about full-spectrum companion work.)

Reproductive Justice: In Conversation with Loretta Ross with Columbia University's School of Social Work

Doulas, Racism, and Whiteness: How Birth Support Workers Process Advocacy towards Women of Color https://www.mdpi.com/2075-4698/12/1/19

Indigenous Experiences of Pregnancy and Birth Hannah Tait Neufeld and Jaime Cidro Demeter Press, 2017.

Killing the Black Body: Race, Reproduction, and the Meaning of Liberty Dorothy Roberts Vintage (1998)

Delivery Room Advocacy: How doulas can mitigate the effects of medical sexism and racism https://brownpoliticalreview.org/2021/03/delivery-room-advocacy/

Vicarious Trauma Toolkit: https://ovc.ojp.gov/program/vtt/introduction