QUEER DOULA TOOLKIT

Resources for doulas and 2SLGBTQ+ birthing folks

DEVELOPED BY:
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IN PARTNERSHIP WITH:

WELLNESS WITHIN
An Organization for Health & Justice

Nova Scotia Public Interest Research Group
NS PIRG
www.nspirg.ca

TEGAN AND SARA FOUNDATION

We hope that you feel validated and supported as you view this toolkit.

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WORDS FROM OUR CREATORS

This project was made possible through the collaboration and passion of Wellness Within, the Nova Scotia Public Interest Research Group (NSPIRG), the Tegan and Sara Foundation, and many community members who contributed their time and experiences. We are so grateful for the labour, support and feedback provided by the 2SLGBTQ+ community - it has intimately shaped the direction and process we have undertaken in developing this toolkit. We hope that you feel represented within this work.

Special thanks to Nicole and Jordan, our Queer Doula Toolkit Coordinators - without your wisdom, leadership and dedication this project would never have come together in such a meaningful and intentional way. Your work is inspiring.

Our artists, Audrey and Julia, thank you for bringing into existence vital tools that have been missing from birthing work for too long - truly representative works of art that we are honored to present as part of this resource collection!

To Martha, Lauren, Kilah, Wanda and the Wellness Within board, thank you for letting us play a part in this journey. Your doula program is so wonderful and necessary, and we have been thrilled for the opportunity to partner with you on this work. I am excited about the future of the Queer Doula program, and am honored to continue our partnership. Lama and Truelee, my NSPIRG team, thanks for always being there to support us, and for always being willing to go on a research mission at a moment's notice! To our incredible Board of Directors - thank you for believing in the importance of this project and being a united force in prioritizing doula education and programming in our work.

We are so grateful for the trust (and funding) placed in us by the Tegan and Sara Foundation. TSF Community Grants provide an invaluable source of funding for organizations and projects overlooked by mainstream funding. Thank you for always holding space for queer justice.

On behalf of the Nova Scotia Public Interest Research Group,

Clark MacIntosh (he/they)
Finance and Resource Centre Coordinator, NSPIRG
Queer Doula Coordinator, Wellness Within

WORDS FROM OUR CREATORS

This Queer Doula Toolkit was created with the goal of contributing to spaces for 2SLGBTQ+ representation within the doula community. So often, birth support literature and education are centred around a heteronormative, cisgender experience of birth, family, and care. Rarely do we see different relationship styles, bodies, gender expressions, or experiences outside of this mainstream, normative framework. This omission can not only be alienating to our 2SLGBTQ+ clients, it can also be harmful to their well-being and birth experience. 2SLGBTQ+ people birth, raise, feed, and nurture children. We support our partners and queer family as they birth, raise, feed, and nurture children. Our experiences in community and in our chosen families have created incredible narratives of care and support.

This toolkit began in the concluding months of 2020 with a community consultation process initiated by NSPIRG. Based on the feedback from that community survey, we, Jordan Roberts (she / her) and Nicole Marcoux (she / her), spent the months straddling 2020 and 2021 writing the bulk of this toolkit. We are both queer, white, cis-gender doulas with the Volunteer Doula Program in Kjipuktuk (Halifax, Nova Scotia). We each have different experiences as birth support workers and personally with pregnancy, birth, and raising children. In writing this guide, we made our best effort to consult resources created by and for people whose pregnancy and birth experiences we have not had, such as those of trans and gender non-conforming people. We expect, and indeed hope, that this toolkit will evolve and change to include more robust information as time goes on. This toolkit was written for doulas, but may be helpful for anyone who is supporting a 2SLGBTQ+ person through pregnancy, labour, and postpartum.

The Queer Doula Toolkit would not exist without the leadership and support of the folks at NSPIRG and the contributions from Wellness Within and the Tegan and Sara Foundation. Gigantic thank yous to Lama and Lauren who researched the sections on pregnancy loss and prenatal education. We are deeply grateful for this collaborative project to provide enhanced care for 2SLGBTQ+ people.

Queer community, queer family, queer love, and doula care holds so much; grief, loss, joy, affirmation, hope, comfort, warmth, and more. We hope this toolkit supports you as you hold these things alongside your clients.

With care,
Nicole and Jordan

A note on language

Throughout this toolkit, we use the term 'client' when referring to the person you are supporting who is pregnant, in labour, giving birth, or having a baby. For some, client can seem impersonal or overly professional for the relationship a doula has with the person they are supporting. We chose this term as one that is gender-neutral and less cumbersome in terms of writing and reading than the continuous use of "person who is pregnant", "person giving birth" etc... Rather than using the term "child," "son/daughter," or other, we use the term "baby."

In any instance of discussing another person, our default pronouns are "they/them," including for baby. We do our best to not assume the gender of anyone doing birth support work or giving birth.

Finally, we have chosen "2SLGBTQ+" as our preferred acronym in this toolkit. This version was chosen for clarity and is not meant to exclude anyone whose identity is not included in it. We also use the term "queer" as an umbrella term to identify gender identity, sexual orientation, relationship styles, and so on. We recognize that not everyone who reads this or is a 2SLGBTQ+ person will identify as queer.

When we refer to this as a Queer Doula Toolkit we are not just referring to the gender identities and sexual orientations of queer clients and families doulas support. We believe that the models of care and community created within doula - client relationships, including those within the Volunteer Doula Program and Wellness Within, are aligned with what is seen in queer community. Care that aims to be built outside of capitalism and addresses the varied needs of those not often represented in the medical system. Care that focuses on the needs of the individual client and family without judgement. Care that is built between people that choose to be in each other's lives in intimate and crucial ways. Care that showcases consensual, individualised, and anti-oppressive communication.

The medical system

Throughout this toolkit there are critiques of the medical system and of medical professionals, birth care workers, and hospital staff, and discussions of ways to support clients who are not being supported by these systems and individuals. Our intention is not to create an adversarial relationship between doulas, queer clients, and medical professionals, birth care workers, and hospital staff, but rather to recognize that historically and in the present day queer identities and lifestlyes are routinely pushed to the margins in any mainstream aspect of society.

Our experiences with the Volunteer Doula Program and Wellness Within have shown how these kinds of organizations can build bridges and provide the advocacy, resources, education, and encouragement for these spaces to do the work of being more welcoming, inclusive, and competent in their care for queer clients and families. The section on advocacy in this toolkit speaks to how individual doulas can do this work. We recognize and thank those within the medical system that work to change attitudes, practices, and policies and push beyond heteronormative and ciscentric assumptions.

Due to the historical and present-day mistreatment of 2SLGBTQ+ people within the medical system, many queer folks rely on community for medical intervention. As an example some trans, non-binary, and gender non-conforming people who want to use hormone injections to affirm their gender will seek out these supplies, resources, and practice without going through the "standard and approved" medical process due to the gatekeeping and binary assumptions often still present in those systems. While we can understand and respect their choices it is still our responsibility as doulas to not provide information, resources, or support beyond our capabilities and to encourage our clients to consult with medical professionals if we feel a need is there. We can continue our role of not giving medical advice ourselves while respecting that our clients are the experts about their body and needs.

As we acknowledge that the medical system has mistreated 2SLGBTQ+ people we want to name that this same system has also been violent towards Black, Indigenous, and People of Colour (BIPOC). Similarly to the police, many Black and Indigenous clients do not see medical professionals, birth care workers, and hospital staff as safe people or birth units as safe places to give birth. Birth alerts, barriers to accessing care in remote communities, mortality rates for Black people giving birth, and racist attitudes towards clients are all examples of why BIPOC clients may have increased anxieties and concerns during pregnancy and labour. Doula programs and services are also often very white-centred and have an over-representation of white care providers.

This toolkit encourages doulas to challenge the heteronormative and ciscentric attitudes present in our society that are mirrored in pregnancy and birth spaces. As white doulas, we encourage other white birth workers to challenge white supremacy, racism, anti-Black racism, and colonialism that is foundational to many systems, including the medical system. The identities of our clients will be multifaceted and we must always be willing to listen to how these identities will impact their wants, needs, priorities, and boundaries around pregnancy, labour, birth, and care.

2SLGBTQ+ Terminology

Identity Terms

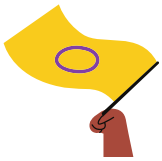
Asexual (Ace): Someone who does not experience sexual attraction for other individuals. Asexuality can be considered a spectrum, with some asexual people experiencing desire for varying types of physical intimacy.

Bisexual: Someone who is attracted to at least two genders.

Cisgender: Identifying with the gender one was assigned at birth.

Gay: Someone who is attracted to the same gender. Often but not always, used to refer to men.

Intersex: General term used to describe someone whose sexual anatomy, genetic makeup, or hormone levels do not fit the binary of male or female at birth. An intersex person may or may not identify as a trans person. Note that "intersex" replaces the term "hermaphrodite," which is considered inaccurate, offensive, and outdated.



Lesbian: A woman who is primarily attracted to other women.

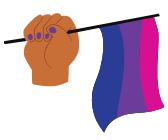
Non-binary (NB): A continuum or spectrum of gender identities, often based on a rejection of the gender binary. Can be an umbrella term or a specific identity.

Pansexual: Someone who is attracted to any or all genders.

Queer: A term more widely used in LGBTQ2A+ communities to refer to the spectrum of non-heterosexual and/or cisgender people. This term was (and still is) used as a hate term and has been reclaimed by the LGBTQ2S+ community.

Transgender (Trans): An umbrella term for a wide range of experiences and identities for people whose gender does not match with the gender they were assigned at birth. This is a self-determined identity and does not depend on treatments, such as hormones or surgery. This term replaces the now outdated, offensive, and inaccurate terms "transsexual" and "transvestite".

Two-Spirit (2-Spirit): A term used by Indigenous communities in North America, used to describe people with diverse gender identities and roles and sexual orientations. ***Non-Indigenous people should never use this term to self-identify.***



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Adapted from Queer Glossary: A to Q Terminology by QMUNITY

2SLGBTQ+ Terminology

Dead name: The name a person (often trans) was given a birth, but no longer uses. This name might appear on a client's medical records, files, health card, and other documentation.

Gender: The social constructions of concepts such as masculinity and femininity. Involved gender roles (the expectations of someone based on their gender) and gender identity (how someone defines their own gender). Fundamentally different from the sex people are assigned at birth.

Gender binary: The idea that there are only two opposite, distinct, and static genders - male and female.

GENDER DYSPHORIA:

Internalized distress experienced when one's assigned gender at birth and gender identity are different.
This term is part of the medical system and people who experience it have different beliefs about it.
Let your client's experience inform your knowledge.

GENDER EUPHORIA:

Feelings of comfort, joy, and/or peace when thinking about one's gender identity and presentation.
A term used to push back against the notion that trans and gender non-conforming people must only experience dysphoria.
A way to claim and express the joy within trans and gender non-conforming identity

Gender non-conforming (GNC): Referring to people who do not conform to society's expectations for their gender roles.

Misgender: To refer to someone (especially a trans person) using an address or pronoun that does not correctly reflect their gender identity. Misgendering, particularly when intentional, can be very damaging.

Outing someone: Accidentally or intentionally publicly revealing another person's sexuality, gender identity, trans status, and/or relationship status without their permission.

Pronouns: A word used to refer to someone without using their name (he/him, she/her, they/their).
Do not make assumptions about someone's pronouns based on their appearance.

Sex: Refers to the physical and physiological characteristics used to assign humans as male, female, or intersex.

2SLGBTQ+ Terminology

Transition:

Process during which trans people may change their gender expression and/or bodies. Loosely refers to 3 areas, some or all of which might be undertaken by a trans person.

1) Social transition:
Change of name, wardrobe, pronouns, hair, legal ID, and so on

2) Medical transition:
Hormonal therapy, which can include hormone blockers for youth

3) Surgical transition:
Including gender-affirming surgeries

Acronyms

2SLGBTQIA+
(LGBTQ+, LGBTQ2S):
2-Spirit, Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, plus all other identities not included within the acronym.
Written differently depending on community.

AFAB/AMAB:
Assigned Female at Birth/Assigned Male at Birth. Denotes the gender assignment given to people at birth, based on their genitalia.

QTIPOC:
Queer, Trans, and Intersex People of Colour.

QTBIPOC:
Queer and Trans, Black, Indigenous, and People of Colour.

Common Relationship Terms

Monogamy:
The practice of maintaining only one romantic/sexual relationship at a time.

Non-monogamy:
An umbrella term to describe the practice of maintaining multiple romantic/sexual relationships.

Polyamory:
The practice of maintaining more than one romantic/sexual relationship simultaneously and consensually.

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2SLGBTQ+ Terminology

Structural/Social Terms

Amatanormativity: The idea that a single, monogamous relationship between two people is necessary to achieve happiness, what everyone wants and that the absence of such a relationship is abnormal.

Biphobia: Aversion/dismissal toward bisexuality and bisexual people as individuals.
It can take the form of denial that bisexuality is a genuine sexual orientation, or of negative stereotypes about people who are bisexual (ie: beliefs that they are promiscuous or dishonest).
Other forms of biphobia include bisexual erasure or assumptions about someone's "true" sexual orientation based on the person they are partnered with at a specific time.

Erasure: Denial/dismissal/invisibility of someone's gender identity or sexual orientation based on assumptions made about their presentation. This is often intentional and done based on the comforts and conveniences of social norms that do not make space for trans, gender non-conforming, and queer identities, bodies, and relationships.

Heteronormative: The social roles and structures that reinforce the idea that heterosexuality is normal and superior to other sexualities.

Homophobia: Fear and hatred of, aversion to, discrimination of homosexual people. There are many levels of homophobia, taking place at institutional and personal/individual levels.

Misogyny: Fear and/or hatred of femininity, leading to the belief that masculinity and maleness is desired and superior.

Patriarchy: A social system where the bulk of power, authority, and control is held by men.
This assigns greater importance to male issues and identities than those of other genders

Transphobia: Fear or dislike of, discrimination against trans people.
Can take the form of disparaging jokes, denial of services, discrimination, name calling, and violence.

GET TO KNOW PRONOUNS

The following is a list of different pronouns people use. This is not an exhaustive list - if someone informs you they use pronouns not listed here, use them!

Show respect for and validate your client's identity by having a conversation about when it is/isn't appropriate to refer to them using their pronouns! Not every client will have the safe and open relationships needed with all the support people and medical personelle in their lives to use their pronouns in all circumstances.

They **Them** **Their** **Theirs** **Themself**	**She** **Her** **Hers** **Hers** **Herself**	**Ze/Zie** **Hir** **Hir** **Hirs** **Hirself**	**Per** **Per** **Pers** **Pers** **Perself**
Ae **Aer** **Aer** **Aers** **Aerself**	**He** **Him** **His** **His** **Himself**	**Ey** **Em** **Eir** **Eirs** **Eirself**	**Yo** **Yo** **Yo's** **Yo's** **Yo'self**

PRACTICE WITH PRONOUNS

The following examples of using pronouns in conversation are based on real-life situations of 2SLGBTQIA+ folks. How might you support clients in each example?

1. **Ae and aers partner plan on co-nursing, so the non-gestational parent is interested in learning about induced lactation.**
2. **Jamie is very proud of perself for discussing with healthcare staff how pers testosterone treatment will be administered if per needs to stay in hospital after giving birth.**
3. **Don wants Annie to be recognized as the non-gestational parent of eirs child, but eir doctor informed them both that because a known sperm donor was used to conceive, Annie can't legally be listed on the birth certificate, denying Annie parental rights.**

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Queering Birth Terms

Not everyone who is pregnant or has a baby is a mom!
The following chart gives a few alternative options you can use for common terms around birthing and labour.
This chart of terms is not exhaustive or authoritative.
Always talk with your doula client about how they talk about their body and birth process and ask how they would like you to talk about it.

Common Language	Non-Gendered Alternatives
Breastfeeding	Chestfeeding, Nursing
Breasts	Chest
Breast Pump	Nursing device, nursing pump
Mom, Mother	Parent, Birthing Parent
Dad, Father	Non-gestational Parent, Co-Parent(s), Partner(s), Support Network
Women in Labour	Labouring Person, Person in Labour, Birthing Person, Person Giving Birth
Woman, Women	Person with a Uterus, Egg Producing Person
Man, Men	Person with sperm, Sperm Producing Person

*Please note: These terms will not be accurate for every situation. It is important to know the terms and language your client uses to ensure you provide safe, compassionate support.

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QUEER FAMILIES AND PARENTING

EXPLAINER ON 2SLGBTQ+ RELATIONSHIPS, PARENTING DYNAMICS, AND GENDERING CHILDREN

Familial relationships between adults and children are as rich, varied, and beautiful as 2SLGBTQ+ people are themselves! Sometimes all people in a relationship will take on parental roles, sometimes they won't. When you meet with a client and discuss their support networks, don't assume their romantic partner(s) will take on parenting roles.

Polyamorous, open, and other non-monogamous relationship styles are ones in which there are more than two people romantically, sexually, affectionally, or otherwise involved. Each relationship will be different, depending on the needs and preferences of the people involved. Here are some general guidelines and definitions for these relationship styles. **This is not an exhaustive list.**

NON-MONOGAMY

An umbrella term to describe a relationship where monogamy (the practice of having one sexual or romantic partner) is not the structure. Non-monogamous folks might be polyamorous, have an open relationship, or use a different term to describe their relationship. If you have clients that disclose themselves or their relationship(s) as non-monogamous, you might meet or hear about more than one partner.

OPEN RELATIONSHIP

Generally speaking, an open relationship is one where there are primary or anchor partners who also date or have sexual relationships with other people. Where polyamory emphasizes multiple loves and relationships, an open relationship might not include love or commitment in the same way.

POLYAMORY

Literally defined polyamory means "many loves." This is a relationship style where there might be romantic or sexual relationships between more than two people, with the consent of everyone involved. Polyamorous folks are typically open to emotional connection and relationships with multiple people. Some examples of polyamorous relationships include (but are definitely not limited to):

- **Someone has multiple partners or spouses (regardless of legal marital status)**
- **Three (or more) people might date each other**
- **Two people could be each other's primary or anchor partners and also date other people**
- **Two people are legally married and have children together and each partner lives with different respective partners while co-parenting**

You might also have a client who is in a relationship with one or zero people but still considers themselves polyamorous.

At times, the differences between these terms and relationship styles can be semantical. Some people will practice what is by definition 'polyamory' without ever using that term. Don't get too caught up in the terminology! The most important thing to remember when you're meeting with a client who has a relationship style you might not be familiar with, is to not judge their decisions and ensure the continued trusted communication between a doula and a client.

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

HOW WILL RELATIONSHIP STYLES IMPACT MY ROLE AS A DOULA?

Non-monogamous queer relationships mean you might not be dealing with a normative "mom" and "dad" parenting dynamic. There might be more than two people who will be parenting baby, they might use terms other than "mom" or "dad" when referring to themselves as parents, they might create an entirely new way of describing their role in baby's life that is outside the normative expectations of parenting, and on and on!

Terms

There are endless ways to describe an adult's relationship to a child. Some of your clients may use "mom" and /or "dad," and some may not!
Below is a non-exhaustive list of terms and descriptors you may encounter.

Biological and non-biological parent

These terms are commonly found in parenting literature, but can be challenging as they indicate certain levels of perceived legitimacy as a parent. Some have also pointed out that the term "non-biological parent" doesn't make any sense, since humans are all biological.

Gestational and non-gestational parent

Similarly to "biological parent," this option can feel medicalized and indicate certain levels of legitimacy as a parent. Some people may prefer them as descriptive terms, particularly in a medical setting, for example in explaining to a health care provider what the physical relationship is between parent and baby.

Endless other possibilities!

Zaza, Guard, Parry (short for 'parent'), Mapa ('mama' + 'papa'), Maddy ('mommy' + 'daddy'), and on and on! Some people will opt to wait until baby is old enough to vocalize and let them decide; some will make up their own terms.

Gendering Children

Just as we don't make assumptions about the gender of our clients, as doulas, we should apply the same rules to baby. Some people choose not to gender baby based on their ultrasound or genitals at birth and instead wait until baby is old enough to decide for themselves what their gender is.

A very common question to ask of pregnant people is "is it a boy or a girl?" This question can seem innocent enough: you're showing interest in your clients' baby, you're gathering information, and getting to know the people you are working with. If we dig a little deeper, this question is loaded with expectations about social roles, likes and dislikes, pronouns, nicknames, and so on.

Think of alternatives to this question, based on what you actually want to know about baby. Do you need to know what kind of genitals baby has? As a doula, likely no. Do you need to know the pronouns to use for baby? Absolutely! Do you need to know name options? If your client want to share them, then yes! Do you need to know if there have been any pregnancy complications? Yes. With that in mind, here are some alternative questions to ask about baby, other than the all-too-common "is it a boy or a girl":

- ***What pronouns will you be using for baby? Is it ok if I use those to talk about baby as well?***
- *Do you have names in mind for baby? Would it be ok if I called baby by those names or is there a better name or nickname I should use?*
- ***When baby is born, would you like to keep their sex private? If so, how can I support that need in the delivery room and in our follow-up meetings?***

CHEST HEALTH AND CHEST FEEDING

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+ folks 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.

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CHEST HEALTH AND CHEST FEEDING RESOURCES

Canadian Breastfeeding Foundation
The Protocols for Inducing Lactation and Maximizing Milk Production
https://www.canadianbreastfeedingfoundation.org/induced/regular_protocol.shtml

Milk Junkies
Trans Women and Breastfeeding: The Health Care Provider
http://www.milkjunkies.net/2013/07/trans-women-and-breastfeeding-health.html

Tips for Transgender Breastfeeders and Their Lactation Educators
http://www.milkjunkies.net/2012/03/tips-for-transgender-breastfeeders-and.html

Links
http://www.milkjunkies.net/p/links.html
- Resources and links to online support groups, Facebook groups, and parenting groups for 2SLGBTQ+ parents and chestfeeding.

MacDonald, T., Noel-Weiss, J., West, D. *et al.* **Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity: a qualitative study.** *BMC Pregnancy Childbirth* **16,** 106 (2016). https://doi.org/10.1186/s12884-016-0907-y

LGBTQ Parents Network. *Lactation Resources.*
https://lgbtqpn.ca/resource-topic/family-planning-course-materials/lactation/
- Note: this site is now archived and all material remains available. Some of the articles listed use outdated or harmful terminology.

The American Journal of Maternal/Child Nursing. *Transgender Men & Lactation: What Nurses Need to Know.* http://lgbtqpn.ca/wp-content/uploads/2015/02/Transgender-Men-and-Lactation-What-Nurses-Need-to-Know.pdf

Facebook Support Groups
Birthing and Breast or Chestfeeding Trans People and Allies
https://www.facebook.com/groups/449750635045499/?fref=ts

Paynter, M. **Medication and Facilitation of Transgender Women's Lactation**. *Journal of Human Lactation*, **35 (2)**, 239-243 (2019). https://doi/10.1177/0890334419829729

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Advocacy / Asserting Yourself With Health Care Professionals

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-centered care from the start, without requiring a need for advocacy. The health care system is not built to center, normalize, anticipate, or provide for queer clients as a general rule. While many efforts have been made to address this in medical schools, clinical practice, and hospital policy there is still a ways to go. 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 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 using their name (not their deadname) and correct pronouns, and to correct the use of deadnames, assumed pronouns, and gendered language with the nursing staff in the birth unit. Later in labour, or with other birth care workers, that priority may shift. For example, if an anesthesiologist misgenders them 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 properly genders and addresses them as they will be a physically close and intimate care provider.

A client may be ok with you correcting / advocating in front of them or may want you to do it out of earshot as they focus on labour. 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).

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Advocacy / Asserting Yourself Continued...

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 queer-competent 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. When you are not wearing your doula hat your responses to people misgendering someone you care about may include expressions of anger, frustration, or statements about this person's character. While those are valid responses (as misgendering, deadnaming, homophobia, and transphobia can be violence) they may not be the best emotions to have present when supporting a client and "mediating" between them and someone who will be part of their pregnancy and labour. 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 queer competent 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 deadnaming, misgendering, homophobia, and transphobia 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 behaviour, 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 behaviours 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 behaviours 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.

Coping and Support Strategies:

ENCOUNTERING HOMO/TRANSPHOBIA AND HETERO/CISNORMATIVITY IN HEALTHCARE

Here are some things you can encourage and support with your client.
Your client can use these strategies in the moment (at prenatal appointments, during labour, and throughout postpartum care) and also afterwards, to debrief and process.

1. Have a list of "pull cord" phrases for when you encounter inappropriate questions and attitudes from health care professionals, birth care workers, and hospital staff:

"I do not see how that is relevant to this appointment."

"I am not comfortable answering that question."

"I have come to talk about _____ not _____."

"Can you tell me if what you are commenting on is related to why I am here?"

"It sounds like you have questions / misconceptions about queer identities and bodies. You can seek self-education or professional development in your field."

2. If there are specific interactions you are worried about, ask your doula to role-play while you practice setting boundaries and communicating the kind of care you expect.

3. Assemble your team! Keep them looped in on your appointment days and times and let them know what you are concerned about or know you will encounter. They can then know to send words of care and affirmation when you are about to head to an appointment and / or to check in after.

4. If it feels safe and comfortable, wear things that can "flag" or "code" your queerness to appointments and the birth. Pronoun pins, pride gear, clothes, accessories, make-up etc… Queer flagging, whatever way that feels right for you, can be a way to assert who you are and take up space.

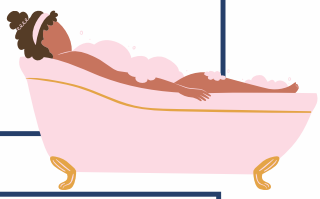
5. If it feels safe and comfortable, ask your doula or the organization your doula practices with to approach the professional(s) or their office to directly or indirectly address an incident of homophobia, transphobia, heteronormativity, and /or cisnormativity that occurred. This can include the offer of training, supports, and resources on gender and sexuality inclusion for birth workers.

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

STRATEGIES FOR WORKING THROUGH ANXIETY AND TRIGGERS

HELPS ME FEEL SAFE

LIST SOME THINGS THAT MAKE YOU FEEL SAFE: (OBJECTS, PEOPLE, SOUNDS, SMELLS)



HELPS ME COPE

HOW DO YOU COPE WITH PAIN AND FEAR: (MEDITATE, HOBBY, FRIENDS, READ, ETC)

There are many aspects of labour and childbirth which may cause 2SLGBTQ+ folks anxiety. Review the following chart of possible anxiety triggers. Make note of which evoke anxiety reactions for you. Describe what is fearful and work to develop a coping strategy that works for you.

****Keep these sheets to look back on and share with your support network and caregivers****

My Triggers	My Fears	My Strategy
Changes in physical appearance (hospital robe, no binder)		
Nakedness / exposure of body		
Internal / pelvic exams		
Secretions & bodily fluids (blood, discharge, amniotic fluid)		
Blood draws / intravenous fluids		
Attachments to machines (EFM cords, IV line, catheter, oxygen mask)		
Restriction to bed		

This section has been influenced by the work of Penny Simkin and Phyllis Klaus, 1994

There are many aspects of labour and childbirth which may cause 2SLGBTQ+ folks anxiety. Review the following chart of possible anxiety triggers. Make note of which evoke anxiety reactions for you. Describe what is fearful and work to develop a coping strategy that works for you.

****Keep these sheets to look back on and share with your support network and caregivers****

My Triggers	My Fears	My Strategy
AROM (Artificial Rupture of Membranes "breaking the water")		
Episiotomy / tearing		
Forceps or vacuum extraction		
Cesarean section		
Holding baby		
Chestfeeding / nursing		
Postpartum (examinations of birth canal, stitches, fundal massage)		

This section has been influenced by the work of Penny Simkin and Phyllis Klaus, 1994

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Pain Related Triggers

There are many aspects of labour and childbirth which may cause 2SLGBTQ+ folks anxiety. Review the following chart of possible anxiety triggers. Make note of which evoke anxiety reactions for you. Describe what is fearful and work to develop a coping strategy that works for you.

****Keep these sheets to look back on and share with your support network and caregivers****

My Triggers	My Fears	My Strategy
Pain with labour contractions		
Pain related behaviour (panic, loss of control)		
Expressions of pain (voice changes, facial expressions)		
Pain medication side-effects; • Narcotics: groggy, sleepy, less pain, more relaxation		
Pain medication side-effects; • Epidural: numb, less mobility, possible inadequate pain relief, less pain, more relaxation		
Post-birth pain experiences (stitches, nursing, fundal massage)		

This section has been influenced by the work of Penny Simkin and Phyllis Klaus, 1994

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Interpersonal / Structural Triggers

My Triggers	My Fears	My Strategy
Misgendering		
Gendered body language		
Healthcare / medical system (structure, policies, history and present)		
Relationship with health care provider (gender, familiarity, trust, gender and sexuality knowledge)		
Strangers (unfamiliar caregivers, health care workers, students at hospital)		
Behaviour of caregiving staff (respect, control, individual treatment, consent to touch, competent care)		
Issues re partner(s), doula, family, friends (disapproval, trust, abandonment,)		

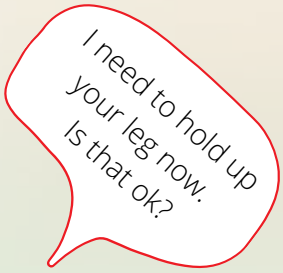
Comfort Positions for Birthing

Visuals typically accompanying comfort positions during labour are hetero- and cis-normative.
This guide hopes to showcase the range of people who can give birth and those who support them.

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 labour. This toolkit aims to create a space for more representation in resources within the doula community and to add to the conversation about how more bodies can be shown, celebrated, and cared for. In addition to the depictions below, here are some things to consider when physically supporting a client through labour;

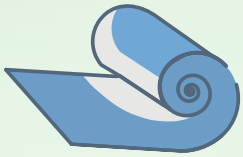
1. Simple stretching before physically comforting and supporting a client during labour will help keep up your stamina and reduce the risk of fall, strain, and injury.

2. Maintain ongoing consent. Ask when you touch new areas and announce what you are doing.



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.

....continued...

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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.

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

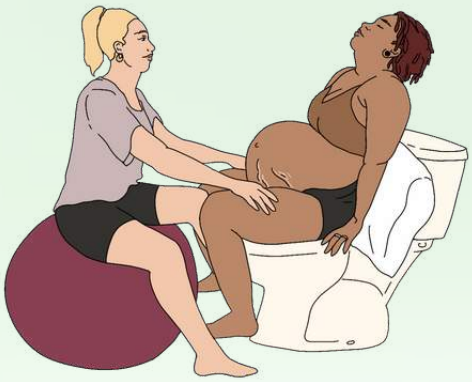
Slow Dancing

Seated Positions

Sitting Upright

Sitting Leaning Forward

Sitting on Commode



Semi-Sitting

Artwork created by: Audrey Chan and Julia Hutt

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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.

Artwork created by: Audrey Chan and Julia Hutt

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LABOUR ANALGESIA

EVERY PERSON IN LABOUR HAS A RIGHT TO PAIN MANAGEMENT, AS WELL AS A RIGHT TO CHOOSE WHAT OPTION IS BEST FOR THEM!

WHO IS THE ANESTHESIA TEAM?

An important part of interdisciplinary health care, the anesthesia team are experts in pain management, airway management, and critical care that may include:

- 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 ongoing research studies.

PHARMACOLOGICAL PAIN CONTROL OPTIONS

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!

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COMPARING PAIN CONTROL METHODS

INHALED N2O

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.

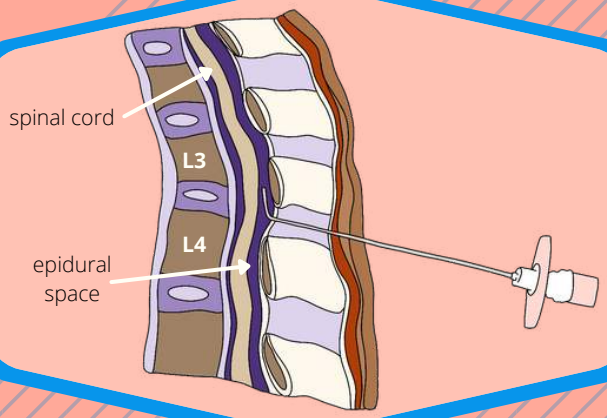
POSITIONS FOR EPIDURAL INSERTION

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**

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EPIDURAL RESTING POSITIONS

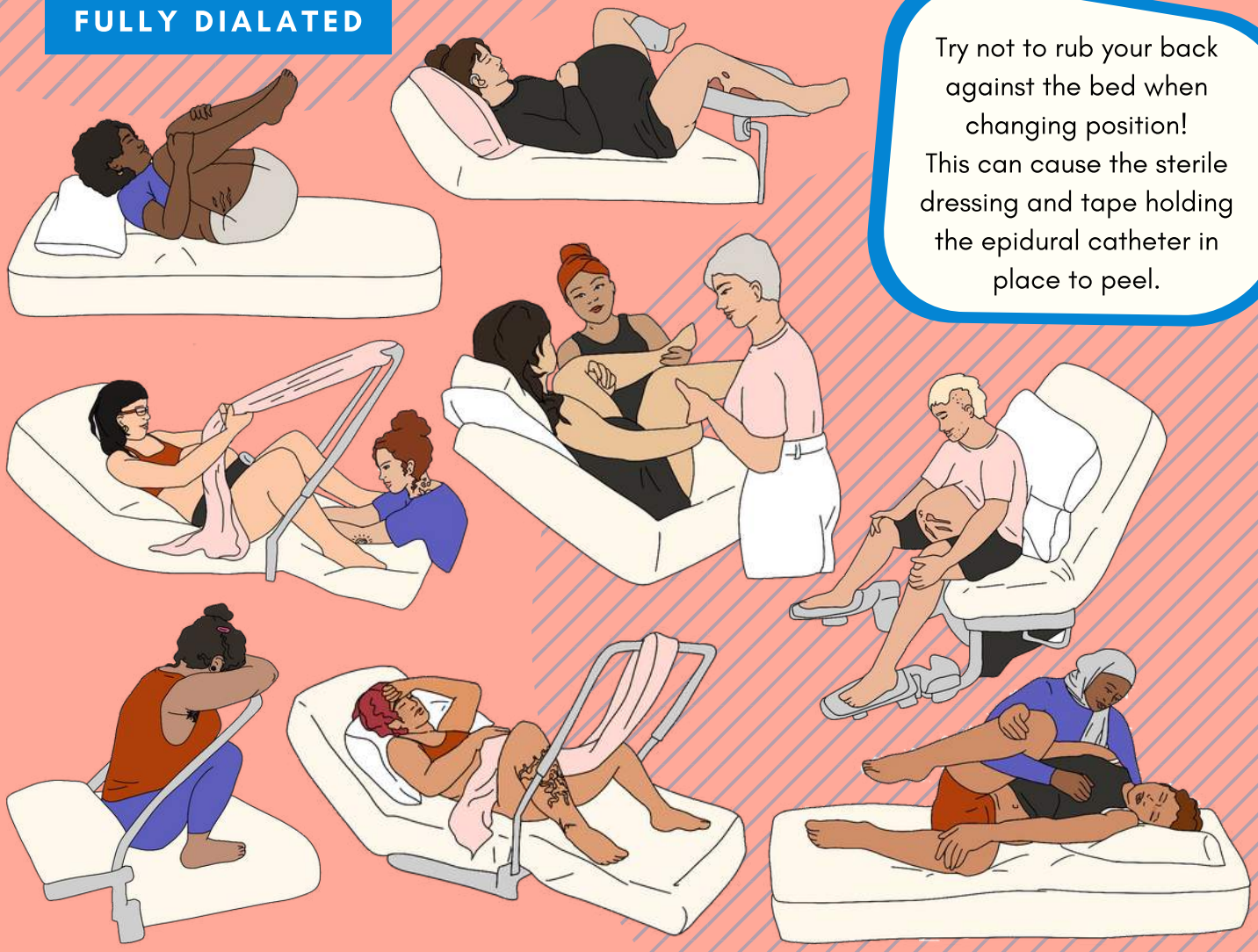
Here are some suggested comfort positions.

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.

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)

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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?!

Birth Plan for: _____

My Pronouns:

Due Date:

I will give birth at:

My Primary Caregiver(s) and their pronoun(s) is/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/labour support people?

My doula can support these by...
What role do you want your doula to take around these concerns? As an advocate? A silent supporter? Other?

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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 co-parents/labour support people?

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Birth Plan for: _____

POSTPARTUM PLANNING:

Plans for **FEEDING:** *(chestfeeding/nursing, formula, co-nursing, a combination)*

How I feel about **VISITORS:** *(who is welcome, times I don't want to be disturbed)*

Pain Control Plan:

Follow-up after discharge:

Additional questions, concerns, needs:

Educational needs:

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Hospital Bag Pack Lists

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?

PACK LIST 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)

REMEMBER!

You will be in various states of dress throughout the birthing process. Plan on wearing what feels most comfortable during the early stages of labour, eventually moving to items that will allow access for delivery and nursing (if you are), as well as any medical interventions such as foetal monitors or intravenous lines.
Some examples of clothing to wear and bring are: pajamas, nursing gown, housecoat, sports bra, camisole/tank/undershirt, loose shorts, towel/scarf for coverage, slippers, flip flops or other easy to put on shoes.
Think about what will be physically comfortable as well as gender affirming.

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Hospital Bag Pack Lists

PACK LIST FOR YOUR BABY

*Please note: 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 center (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.

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Hospital Bag Pack Lists

PACK LIST 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.

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Hospital Bag Pack Lists

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?

PACK LIST 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…

Keep in mind any allergies your client and other supports may have and the food & allergy policies of the hospital!

Choose snacks that don't need to be heated or refrigerated and can be eaten out of the container / packaging.

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NEWBORN CARE PLAN

NAME:

BABY'S CARE PROVIDER:

MY SUPPORT PEOPLE ONCE I'M HOME WITH BABY

INFANT FEEDING PLAN:

CHESTFEEDING, NURSING, FORMULA, A COMBINATION OF BOTH

How can your doula support your feeding plan?

I have the following experience 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):

QUEER AFFIRMING PREGNANCY LOSS RESOURCES

Pregnancy loss, or miscarriage, can be a traumatic and isolating event. Pregnancy loss remains a taboo and stigmatized topic, resulting in further feelings of isolation and fear/hesitancy to seek out support. 2SLGBTQ+ people who experience pregnancy loss are faced with a doubly isolating experience, as many of the supports and resources that do exist are heteronormative, cis-centric, and often do not consider any family or parenting style other than a normative one.

As a doula, your job is to provide information and emotional support. Assure your client they are not alone in their experience, though it may feel that way.

Following is a list of explicit or assumed (based on language) queer-friendly pregnancy loss support resources.

Not included in this list are regionally-specific supports that were not determined to be queer-friendly, such as those offered through your local hospital. Often these support groups or services are heteronormative and do not take the 2SLGBTQ+ birthing or parenting experience into consideration. Your DONA doula trainer can provide the contact information for these services in your doula training.

The Pregnancy and Infant Loss Support Centre (Alberta)

https://pilsc.org/

Offers one-on-one supports, online sessions, and peer groups. Their website uses queer friendly language and inclusion is part of their mission statement.

Pregnancy After Loss Support (online magazine)

Resources for LGBTQ+ families experiencing loss and pregnancy after loss
https://pregnancyafterlosssupport.org/resources-for-lgbtq-families-experiencing-loss-and-pregnancy-after-loss/

This article offers lists of resources, articles, Twitter accounts, and personal stories of LGBTQ+ people who have experienced pregnancy loss and/or pregnancy after a loss.

PREGNANCY LOSS RESOURCES

Baby in Heaven: Info Hub for Grieving Parents (blog)

Resources & Support for LGBTQ Parents
https://babyinheaven.com/support-grieving-lgbtq-parents/
This blog article provides some links and references to academic articles, studies, and pamphlets on pregnancy loss and grief among LGBTQ+ people.

Canadian Mental Health Association: Nova Scotia Division

LGBTQ+ Caregivers
https://novascotia.cmha.ca/population-resources/lgbtq-caregivers/
A library of links, including an info sheet on LGBT pregnancy loss, as well as guidebooks and academic studies.

Reproductive losses: challenges to LGBTQ family-making, by Christa Craven. 2019.

Book is available in Novanet and can be borrowed with any Nova Scotia public library card. Contact your local university library to borrow or follow the instructions here: https://www.novanet.ca/about/mission-core-activities/community-borrowers/

The accompanying website for this book could also be helpful:
https://lgbtqreproductiveloss.org/about-2

Xtra Magazine

When miscarriage happens to LGBTQ2 parents
https://www.dailyxtra.com/miscarriage-lgbtq-parents-loss-177106

Huffington Post

LGBTQ Pregnancy Loss And Miscarriage Often Means Grieving In The Gaps
https://www.huffingtonpost.ca/entry/lgbtq-miscarriage-support_ca_5da5cadde4b0058374e94b01

GUTS Magazine

One Hundred and Three Swims
http://gutsmagazine.ca/one-hundred-and-three-swims/

The Cut

For Two Months My Future Included a Baby...
https://www.thecut.com/2020/05/for-two-months-my-future-included-a-baby.html

Kaddish: A Podcast on Death and Mourning

A Container Big Enough to Hold Us
https://soundcloud.com/user-544994582/episode-5-a-container-big-enough-to-hold-us
A podcast episode about queer reproductive loss.

QUEER SAFE PRENATAL RESOURCES

Below is a list of explicit or assumed (based on language) queer-friendly prenatal classes and resources.

Not included in this list are regionally-specific supports that were not determined to be queer-friendly, such as those offered through your local hospital. Often these support groups or services are heteronormative and do not take the 2SLGBTQ+ birthing or parenting experience into consideration. Your DONA doula trainer can provide the contact information for these services in your doula training.

The Nesting Place
- Offers online, queer-friendly prenatal classes
- https://www.thenestingplace.ca/classes-prenatal-baby/prenatal-classes/

Lamaze International. Welcoming All Families: The Need for LGBTQ Specific Childbirth Classes
- Blog post with book and website resources to access about prenatal care
- https://www.lamaze.org/Connecting-the-Dots/series-welcoming-all-families-the-need-for-lgbtq-specific-childbirth-classes

Full Spectrum Doula (Toronto)
- 2 Spirit, Queer, and Trans Prenatal Childbirth Education
- https://fullspectrumdoula.ca/2sqt-prenatal-class/

MAIA Midwifery & Fertility (USA)
- Offer virtual groups and classes such as Centering Queer and Trans Pregnancy Group, Childbirth Class for LGBTQ+ Families, & Queer/Trans Early Parenting Support
- http://maiamidwifery.com/classes-webinars/

Kira Liss Birth & Movement
- Offer virtual Childbirth Education and Movement Classes (pre or postnatal)
- http://www.kiraliss.com/

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Recommended Resources

Aizley, Harlyn. *Confessions of the Other Mother: Nonbiological Lesbian Moms Tell All.* 2006. Penguin Random House.

MacDonald, Trevor. *Where's the Mother?: Stories from a Transgender Dad.* 2016. Trans Canada Press.

Graefe, Sara. *Swelling with Pride: Queer Conception and Adoption Stories.* 2018.Caitlin Press.

Midwives Association of British Columbia. *LGBTQIA2S Pregnancy and Birth Resources.*

- https://www.bcmidwives.com/Resources.html

Queering Parenthood. *Community Resources*.

- http://queeringparenthood.com/communityresources.php

LGBTQ Parents Network. *Scenes from a Fertility Clinic*.

- https://lgbtqpn.ca/library/scenes-from-a-fertility-clinic/
  - Educational videos and accompanying materials are intended to be used by people working in fertility services who are interested in improving the quality of their service to LGBTQ people, and by LGBTQ people who are considering using the services of sperm banks and/of fertility clinics.

Love Over Fear Wellness & Birth

- http://www.loveoverfearwellness.com, @loveoverfearwellness (Instagram)
  - Queer doula and radical educator

Recommended Social Media

Trans and Queer Pregnancy and Parenting Group. Hosted by the Strathcona Midwifery Collective

- https://www.facebook.com/tqppgroup/
  - Offer Trans + Queer Pregnancy + Parenting Group Virtually through Zoom (all gatherings are free)

Birthing Beyond the Binary

- https://www.facebook.com/groups/1225482460806425/about
  - "Education and community cultivation for queer, trans, and gender non-conforming and people and healthcare providers, focusing on preconception, conception, gestation/pregnancy, birth and postpartum. Birthing Beyond the Binary is based in applied attachment theory, quantum midwifery and self-directed models. This is a space to access resources, be supported in your process and build community." Group Description.

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