BLACK DOULA TOOLKIT

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We acknowledge the land on which we live and work is the unceded and unsurrendered territory of the Mi'kmaw people. We are all Treaty people.

Wellness Within: An Organization for Health and Justice is a registered non-profit organization in Nova Scotia working for reproductive justice, prison abolition, and health equity.

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INTRODUCTION

In Mi'kma'ki (Nova Scotia), we carry a rich legacy of over 400 years of Black History. Our province carries with it the celebrations, resiliency, and influence of the Black Community from one end to the other. It carries with it the stain of slavery, the story of refugees and loyalists, and of ongoing immigration - our Black population is varied with ancestry from the Caribbean, the African continent, and the Americas, as well as a growing population of immigrant Black people.

Despite this, in birthing practices we see the impact of anti-Black health policy and bias among practitioners. Data in both Canada (limited) and the United States show how this can impact outcomes for both the birthing parent/mother, and the baby.

This toolkit will work to break through the narrative and act as a celebration of Black birthing and Black joy. It is written by a Black womanist, for Black women and birthing people.

It is important to note that despite our ability to recognize our familiarity, each origin of African Descent differs. While we share a common history throughout the diaspora, and there are threads of culture and customs that weave us together, the tapestry that these have created are developed into their own customs that vary greatly from person to person.

> In this here place, we flesh; flesh that weeps, laughs; flesh that dances on bare feet in grass. Love it. Love it hard. Yonder they do not love your flesh. They despise it. They don't love your eyes; they'd just as soon pick em out. No more do they love the skin on your back. Yonder they flay it. And O my people they do not love your hands. Those they only use, tie, bind, chop off and leave empty. Love your hands! Love them. Raise them up and kiss them. Touch others with them, pat them together, stroke them on your face 'cause they don't love that either. You got to love it, you! And no, they ain't in love with your mouth. Yonder, out there, they will see it broken and break it again. What you say out of it they will not heed. What you scream from it they do not hear. What you put into it to nourish your body they will snatch away and give you leavins instead. No, they don't love your mouth. You got to love it. This is flesh I'm talking about here. Flesh that needs to be loved. Feet that need to rest and to dance; backs that need support; shoulders that need arms, strong arms I'm telling you. And O my people, out yonder, hear me, they do not love your neck unnoosed and straight. So love your neck; put a hand on it, grace it, stroke it and hold it up. and all your inside parts that they'd just as soon slop for hogs, you got to love them. The dark, dark liver—love it, love it and the beat and beating heart, love that too. More than eyes or feet. More than lungs that have yet to draw free air. More than your life-holding womb and your life-giving private parts, hear me now, love your heart. For this is the prize.

- Toni Morrison, Beloved

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SPIRITUALITY AND RELIGION

Through countless conversations with Black families from a multitude of backgrounds in Nova Scotia, there is often a common thread of the importance of spirituality. The theme of connection, in particular at moments like birth, is one that you will see reflected in how Black families often gather together. It is not just a connection to those present in the room, but an understanding of connection to something greater than ourselves – depending on faith tradition there will be different names or iterations of deity. A connection to our ancestors, to our roots, is important to many Black families and this is demonstrated through a desire for traditions that are part of reconnection to our African ancestry.

Affirmations, Mantras, or Prayers can serve as a connection to our spirituality. These can be used as provided, or as a point of inspiration for you to help your client develop some for themselves. Black women have been taught through years and generations of systemic oppression not to be in a moment and trust themselves. These affirmations can serve as true acts of liberation.

I trust my body.

I am present and experiencing this miracle.

I am wholly capable of birthing my baby.

I am beautiful in birthing, my Blackness is beautiful.

I am powerful, and my body is prepared for birth. I am ready to birth my baby.

I am surrounded by the love of my ancestors, who have birthed well for generations.

When I get overwhelmed, I turn to my breath.

Black joy is my birthright.

ADDRESSING COMMON HEALTH CONCERNS FOR PREGNANT PEOPLE OF AFRICAN DESCENT

In North America it is clear that Black parents' concerns may not be taken seriously by health care professionals. Discrimination in the health care context is systemic and often indirect (Ontario Human Rights Commission, 2022). Silent racism, or microagressions, are often subtle, and difficult to discern.

As doulas, we need to maintain focus and awareness with the birthing person as it is their birthing journey.

There is a significant lack of quality research and race-disaggregated health data collected in Canada, and even less collected by Black researchers. (Adhopia 2021) Data from the United States gives us a spotlight to hold on our country's health care services and highlights what Black women know: we are not taken as seriously with concerns or valued when we encounter health care professionals and systems. Data that is available shows that:

- Black women are less likely to be diagnosed with endometriosis, compared to white women (Bougie et al. 2019)
- Black Nova Scotian are less likely to be screened for both cervical and breast cancer than white Nova Scotian women. Trends for Black women across Canada are unclear due to a lack of data and research (Nnorom, 2019)
- Infants born to Black mothers are 2.94 more at risk of being preterm compared to infants born to white mothers. (McKinnon et al. 2016)
- In the US, Black women are three times more likely to die from a pregnancy-related cause than white women. (CDC, 2022).

APPROPRIATE LANGUAGE

Immanuel Kant wrote: "We do not see things as they are, but as we are". Readers of this toolkit experience differences in privilege (race, sexuality, gender, ability, and income) that affect how they see and perceive health experiences and systems. To a Black woman, and especially so to a Black woman who has newly immigrated, and/or speaking with thick accents or in a language other than English, the health system is an obstacle course wherein there can be a multitude of challenges.

Language is important to have clarity on, and it's best to ask your client how they identify. These terms are **some** of the more commonly used terms.

- African-Canadian: Anyone who is a permanent resident in Canada or citizen with African ancestry.
- African Nova Scotian: Those who have heritage to Nova Scotia through the period of enslavement and whose ancestry resides in Africa
- Black- can refer to anyone with African heritage
- Afro-Caribbean- Those with ancestry to Africa and from the Caribbean
- African- Those who come from Africa
- Africadian – a term coined by George Elliot Clarkes to describe Black populations in Nova Scotia and New Brunswick (Acadia or l'Acadie) (Elliott Clarke 2023).

USE PEOPLE-FIRST LANGUAGE

To prevent the use of dehumanizing language, focus on the *people* rather than the method of categorization.

Ex. People experiencing incarceration, not inmates; enslaved peoples, not slaves; and people with disabilities and not disabled people.

BLACK FAMILIES AND PARENTING

Black families are beautiful, diverse, and creative. There are a number of ways that Black families may/may not come together at the time of birthing. This discussion is intended to give some ideas on how family is identified and gathers.

Many families in historic Black Communities are large and extended, with siblings, cousins, grandparents, aunties, all very close to the birthing parent.

The birthing parent may be welcoming larger numbers of family members into the birthing room. It is important as the doula that you advocate for this kind of environment. In most situations it is clinically safe to have many people present in the birthing room – discuss with the members of the health care team if they bring up concerns regarding a limit on numbers.

Presence in the birthing room is an important, even spiritual sharing together. Often those who intend to be part of the birth parent/mother and infant's life will be there to help bring the baby into the world.

Parents may come in alone, or with chosen family (blood family or friends) – again welcoming folks together in these sacred moments is important. The advocacy work of the doula cannot be understated here.

BREASTFEEDING/CHESTFEEDING RESOURCES

TERMINOLOGY

All humans have nipples and breast, or chest, tissue. Some people use the term "breasts" and some use "chest" to talk about that part of their body. Similarly, the term breastfeeding can be used to explain a method of feeding a baby, but some people will prefer chestfeeding or nursing. Always talk with your client about how they prefer to talk about their body and feeding method for baby.

CHEST BINDING

Some people may use chest binders, which are gender-affirming garments worn under shirts to flatten their chest. If your client binds their chest and is pregnant or/plans to chestfeed, there are some considerations to be aware of. Chest-binding soon after delivering baby can increase the risk of blocked milk ducts and mastitis, or decrease milk supply. Sometimes, careful binding is possible, once lactation has been established, but this varies from person to person. Talk with your client about the possible consequences of this situation, such as dysphoria from not being able to bind and/or the impact of binding on lactation.

INDUCING LACTATION

Induced lactation is a researched practice widely used by parents of adoptive children or children born through surrogacy. Unsurprisingly, the research done on induced lactation for 2SLGBTQ+ people is significantly lacking. Anecdotal evidence indicates that induced lactation is possible for many types of bodies, including trans men and women. As a doula, you should not be providing specific instructions for your clients on how to induce lactation. Assure them that trans or non-gestational caregivers are capable of chestfeeding, but that as a doula, you are not able to provide details on any particular protocols. Encourage your clients to read the protocols for themselves and take that information to their doctor or health care provider. Typically, inducing lactation involves taking birth control pills (which mimic pregnancy) as well as an additional hormone for a number of months before baby is born. Then, birth control pills are stopped and pumping begins. It can be a lengthy process of pumping before milk production can start. A reminder, that chestfeeding is not only about milk production. Skin-to-skin contact is important for baby's health and for creating bonds between baby and their caregiver. If your client has tried to induce lactation with no result, remind them that even if baby is latching with no result, they are spending important bonding time together. Chestfeeding can also continue with the help of an at-chest supplement feeder, often called a 'supplemental nursing system.' This is a common tool used for nursing parents who, for various reasons, might not be producing as much milk as baby requires. A thin, flexible tube is run from a bottle of milk and held at the nipple, into baby's mouth while nursing continues.

ADVOCACY AND ASSERTING YOURSELF WITH HEALTH CARE PROFESSIONALS

It is our job as doulas and advocates to ensure our clients know what their rights are and are supported to express their rights in health care contexts.

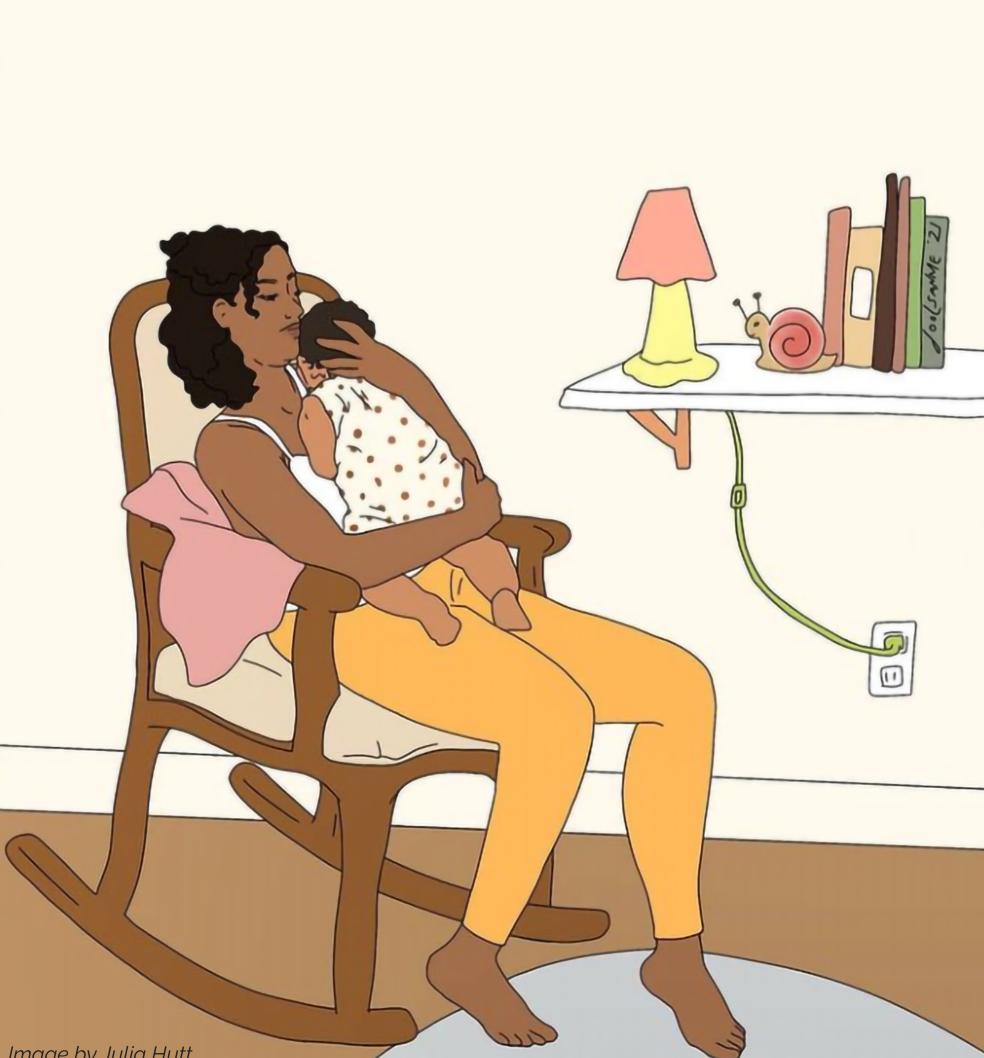


Image by Julia Hutt

> "This brown, exploited, silenced, shamed, celebrated and tired container holding all of my identities felt truly held for the first time during birth doula training. Within this space I learned how to support and comfort birthing bodies to honour a birth experience that they will remember for the rest of their lives. I learned about different cultural, religious and medical interventions. I gained access to information typically reserved for white folks in white spaces."

(Kilah Rolle, 2019)

PATIENT RIGHTS

As a patient, you are entitled to dignity and respect. When it comes to health care in Canada, you have certain rights that are protected by law.

Right to Information

- Have a health care professional clearly explain all aspects of your health, diagnosis, treatment, options and, prognosis.
- Ask questions and express concerns you have.
- Request access to your health records or to them have transferred to another health care provider.
- Request and seek a second opinion.

Content adjusted from: nwac.ca/browse/

Right to Medical Treatment

- Receive culturally safe, quality, competent, timely care that is free from discrimination in a safe environment while being treated with respect and compassion.

Right to Privacy

- Receive consultations, treatments, and evaluations while ensuring confidentiality and respecting your privacy. Be assured that your health information is secure and remains confidential.

Right to Choices

- **Participate** - Participate with the health care team in developing your health decisions and treatment plans in a manner that addresses your needs and wishes.
- **Support** - Be accompanied or represented by a person of your choosing who can support you in making decisions about your care.
- **Consent** - Give or refuse (unless stipulated by law) consent for any medical intervention or procedure and be informed of the consequences for both acceptance and refusal.

Black doulas are doing the work of learning to be held and empowered in ease and grace alongside their clients as well. It is important that when we do this important work advocating for others, we hold ourselves gently, and honour "who we be" – who we are becoming.

The need for advocacy is not what we want as doulas. We want the health care professionals, birth care workers, and hospital staff interacting with our clients to provide competent, inclusive, respectful, client-centred care from the start, without requiring a need for advocacy. Providing advocacy as a doula is not to say that a client cannot speak or advocate for themselves, just that sometimes, especially while in labour or post-partum, it's not the role that they want to take or have the capacity for.

During prenatal support as you learn about your client you will learn what is important to them about their life, experiences and identity. As you move towards the birth, talk about how that importance may or may not shift during labour and birth and how the client wants you to advocate for them. For instance, it may be important to your client that their doula inform the admitting staff about topics that may resurface their trauma. Health care providers should not assume another parent/partner is involved with the birth, but they often do, and you can provide support by asking them not to. Later in labour, or with other birth care workers, that priority may shift. For example, if an anesthesiologist makes a comment about "the father" during the administration of an epidural your client may be concentrating more on the pain intensity they would likely be feeling at that time and the focused nature of this intervention. This is also a relatively brief hospital staff interaction. On the other hand, it may be very important to the client that an anesthesiologist is aware of triggering subjects, especially if it's in relation to someone who may be a safety concern.

A client may be ok with you correcting / advocating in front of them or may want you to do it out of earshot as further mention of a subject may be more upsetting for the client to hear. A client may want to correct and advocate for themselves and have you step in only as needed or when labour takes their focus away from that. Talk with your client in advance of labour, during prenatal visits and check ins, about their priorities and boundaries, how those priorities and boundaries may shift during labour, birth, and recovery in hospital, and how this can be communicated "on the fly" (perhaps with code words or signals).

When advocating with health care professionals, birth care workers, and hospital staff, it is important to remember that while they may not be providing the kind of trauma-informed care your client deserves, there may be few to no options for replacing this person in your client's life. As an advocate it is important to remember that the goal is to address the client's needs in a way that preserves the relationship between them and the professional. If this is someone who will be with your client throughout their labour, birth, and recovery, taking an approach that works with the professional and guides them to a place to support your client is key. Your job is to not make it worse for your client. It may not be the space to educate them on trauma-informed care but it can be a space to educate them on how to care for your client. You, or the organization you are affiliated with, may want to follow-up with that individual, unit, or clinic after to address the concern more fully or to make a formal complaint if this is an avenue your client wants to take.

Your client is, of course, welcome and encouraged to respond to re-traumatizing comments or behaviors with whatever range of emotion they feel is appropriate in the moment. As an advocate you can enhance their self advocacy by backing what they say and "smoothing over" as needed depending on the circumstance. Smoothing over does not mean tone policing your client, apologizing for their behavior, or acting in such a way as to dismiss or diminish what they stated. As an advocate your role is to navigate the space between your client's needs and the other person's attitudes and behaviors in a way that always centers your client.

Witnessing a client not receiving the support and care they deserve is a challenge for a doula. Depending on how your lived experience and the experience of your client does and does not overlap you may see attitudes and behaviors you have encountered before while also gaining insight into experiences your identity has shielded you from. If you do experience these insights, find a support person of your own that you can debrief and process with, while respecting confidentiality. Your client should not be the one to support you as you work through these emotions and reactions.

MICROAGRESSIONS AND RACISM – WHAT CAN I DO, AND SELF-CARE

Microagressions are statements, actions, or incidents where we see subtle, or indirect racial discrimination. It inclutdes verbal, behavioural, or environmental slights. It's the asking to or touching of natural hair. It's the questions about parentage of other children or telling a Black person and/or immigrant they are "articulate".

As a doula, having the capacity to name these things as microagressions is important. Here are some go-to phrases that you can stop those conversations:

"What did you mean by _______?"

"It's not appropriate to say [client] is articulate (or _______)"

"What does that question have to do with the care [client] is receiving?"

Remind your client that they do not have to answer questions that they feel upset or uncomfortable with, and that the two of you could discuss the question before deciding to answer.

The Black Mamas Matter Alliance out of the United States has developed a framework for Black Maternal Health research and advocacy. Some of this framework can be applied at the level of one doula advocating in the pregnancy and birthing process, whereas others offer the opportunity for larger scale advocacy and policy work:

1. **Recognize and respect** the rights of Black mamas.
2. **Understand** the historical, sociocultural, political and economic contexts in which Black mamas live their lives.
3. **Invest** in Black women as researchers.
4. **Fund and conduct** ethical research that benefits Black mamas.
5. **Honor and commit** to community engagement throughout the entire research process.
6. **Include** health equity and social justice as key themes in research with Black mamas.

(Black Mamas Matter Alliance, 2019)

COMFORT POSITIONS FOR BIRTHING

It is impossible for a single page to display the diversity and pairings of bodies that may come together to share care and comfort during labor. Here are some things to consider when physically supporting a client through labour;

1. Simple stretching before physically comforting and supporting a client during labour will help keep up your stamina and reduce the risk of fall, strain, and injury.
2. **Maintain ongoing consent.** Ask when you touch new areas and announce what you are doing. Check in with your client to ensure that they are continuing to feel okay and safe.
3. Communication is key, especially if helping someone transition positions, such as standing to sitting or getting up off of the floor. If you are supporting a client's weight make sure there are verbal signals for when you are ready to bear weight and when you are letting go.
4. Keep it cozy with cushions, padded floor mats, kneepads, gardening kneelpads etc... These are important for the doula as well as the client and can help keep up your stamina and reduce the risk of fall, strain, and injury.
5. Know your limits. Being a doula often means putting your physical needs behind your client's during labour and birth. Doing this when it comes to comfort positions can increase fatigue in a way that means your ability to support a long labour is compromised and bearing too much weight or putting yourself in an uncomfortable position to support someone else creates a fall risk. Know what limits are firm for you and which ones you can gently push in the way this role sometimes calls for.
6. Regularly changing positions is good for the comfort and labour of your client and for the doula to maintain stamina and reduce strain.
7. When changing positions, think about where your client and baby are at in labour and choose positions that can help or slow what's needed (moving baby down the canal, rotating baby, encouraging cervix dilation etc...). There is a negotiation between comfort positions and the labour process.
8. Consider what items you may need or want to incorporate into these comfort positions: mobility aids, birth / exercise balls, yoga blocks, rebozo / scarf, stools, chairs, pillows etc...
9. Talk about comfort positions as part of planning for labour. Each individual is going to have different needs, wants, and boundaries about comfort and touch during labour.
10. Practice comfort positions together in advance, learn about how your specific bodies can interact and work with each other.
11. Talk in advance about how you will communicate about comfort measures and positions during labour as it may be difficult for your client to formulate asks and negotiate boundaries while in labour.
12. Talk about how different interventions (an epidural, for example) may impact and enhance comfort measures and positions and how to plan for those changes.

Image by Julia Hutt

COMFORT POSITIONS FOR BIRTHING

Considerations for Selecting Positions

Positions that have your client standing and sitting upright allow for gravity to assist with labour.

Positions that involve bending and lunging provide comfort to back labour.

Positions that involve squatting and opening legs / thighs help relax the perineum and provide comfort to the pelvis.

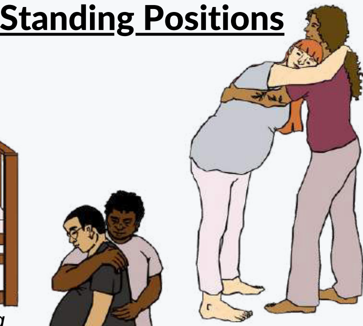
Consider the needs of the labour process and baby when using the following:

Positions that involve movement (rocking, bouncing, walking) can speed up labour.

Positions that involve laying on one side or the other can impact the rotation of baby.

Standing Positions

Lunge Standing



Leaning Forward

Standing Supported

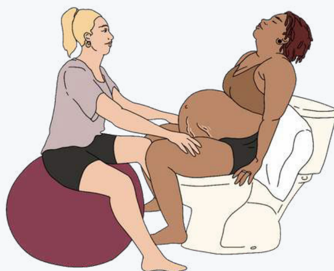
Slow Dancing

Seated Positions

Sitting Upright

Sitting Leaning Forward

Sitting on Commode

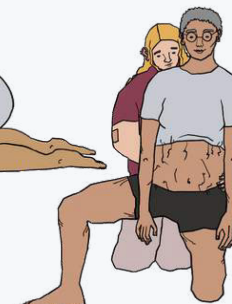


Semi-Sitting

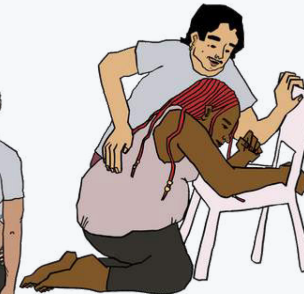
Kneeling / Lying Positions

Kneeling Over Birth Ball

Side-Lying



Kneeling Lunge

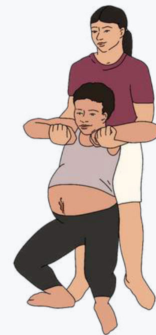


Kneeling Using Chair

Knees to Chest

Hands and Knees

Squatting Positions



Supported Squat

Lap Squat

The Dangle

Tips for supporting people's weight:

Maintain a "low and wide" stance when standing, keep your feet planted flat with knees slightly bent and shoulder width apart.

Never bend at the waist to lift.

Bend at the knees and lift with your legs, keeping your core stable.

Use your thighs as a way to support your client's weight when they are squatting, bent, moving from a standing position down to the floor, or getting up.

Your "trunk" is a strong core and can often support people's weight better than your arms or chest, where people typically lean in order to be supported.

UNDERSTANDING PAIN

The pain experienced by Black birthing people is often dismissed, ignored, or underestimated by their caregivers. There are longstanding, false and unconscious beliefs among health care professionals that Black people have higher pain tolerance and resilience than white people. There is also racism in denial of care.

Black women experience pain and deserve to be heard and believed in their experiences of pain. We are deserving of treatment of pain, and acknowledgement of our own knowledge of our bodies.

LABOUR ANALGESIA DEFINITIONS

Anesthesiologist or anesthetist - A doctor who has specialized training in anesthesia, and, sometimes, additional obstetric training. Residents - Doctors who have completed medical school and are in the midst of their anesthesia specialty training. Anesthesia assistants (AA) - Specially trained health professionals under the direct or indirect supervision of an anesthesiologist. These are a respiratory therapists or registered nurses receiving additional anesthesia training. Research team - Sometimes research team members may ask patients if they would consider participating in An important part of interdisciplinary health care, the anesthesia team are experts in pain management, airway management, and critical care that may include: ongoing research studies.

Epidurals: The "gold standard" of pain management in labour.

- Using sterile technique, a needle is used to locate the epidural space and an epidural catheter (very thin, flexible tubing) is guided into position. The needle is removed, and the epidural catheter is taped in place. A pump will deliver medication through the catheter throughout the birthing person's labour and delivery. Often, the birthing person will be given a button to press if they feel that they need an extra dose of medication.

Inhaled nitrous oxide (N2O): "laughing gas"

- Colourless, odourless gas that is inhaled by the birthing person on demand.

Patient controlled analgesia (PCA): "pain pump"

- Intravenous opioids that are delivered through the birthing person's existing IV when they press a button attached to the pump. The pump has many safety mechanisms, including a lockout interval that prevents accidental overdose. No one other than the person in labour should press the PCA button!

There are many additional ways to help manage discomfort or pain during labour that do not involve medications or procedures involving the anesthesia team!

COMPARING PAIN CONTROL METHODS

INHALED N20

Benefits

- Rapid pain relief
- Can be administered by nurses, midwives
- Does not interfere with contractions or progression of labour

Potential Side Effects

- Drowsiness / sedation
- Dizziness
- Dry mouth
- Nausea
- Vomiting
- Euphoria or "feeling high"

Disadvantages

- Short duration (only lasts while inhaling gas)
- Lower patient satisfaction compared to epidural

PATIENT CONTROLLED ANALGESIA

Benefits

- Opioids used are short acting
- Relatively fast onset of action
- Patient controlled

Potential Side Effects

- Drowsiness / sedation
- Dizziness
- Itchiness
- Nausea
- Vomiting
- Constipation

Disadvantages

- Lower patient satisfaction compared to epidural
- Can be difficult to coordinate medication effect with contraction pain

Rare Risk

- Respiratory depression in the birthing person or the baby

EPIDURAL

Benefits

- Highest rates of pain relief and patient satisfaction
- Used during labour, delivery, and can provide anesthesia for emergency c-section
- Can help to manage high blood pressure & reduce stress on the heart in certain circumstances
- May lead to improved blood flow through the placenta
- Lets the birthing person rest

Potential Side Effects

- Itchy feeling
- Motor block (weakness in legs or feeling of heaviness)
- Low blood pressure
- Nausea
- Vomiting

Disadvantages

- Invasive Procedure
- Can limit movement ie: no showers, tub, mobility assessed on individual basis
- Post birth numbness / weakness
- Requires specialist
- Potential Risks
- Failure, might require replacement of the epidural
- Post-dural puncture headache: aka PDPH, spinal headache

Very Rare

- Epidural hematoma (bleeding causing compression of the spinal cord)
- Epidural abscess (infection around the spinal cord)
- Nerve injury, temporary or permanent

POSITIONING FOR EPIDURALS

Positioning is very important for successful epidural placement. It requires teamwork between the birthing person and the anesthesiologist. Optimal positioning will minimize the time it takes to place the epidural.

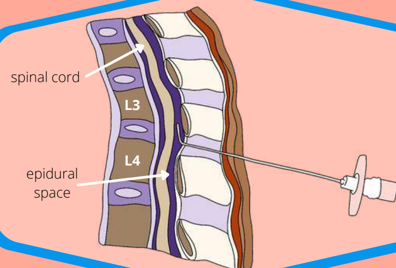
POSITIONS FOR EPIDURAL INSERTION

Preferred Position

- Sitting upright, as far back to the edge of the bed as possible
- Weight evenly distributed on seat bones
- Legs can be straight or bent in a "butterfly" position, as long as both legs are mirror images of one another
- Head tucked, with chin to chest
- Shoulders relaxed
- Pelvis tucked under body
- Curl body around baby, pushing the lower back out towards the anesthesiologist
- A support person may be asked to help by holding the client's shoulders
- A pillow positioned lengthwise underneath the client's arms may be helpful

Alternate Position

- Side lying, with their back flush to the edge of the bed
- Otherwise the same as above
- Side lying position can be more technically challenging for the anesthesiologist, so may not always be appropriate



What NOT to do:

- **Arching the lower back away from the anesthesiologist**
- **Bending forward at the hips with a straight back instead of curling the lower back out to the anesthesiologist**
- **Leaning to one side**

EPIDURAL RESTING POSITIONS

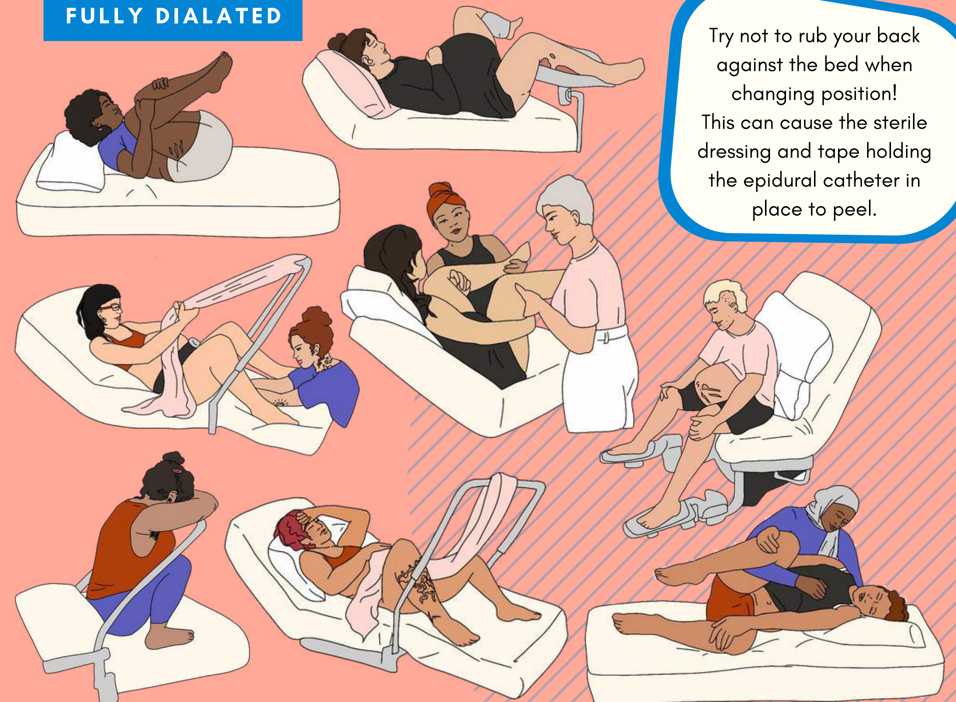
Here are some suggested comfort positions.

Most hospitals have protocols in place that dictate positioning for a brief period of time after epidural placement.

Any position in a bed is safe after epidural placement, however positions out of bed need to be assessed on an individual basis.

WHILE DIALATING

FULLY DIALATED



Try not to rub your back against the bed when changing position! This can cause the sterile dressing and tape holding the epidural catheter in place to peel.

Produced by Nova Scotia Public Interest Research Group and Wellness Within NS

EPIDURALS: DESTIGMATIZING COMMON MYTHS

Myth: "Epidurals increase my risk of requiring a c-section"

FACT: EPIDURALS DO NOT AFFECT RISK OF CESAREAN DELIVERY

Myth: "They make labour longer!"

FACT: EPIDURALS DO NOT SLOW LABOUR PROGRESS
(IN FACT, THEY MAY SPEED UP THE FIRST STAGE OF LABOUR)

Myth: "I heard they aren't safe..."

FACT: EPIDURALS ARE SAFE FOR BOTH BIRTHING PEOPLE AND BABIES

Myth: "But epidurals cause chronic back pain"

FACT: THEY ARE NOT ASSOCIATED WITH CHRONIC BACK PAIN

Myth: "The needle will go into my spinal cord"

FACT: IT DOES NOT ENTER THE SPINAL CORD

Myth: "I am a failure if I need an epidural..."

FACT: HAVING AN EPIDURAL DOES IS NOT A FAILURE!
THEY ARE A PAIN MANAGEMENT TOOL – MANAGING PAIN IS CARING FOR YOUR BODY

Myth: Epidurals cause autism

FACT: THEY DO NOT CAUSE AUTISM

Myth: "I'll loose all feeling below the epidural!"

FACT: EPIDURALS CONTROL PAIN WITHOUT FULL LOSS OF SENSATIONS SUCH AS TOUCH AND PRESSURE

Myth: "I have to consent to an epidural whether I want one or not..."

THEY ARE NEVER MANDATORY
(BUT THERE MAY BE SITUATIONS WHEN THEY ARE STRONGLY RECOMMENDED BY THE HEALTHCARE TEAM)

Produced by Nova Scotia Public Interest Research Group and Wellness Within NS

UNDERSTANDING THE C-SECTION
WITH ANESTHESIOLOGIST DR HILARY MACCORMICK

Neuraxial anesthesia is the preferred anesthesia technique for cesarean births because:

- Allows the birthing person to remain awake for their birthing experience
- Allows the presence of a support person in the operating room
- Limits drug transfer to the baby
- Avoids the risks of general anesthesia (which are higher during pregnancy)
- Less blood loss
- Less pain after surgery

Whether planned or unplanned, a c-section can be a stressful and scary event!

The anesthesia team's job is not limited to keeping the birthing person and baby safe, we are also committed to relieving anxieties and doing whatever we can to provide the best birth experience possible.

WHILE IT IS NORMAL FOR THE BIRTHING PERSON TO FEEL SENSATIONS OF TOUCH AND PRESSURE, IT SHOULD NOT BE SHARP OR PAINFUL!

Types of Neuraxial Anesthesia

Epidural

- If a person in labour has an epidural and requires an unplanned c-section, the epidural can be used to provide more medication so that the birthing person will be comfortable ("frozen") for the surgery

Spinal

- Similar to epidural, but a single dose of medication is injected
- No tubing left in place
- Works faster than an epidural
- Effects last approx 2 hours

CSE

- Combined spinal epidurals are a combination of both epidural and spinal techniques

**** Typically the birthing person will be unable to move their lower torso and legs until the medication wears off after surgery, however it is important to know that some people do maintain some movement in their legs and feet during surgery! This does not necessarily mean the anesthesia is not working. ****

DID YOU KNOW: IN MANY HOSPITALS, IT IS POSSIBLE FOR THE BABY TO HAVE SKIN-TO-SKIN TIME IN THE OPERATING ROOM WITH THE BIRTHING OR SUPPORT PERSON?!

Produced by Nova Scotia Public Interest Research Group and Wellness Within NS

BIRTH PLAN

Due date:

I will give birth at:

My primary caregiver(s) and their pronouns are:

My support people and their pronouns are:

Important issues, fears, concerns
(what do you need birth-unit staff to know about you? Your family? your co-parents, partner or ex-partner? Are there any people you feel may pose a safety risk to you?):

How can your doula and hospital staff ensure you feel safe?:

My doula can support me by...
(what role do you want your dola to take around these concerns? An advocate, silent supporter, other?):

BIRTH PLAN FOR LABOUR PREFERENCES

Stage 1

Pain Control:

Medical Interventions:

Stage 2

Positioning:

Pushing Efforts:

Medical/Surgical Interventions:

Other important information regarding labour and birth

Unexpected labour events
(Complicated or prolonged labour or fetal problems, Cesarean delivery, etc):

Are there any other needs or information you would like your doula or caregivers to know about you?

What do you need birth-unit staff to know about you? Your family? Your coparents/labour support people?

HOSPITAL BAG PACKLISTS

Think of a place where you feel your most calm. List some things / objects / people / sounds / smells that make you feel safe. How can these things be brought into / replicated during labour and birth?

PACKLIST FOR THE PERSON GIVING BIRTH

- Provincial health card
- Any medications you are taking
- Comfortable clothing for you to wear during labour and birth
- Comfortable clothing for the recovery room (plan to stay one or two nights)
- At least five pairs of underwear
- Water bottle
- Menstrual pads (super absorbent are required)
- Nursing Bra
- Cell phone
- Phone charger
- Camera / video camera
- Toiletries (toothbrush, toothpaste, hairbrush, soap, shampoo, deodorant, brush, comb, chap stick, hair elastics etc...)
- 2 pens and some paper / a notebook (for keeping track of your babies eating, urine and bowel movements). You can also use a "notes app" on your phone
- Small amount of money (snacks/miscellaneous items)
- Personal comfort items that help you when feeling stressed (fidgets, stuffed animals, books, headphones to listen to music, etc.)

PACKLIST FOR YOUR BABY

**Please note that the list assumes a single baby birth. Adjust accordingly!*

- Two to three dozen diapers (newborns use approximately 12-14 per day)
- Newborn emery board/nail file
- Clothing for baby to wear in the health centre (2-3 sleepers, 2-3 undershirts)
- Clothing for your baby to wear home
- One receiving blanket
- One heavy blanket
- One CMVSS (Canadian Motor Vehicle Safety Standard) infant car seat removed from the box and assembled.

Birth unit staff will review any questions you have about car seats in an effort to help you position your baby safely in the car seat. You are expected to have attempted to put the car seat into your car yourself in advance as staff cannot go to the car with you. Snowsuits and bunting bags are not recommended to be used for taking babies in car seats as the straps do not get snug enough.

PACKLIST FOR THE DOULA

Anything that touches a person needs to be a material that can be washed / sanitized. Regularly clean items during and between births.

- Nametag / hospital ID
- Related paperwork, notebooks, and resources (like this toolkit!)
- Cold sources for pain relief & comfort (ice packs, "magic bags")
- Heat sources for pain relief & comfort (hot water bottles, "magic bags")
- Stopwatch (or phone app with this function)
- Bath pillow
- Massage tools
- Massage oils (unscented)
- Diversions (cards, knitting or sewing project, "fidgets" etc… nothing that takes your attention away)
- Knee pads / garden kneeler / cushion
- Hand held mirror
- Medical gloves
- Sanitizer
- Specialty birth equipment; tens unit, birth ball, inflatable pool etc
- Special items requested by your client
- Cell phone / tablet and charger
- Personal items; toothbrush, toothpaste, hairbrush, comb, elastics / hairbands, breath freshener, deodorant, medications
- Change of clothing including layers for warm and cold
- Bathing suit / clothes that can get wet for tub support
- Towel
- Food and drink, lots of water / water bottle. Choose snacks that don't need to be heated or refrigerated and can be eaten out of the container / packaging. Keep in mind any allergies your client and their other supports may have and the food and allergy policies of the hospital. Money / change for vending machines, parking etc…

You don't need to have *every* item on this list. Some birth-related items may be provided by the midwife or hospital. Birth support items can be very expensive. Ask your client what items and supports are most important to them. Talk about how the desire / need for a certain kind of comfort or support may inform when to go to the hospital.

PACKLIST FOR OTHER SUPPORT PEOPLE

- Cell phone / tablet and charger
- Personal items; toothbrush, toothpaste, hairbrush, comb, elastics / hairbands, breath freshener, deodorant, medications
- Change of clothing including layers for warm and cold
- Bathing suit / clothes that can get wet for tub support
- Towel
- Food and drink, lots of water / water bottle.
- Money / change for vending machines, parking etc…

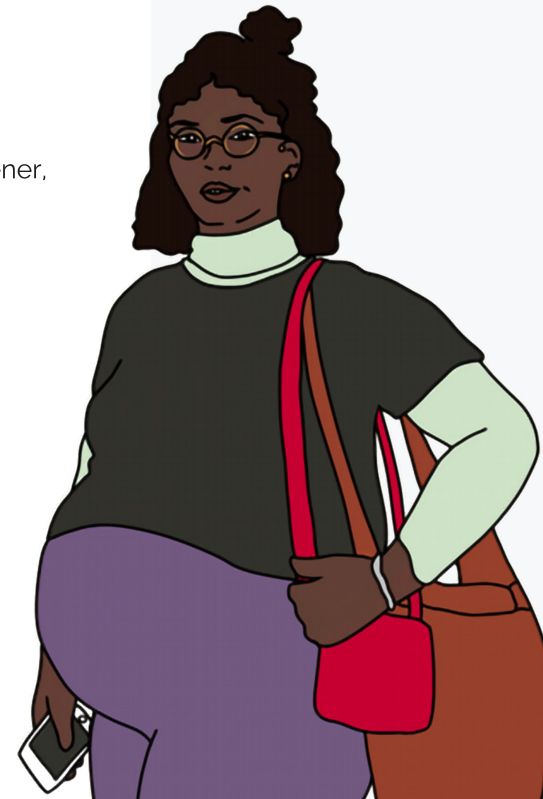


Image by Julia Hutt

NEWBORN CARE PLAN

Name:

Baby's care provider:

My support people once I'm home with baby:

How can your doula support your feeding plan?

I have the following experiences with newborns:

Newborn care issues, fears or concerns:

Newborn exam and procedures, including immediate immunizations:

Unexpected problems with the newborn:

Educational needs (baby care/feeding):

ABORTION AND PREGNANCY LOSS

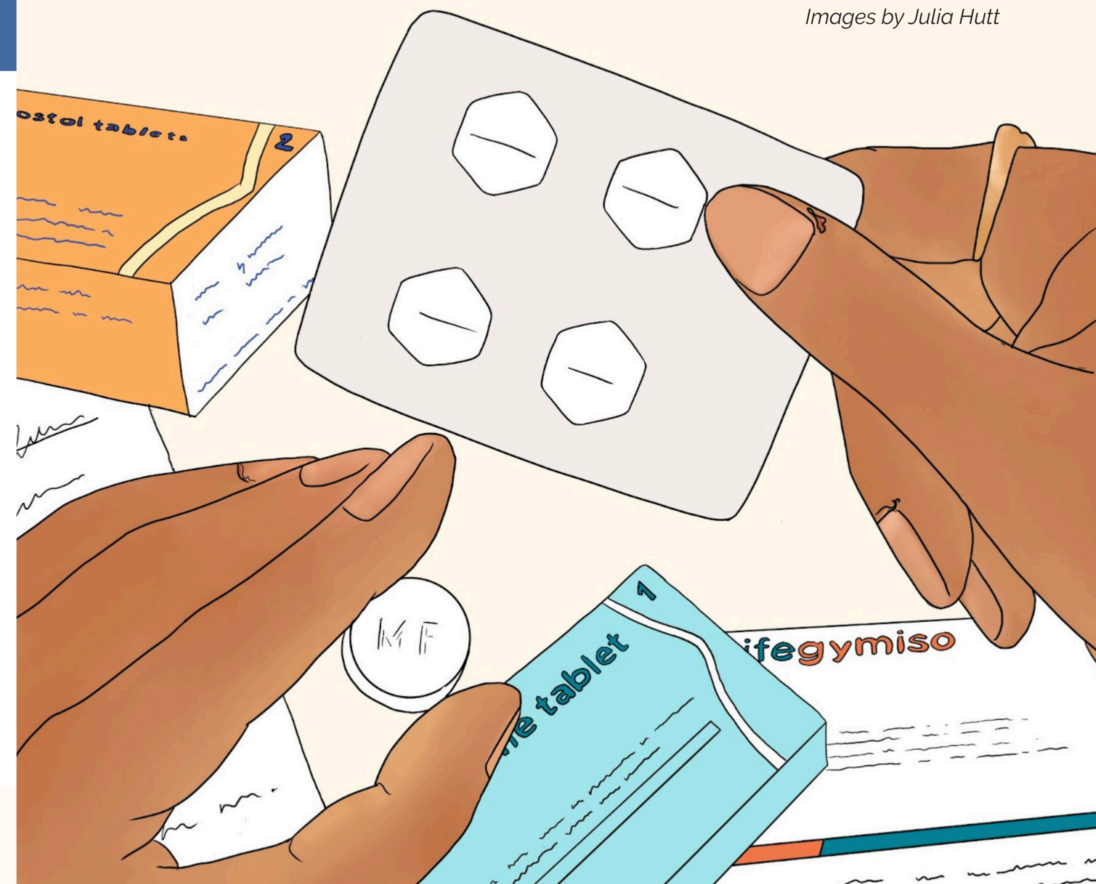
As doulas, it is important we provide unconditional support regardless of what our pregnant client experiences and what they decide. In Canada, there are no legal restrictions on abortion. Abortion is considered health care at all gestational ages.

In Nova Scotia, patients across the provinces can self-refer to the centralized toll-free abortion care line, 1-833-352-0719. Nurses who answer the phone will arrange care.

Physicians and nurse practitioners across the province can prescribe medication abortion (mifepristone and misoprostol) up to 9 weeks gestation. The medications are free with a NS health card and can be picked up at your local pharmacy to take at home.

Physicians in NS are trained to provide aspiration (surgical) abortion to 16 weeks. If care is required beyond those timelines, nurses will assist with arranging care out of province with providers who have the training and equipment needed.

Images by Julia Hutt



Wellness Within published a **guide to abortion access** across the country in spring 2022.

In Nova Scotia, only the patient themselves may go into the abortion clinic or hospital for an aspiration procedure. This is a security policy to prevent abusive or coercive partners, parents, exes and others from harming staff or patients. As a result, doulas may not enter the space. You can however drive patients to and from appointments and provide support before and after, as well as during home abortion (medication abortion).

Most abortion in the world is through medication and is experienced in the comfort and privacy of one's own home.

CPS STATISTICS

Canada's child welfare system disproportionately targets Black families. While data capturing the exact numbers of Black families and children impacted by CPS is limited due to Canada's failure to prioritize this data, it is well known that Canada's child welfare system is embedded with racist practices that over surveille and police Black families. The Ontario Human Rights Commission (n.d.) provides the following points:

- Black children investigated by child welfare agencies were 28% more likely to be placed in care compared to white children investigated.
- The overrepresentation of Black children in the child welfare system has been connected to the history of racism against African Canadians, originating with slavery in Canada.
- The African Canadian Legal Clinic suggests that the overrepresentation of Black children in the child welfare system is in part due to economic disadvantage as well as the over-surveilling of Black families due to racist stereotypes.
- Historic and ongoing racism in systems such as employment, education and the criminal justice system contribute to high levels of poverty and disadvantage among Black children and families in Canada. Poverty and oppression may disproportionately increase Black families' needs resulting in their involvement in the child welfare system.

Research suggests that professionals such as school and medical staff over-report racialized families to child welfare systems.

RESOURCES FOR AND CREATED BY BLACK FOLX

Ontario Black Doula Society
blackdoulas.ca

Parenting for Liberation
parentingforliberation.org

Mommy Monitor
mommymonitor.ca

Black Mamas Matter Alliance
blackmamasmatter.org

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wellnesswithinns.org

canadianwomen.org