"Relational Spaces in Maternal Healthcare: A Qualitative Study of Young Mothers’ Experiences with Community-based Doula Care”

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Social Work

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in partial fulfillment of the requirements for the degree of Master of Social Work

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# Table of Contents

Abstract ................................................................................................................ iv
Acknowledgments .................................................................................................. v

Chapter One: Introduction ..................................................................................... 1
   About the Researcher ......................................................................................... 6
   Methodology .................................................................................................... 11
      Research questions. ....................................................................................... 11
      Theoretical frameworks and approach to research. ................................. 12
      Methods. ...................................................................................................... 15
      Recruitment and selection procedures. ..................................................... 16
      Data collection. ............................................................................................ 18
      Data analysis. ............................................................................................... 19
      Credibility and trustworthiness. ................................................................. 21
      Limitations of methodology. ...................................................................... 22

Key Terms ............................................................................................................. 24
   Young mothers. ............................................................................................... 24
   At risk. ............................................................................................................ 25
   Woman-centered. ............................................................................................ 27
   Relationship-based. ......................................................................................... 28
   Social support. ............................................................................................... 29
   Stigma. ............................................................................................................ 31

Chapter Two: Literature Review .......................................................................... 35
   Defining Doula Care ....................................................................................... 35
   Evidence on the Effectiveness of Doula Care .............................................. 36
   Doula Care as Enriching the Childbirth Team ............................................. 41
   Doula Care as a Profession ............................................................................ 49
   Structural Barriers to Adequate Maternal Healthcare for Women who are “At Risk” 51
   Doula Care with Women who are “At Risk”: Addressing Inequities ............. 56
   Teenage Pregnancy and Existing Services for Young Mothers .................... 63
   Integrating a Woman-centered Care Model into the Maternal Healthcare System 66
   Assessing the Potential for Change ............................................................... 70

Chapter Three: Enriching Maternal Healthcare for Young Mothers through Doula Care 74
   The Participants .............................................................................................. 74
      Young mothers. ............................................................................................ 74
      Doulas. ........................................................................................................ 74
      Pseudonyms. ............................................................................................... 74
   The Impact of Stigma ..................................................................................... 75
   Barriers to Communication with Healthcare Providers ............................... 85
   Diminished Control and the Compromising of Informed Choice .................. 92
Chapter Four: Understanding Doula Care with Young Mothers ........................................ 102
Doula as Encouraging a Positive Birth Experience ......................................................... 102
Trust and Connectedness in Young Mothers' Relationships with their Doulas .............. 112
The Impact of Social Support ......................................................................................... 123

Chapter Five: Advancing and Protecting Doula Care .................................................. 129
Increasing the Accessibility and Availability of Doula Care .......................................... 129
Protecting the Relationship-based Nature of Doula Care ............................................. 150
Locating services in the community.............................................................................. 150
Matching women during pregnancy ............................................................................ 153
Ensuring women's choice in matching ...................................................................... 156

Chapter Six: Conclusion ............................................................................................... 161
Researcher Recommendations and Critical Self-Reflection .......................................... 163
Implications for Social Work ......................................................................................... 168
Limitations ................................................................................................................... 170
Future Research ........................................................................................................... 171
Dissemination ............................................................................................................... 173

References ..................................................................................................................... 174
Appendix A: Interview Guide for Clients of Doula Care ................................................. 187
Appendix B: Interview Guide for Doulas ........................................................................ 190
Appendix C: Recruitment Email for Clients of Doula Care .......................................... 193
Appendix D: Recruitment Email for Doulas .................................................................... 195
Abstract

Eight interviews were conducted with doulas and young mothers who were clients of a community-based doula program. A postmodern feminist perspective and an anti-oppressive approach were used to explore their experiences and the potential for increasing accessibility to doula care. Findings suggest that, for study participants, doula care is seen to enrich maternal healthcare for young mothers, due, in part, to the creation of a relational space between young mothers and their doulas. Within the context of the relationships that form between young mothers and their doulas it can become more possible for young mothers to access strong social support and to experience a greater sense of control over their birth experiences. Participants advised that efforts to increase the accessibility of doula care should incorporate measures to support these relationships.
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Much appreciation to family and friends, who listened to me think “out loud”, connected me with resources, offered their thoughts, or provided encouragement. In particular: Stephanie Austin, Ellen Hawman, Karla Holland, Tim Holland, James Jamieson, Jeremiah Kalyniak, Karen O’Krafka, and Rachel Sutton. A special thanks to my parents, Marg and Stew Holland, for their generous support during the writing phase.
Chapter One: Introduction

Increasing the availability and accessibility of doula care would arguably enrich maternal services and minimize current inequities in the birthing care that women receive. Doula care in Canada is primarily available on a private fee-for-service basis; a few community-based doula programs have been designed to increase the accessibility of doula care and offer volunteer doula services to women who are at risk. The community-based doula care model is a relatively new approach that can be understood as an intensive, strengths-based intervention (Abramson, Breedlove, & Issacs, 2006), under-recognized relative to its degree of success. This thesis explores the experiences of young mothers who access community-based doula care, as well as the possibilities and barriers to increasing the availability and accessibility of doula care.

Over the last few decades a growing body of research, many studies involving randomized controlled trials, has offered compelling evidence on the effects of doula care, particularly on obstetric outcomes. Yet there is a relative paucity of qualitative research studies that explore women’s experiences with doula care. Only one previous study by Breedlove (2005) has examined young mothers’ perceptions of social support received through a community-based doula program, in the United States. The current study is the first to explore the experiences of both doulas and clients of community-based doula care, and is the first to assess their views on increasing the availability and accessibility of doula care. Involving both doulas and clients of community-based doula care in this study has provided an opportunity to investigate experiences of doula care from these different perspectives; some findings, particularly on the nature of the

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1 Briefly, a doula is a woman experienced in childbirth who provides information and emotional support to women during pregnancy, labour and birth. I will define doula care in greater depth in Chapter Two.
relationship between young mothers and their doulas, surfaced in a way that they may not have had the study investigated the views and experiences of only one of these groups of women. In addition, assessing participant views on the availability and accessibility of doula care provided an opportunity to explore the perceptions of grassroots stakeholders on the potential for social change.

In conducting this study as a Masters of Social Work thesis I have drawn heavily on the links between social work and women's experiences of marginalization, social disenfranchisement, privilege and oppression. I will draw upon social work's history of highlighting power dynamics in helping relationships when exploring the relationship between young mothers and their doulas. I will also consider the possibilities for linkages between doula care and established institutions and community services that work with women who are at risk (e.g., hospitals, Children's Aid Society (CAS), sexual health clinics).

The data for this thesis has been drawn from semi-structured interviews with doulas and young mothers who were clients of the Birth Companion Program, a community-based doula program located in Ottawa, Ontario. The Birth Companion Program is an initiative of Canadian Mothercraft of Ottawa-Carleton. It began in 1990 and provides volunteer doula support to women who are socially, financially or culturally isolated. Birth Companion volunteers are trained by program staff to provide emotional, informational, and physical support during pregnancy, labour and birth, and in the postpartum period. Birth Companions are matched one-to-one with pregnant women and are on-call to their matches at all times; they often attend prenatal classes and medical

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2 The program predominately serves young mothers (approximately 70% of clientele) and new Canadians (approximately 30% of clientele). Given the scope and limitations of this study I have chosen to focus on the experiences of young mothers.
appointments, respond to questions and provide information, network matches with community resources, and provide support and information on breastfeeding and infant care. The Birth Companion Program in Ottawa is at the forefront of community-based doula care in Canada and there is only a smattering of similar community-based doula programs across Canada and the U.S.

The provision of physical and emotional support during labour by lay women is centuries old. In the early 20th century birth was moved from the home into the hospital and became increasingly medicalized, which relegated lay women to the fringes of maternity care. A wave of birth activism in the 1960s and 1970s fought for the recognition of birthing women’s needs for social and emotional support, focusing efforts on gaining the right of partners to enter the delivery room (Meyer, Arnold, & Pascali-Bonaro, 2001). More recently, women’s interest in woman-centered models of care and a consumer-driven resurgence in the birth movement culminated in the regulation and public funding of Ontario midwives in 1993 (Shroff, 1997). Midwives in Ontario are now covered under Ontario’s Health Insurance Plan (OHIP) and can act as primary caregivers for women with a low-risk of complications at home or in hospital; many other provinces have followed suit. Throughout this work I will draw on literature on the integration of midwifery as authors on midwifery’s professional project can offer lessons learned and better inform efforts to increase the accessibility of doula care.

Both midwives and doulas attend relatively few births (compared to the number of births attended by obstetricians) yet are rated by women as valued sources of support.

To my knowledge, it is the longest running community-based doula care program in Canada and has provided program materials and advice to assist with the initiation of similar programs in approximately five other Canadian communities. Most recently, the Birth Companion Program has entered into a partnership with the Wabano Centre for Aboriginal Health, also in Ottawa, to adapt the program and make it more culturally relevant for Aboriginal volunteers (First Nations Centre, 2008).
supportive care (Sakala, Declerq, & Corry, 2002). Midwives currently provide primary
care to 3% of pregnant women across Canada (Canadian Institute for Health Information,
2004); with over 300 registered Ontario midwives (Bourgeault, 2006) serving more than
6% of women in this province (Ontario Ministry of Health, 2003). To my knowledge,
Canadian statistics on the use and clientele of doula care are not available; in the U.S.
doulas currently attend approximately 5% of births while midwives attend 11% (Sakala et
al., 2002) and doula care clients are predominately white, married women, with an
average age of 30 (Lantz, Low, Varkey, & Watson, 2005).

Midwives and doulas share a woman-centered approach to childbirth; and, as
Daviss (2001) writes, share with many women in the alternative birth movement the
ideology that birth is a normal physiologic event and the belief that women’s informed
choices (including about where to give birth) are central to creating positive birth
experiences. Doula work is often a stepping stone to midwifery, with preliminary
research indicating that one in four doulas are planning a career in midwifery (Lantz et
al., 2005). In relation to midwives and other childbirth professionals (i.e., nurses and
obstetricians), I would suggest that doulas can be understood as paraprofessionals. A
paraprofessional is defined by Lantz et al. (2005) as someone with a lower level of
training who works in tandem with another professional.

Daviss (2001) acknowledges that there has been a “wane in consumer interest in
the alternative birth movement following midwifery legislation” and questions if this
waning interest is a “lull in the citizen surge of interest in natural childbirth” or if it may
in fact mark the end of the movement (p.83). Lantz et al. (2005) suggest that doula care
may be the next ‘surge’ and position doula care as an important current aspect of an
ongoing movement attempting to “demedicalize” childbirth (p.110). Among the growing body of research on doula care, Hodnett, Gates, Hofmeyer, and Sakala’s (2003) review of studies on the effectiveness of doula care is the most often cited. Hodnett et al. (2003) conclude, among other benefits, that doula-supported women are less likely to have operative birth and are more likely to be satisfied with their childbirth experiences. In response to such evidence on the effectiveness of doula care, demand for doulas’ services has been growing significantly, “exploding in the last five years” (Lantz et al., 2005, p.111). Yet doulas are newly emerging paraprofessionals and are still developing a position vis-à-vis the maternal healthcare system (Lantz et al., 2005). Quite recently, the British Columbia Ministry of Health commissioned a report on the province’s caesarean birth rate; the Caesarean Birth Task Force included, among their recommendations in their final report, the suggestion that public funding of doula care should be considered (British Columbia Perinatal Health Program, 2008). As such, this study is a timely investigation that explores the experiences of clients and doulas of a community-based doula program as well as their views on increasing the accessibility and availability of doula care.

I undertook this investigation with the intention of exploring the potential for the regulation and public funding of doula care. I surmised that professionalizing doula care and bringing it through a process of regulation and public funding (similar to that which Ontario midwives underwent in the 1990s) was the most effective way of increasing the availability and accessibility of doula care. Working from that assumption, one of my key

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4 Throughout this work I refer to “regulation and public funding”. In the current political context I see regulation as necessary to public funding and view it primarily as a means to an end, rather than a goal in and of itself. Participant views on the merits and drawbacks of regulation receive some attention in Chapter Five, but an in-depth discussion of the politics surrounding regulation is beyond the scope of this work.
research questions at the outset was "What is the best means of mobilizing women and communities for the regulation and public funding of doula care?" I intended for this investigation to be action-oriented and to explore the capacities of a social movement for the regulation and public funding of doula care. As such, many of the questions in my interview guides (see Appendixes A & B) were framed accordingly (e.g., How do you think doulas across Canada, in general, would respond to this movement? What resources do you think this movement has?). While participants shared their views on increasing the availability and accessibility of doula care (and on the potential of regulating and publicly funding doula care as one means of doing so) participants did not explicitly call for mobilizing around the regulation and public funding of doula care. I have responded by reframing this component of the discussion in a way that reflects and represents the data; focusing instead on exploring participant views on the potential for regulation and public funding and on increasing the availability and accessibility of doula care.

In this chapter I begin by discussing my own social location as a researcher and the ways in which my own experiences and views have shaped and informed the research. I will provide a detailed description of the methodology and process of analysis, and will describe the application of a postmodern feminist perspective and an anti-oppressive approach as the theoretical frameworks for this study. I will also outline several key terms that will be used throughout the work.

About the Researcher

I recognize that my research has been informed and influenced by my own social location, experiences and interests. According to Kirsch (1999), "the goal of situating
ourselves in our work and acknowledging our limited perspectives is not to overcome these limits—an impossible task—but to reveal to readers how our research agenda, political commitments, and personal motivations shape our observations in the field, the conclusions we draw, and the research reports we write” (p.14). I have long held interests in maternal health and feminist activism and have often envisioned myself working within the birth community in some capacity. Over the past three years, my interest in labour support for women who are at risk has been strengthened through working as a volunteer doula with the Birth Companion Program; in this capacity I have provided information and support throughout pregnancy, birth and the postpartum period to four young mothers ages 16-17.

In relation to the study participants I was both an “insider” and an “outsider”. I had hoped that study participants would be able to relate to me as an interviewer due to my involvement with the Birth Companion Program community; Morris (2002) advises that if the interviewer has a similar background to the participants and is non-judgmental and non-directive then the interview may be particularly thorough and in-depth. Similarly, feminist scholars have noted that when a researcher shares a common standpoint with an interviewee (known to both prior to the interview) that the positioning of the researcher as an insider can enhance rapport and trust (Collins, 1991 as cited in Blee & Taylor, 2002). However, in other ways I was positioned as an outsider because many of the young mothers who I interviewed have struggled with social, financial or cultural isolation and I have not. I have also never given birth and do not have any children. These differences may have decreased the participants’ trust in me and in the objectives of my research.
I sought to foster trust in myself and in the study among participants by being conscious of our different life experiences and by attempting to minimize power differentials. For example, I tried to create an interview dynamic where participants could share their experiences through conversation, rather than feeling interrogated (e.g., before beginning the interviews I explained my research interest in the Birth Companion Program and invited participants to ask any questions of me about the project). During interviews and throughout all phases of the study, I have aimed to adhere to bell hooks’ suggestion that “when we write about the experience of a group to which we do not belong, we should think about the ethics of our action, considering whether or not our work will be used to reinforce and perpetuate domination” (Morris, 2002, p.57); I have attempted to do so by engaging in critical reflection throughout the study and by making attempts to situate and analyze my own voice and perspective in this work.

My own biases and views on natural childbirth have influenced this research and warrant discussion at the outset. I agree with post-structuralist critics of the natural childbirth movement who suggest that childbirth “is” not inherently either natural or dependent on medical technology; but can rather be understood as natural for those who define it as such and medical for those who define it as such (Treichler, 1990). However, I personally define childbirth as “natural”, meaning that I consider pregnancy, labour and delivery to be “normal” physiological states and I think that keeping interventions to a minimum better promotes maternal and infant health. Yet at the same time I recognize that glorifying “the natural” can construct those births that do not conform to this ideal as “unnatural” which can deny women who experience such births both “agency and humanity” (Michie and Cahn, 1996, p.48). I think that women can use medical
technology for their own purposes and benefits; yet also believe that women's agency is often exercised in a medical context that constrains their access to informed choice and decision making. In other words, I am critical of the ways in which medical dominance in maternal healthcare (Wrede, Benoit, & Sandall, 2001) continues to shape women's definitions of childbirth and their use of medical technology in childbirth. A failure to examine the context within which women make childbirth choices "obscures the way in which the quest for profit, medical interests, and the legacy of patriarchy complicate women's efforts to use technology for their own purposes" (Beckett, 2005, p. 269).

I recognize that there are risks and limitations to taking a "natural" perspective on birthing while investigating the benefits of doula care with young mothers and the potential for increasing the accessibility of doula care. My research interests and my expectations for this study have both been shaped by this perspective to a significant degree. This "natural" perspective on childbirth served in many ways as a starting point for the study and acted as a core assumption upon which other claims were based; it was primarily during the writing phase that I contended with negotiating the ways that this perspective may have shaped the research. I undertook this study with the view that the social and political contexts in which women make childbirth choices beg to be deconstructed and analyzed (Beckett, 2005), and I did examine participant experiences with this in mind. However, any attempt to examine social and political context occurs within a context that itself carries social and political implications; for example, I am cognizant that taking a "natural" perspective as a researcher may have limited or constrained what participants shared during their interviews or my own reading of the data during analysis.
In contending with negotiating the ways that this "natural" perspective may have shaped the research I have become increasingly aware of the political context within which this view has developed and the implications, as a researcher, of holding a particular definition of childbirth. The importance of women's choices and their sense of control during labour runs as an undercurrent through much of the feminist literature on the medicalization of childbirth (e.g., Fox & Worts, 1999; Martin, 1990; Rothman, 1994) and the centrality of these issues is also evident in the findings of this study. In trying to reclaim choice and control for women in labour, the alternative birth movement has in some ways replaced the "story" of childbirth as "medical" with a "story" of childbirth as "natural" (O'Reilly, 2004); however well-intended, this newer "story" can also serve to constrict and constrain birthing women. A century ago, obstetrics positioned itself in opposition to the "risks" of non-medicalized birth as a means of establishing the "safety" of obstetric care and the alternative birth movement has arguably used the same strategy; reinforcing the constructedness of these two philosophies and approaches to childbirth as being in opposition to one another. The integration of midwifery into Ontario's maternal healthcare system can be seen as indicating a shift toward focusing on the possibilities between these definitions and approaches to childbirth (i.e., woman-centered and medical). Bergum and Dossetor (2005), in their work on ethics and relational space, suggest that it is by focusing on the spaces in between that possibilities for ethical understanding become more possible and that we are able to "face the reality of both/and—both the rational and the emotional, [their] successes and failures" (p.xx). I have aimed to move my analysis and writing into this space in between, to work from a
perspective of both woman-centered approaches and medical approaches to childbirth and to enable exploration on the possibilities therein.

This aim of working from a perspective of “both/and” has involved critical reflection in order to acknowledge and challenge my biases and to make room for participant views to emerge in ways that I did not expect. According to Tutty, Rothery, and Grinnell (1996), the more that a researcher can identify how and when their views, assumptions, values, feelings, and experiences affect their interpretation of the interviewee’s information “the better [they] will be able to understand and accurately articulate [their] interviewee’s perspective” (p.61). I do not think that a researcher’s bias can be entirely eliminated but I do think that efforts to minimize the influence of my own views and biases have resulted in a more balanced discussion of the issues. I will describe some of the ways that I tried to manage the influence of my biases in the methodology section which follows.

Methodology

This study explores young mothers’ experiences with doula care and the potential for building public support to increase the accessibility and availability of doula care.

Research questions. The central questions of this study are:

- What are the experiences of women who are at risk (in particular, young mothers) who access doula care?
- What, if any, are the benefits of doula care for women who are at risk (in particular, young mothers)?
• What challenges might be presented in undertaking efforts to increase accessibility to doula care? In particular, how might a woman-centered model of care best be incorporated into the medical system?

• What recommendations would doulas and their clients propose regarding increasing the availability and accessibility of doula care?

Theoretical frameworks and approach to research. A postmodern feminist perspective and an anti-oppressive approach provided the theoretical frameworks for this work. Postmodern theories identify particularity (rather than universality), put an emphasis on deconstruction, and reveal the ways that meaning is signified through language (McLaughlin, 2003). Postmodernists argue that meaning and identity are produced through binary oppositions in language (e.g., "technological" and "natural") and that language is a factor in power relations because it signifies "proper" and "unproper" (McLaughlin, 2003).

Some feminist critics of postmodernism suggest that the implications of postmodernism halt any efforts to work toward political projects which rest on certain central assumptions (e.g., that women deserve equal access to adequate healthcare) (McLaughlin, 2003). However, McNay (1992) argues that postmodern feminism can position women as "self determining agents" who are capable of creating social change by challenging structures and domination. McNay (1992) suggests that feminists “have drawn extensively on the poststructuralist argument that rather than having a fixed core or essence, subjectivity is constructed through language and is, therefore, an open-ended, contradictory and culturally specific amalgam of different subject positions” (p.2). Instead of viewing women’s experiences as shared, such assumptions can be
deconstructed and then understood and interpreted through social and cultural discourses, offering new opportunities for political activity (McLaughlin, 2003).

Dominelli (2002) makes the case that anti-oppressive practice offers insights beyond what she sees as “the pessimism of postmodernism” (p.162). Dominelli (2002) suggests that emancipatory social change is possible if people organize together in ways that acknowledge their varied starting points and lived experiences of oppression and privilege. Anti-oppressive practice expands on the ‘additive approach’ to viewing oppression where social categories (e.g., race, class, gender) are considered as separate and ranked according to degree of presumed impact. Instead, anti-oppressive practice places an emphasis on intersectionality and on the ways in which varied aspects of identity operate at the same time to intensify experiences of both oppression and privilege (Dominelli, 2002; Mullaly, 2002; Shera, 2003). Razack (1998) further suggests an emphasis on interlocking (rather than intersecting) analysis because it can serve as a reminder of the ways in which systems “secure one another” and how a “subordinate location” may simultaneously “reflect and uphold race and class privilege” (pp.13-14).

Anti-oppressive social change necessitates attention to the ways in which systems of oppression and privilege intersect and interlock because the “ultimate function of differencing” is to “superiorize” dominant groups rather than to “inferiorize” subordinate groups (Gingrich, 2003, p.11); for change to be emancipatory it must attend to the ways in which the status quo privileges dominant groups. For example, Razack (1998) suggests that rights constructs can serve to empower subordinate groups but cautions that thinking strictly in terms of rights can obscure power relations, enable dominant groups to maintain innocence, and hinder efforts for change.
I have drawn from the insights of both a postmodern feminist perspective and an anti-oppressive approach in this work; I interpret these frameworks as compatible and interconnected and place much value in their shared emphasis on subjectivities and social change. I adopted a feminist approach to the design and methods of the research project itself and see feminist theoretical ideas as having much to “offer as a practice-relevant and justice-orientated approach to social work research” (Trinder, 2000, p.39). According to Kirsch (1999), “feminist scholars take the postmodern critique of knowledge as a starting point for developing their research agendas, but add a distinctly feminist goal: that research not only be on women, but also for and by women” (p. 8). Kirsch further argues that feminist research must not only describe, but also challenge, women’s oppression. She calls for “research that is meaningful, empowering, and beneficial to participants, research that has the potential to improve participants’ lives” (p.11). When structuring the interview guide and while conducting the interviews I made efforts to create an interview context that minimized power dynamics and where participants could speak from their experiences and express a range of views. In line with a postmodern feminist approach to research, I have explored the effects of my interpretive role on the research and have analyzed the participants’ interviews with attention to their own interpretive roles (i.e., with attention to how analysis and narrative are constructed within contexts) (Trinder, 2000). I tried to examine the data with the particularity of participant experiences in mind and remained open to seeing how dynamics of power and experiences of oppression and privilege would surface in the data and/or in my own critical reflection on my role as a researcher. Lastly, I solicited participant input at two
stages in the study in order to more accurately represent participant views and to foster a sense of participant investment in the research.

Methods. In this study, I conducted eight\(^5\) single interviews with doulas and young mothers who were clients of a community-based doula program (for complete interview guides see Appendixes A & B). I selected qualitative, rather than quantitative, research methods because I was most interested in hearing from participants about their experiences with, and views on, doula care. Much of the research that has been conducted on doula care to date has focused on the obstetrical outcomes associated with doula care (e.g., Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991; Meyer et al., 2001; Scott, Klaus, & Klaus, 1999). Many of these previous studies have been in the form of randomized controlled trials and have provided valuable epidemiological statistics on the benefits of doula care; yet there are few existing qualitative research studies on doula care (i.e., Breedlove, 2005, Campero et al., 1998; Koumouitzes-Douvia & Carr, 2006; Low, Moffat, & Brennan, 2006) A multifaceted understanding of an issue or intervention often requires both “numbers and... stories” and qualitative methods can investigate an issue in depth (Patton, 2002, p.14). According to Campero et al. (1998), qualitative research is an “indispensable complement” to quantitative epidemiological research in the area of public health because it allows the exploration of the subjective dimension of the processes under study and a deeper understanding of them. This knowledge provides an insight into the processes underlying the intervention’s effects, and into the barriers and facilitating factors that should be considered for its adoption on a routine basis (p.401).

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\(^5\) The number of interviews was largely determined by the time and resources available to me in undertaking a Masters of Social Work thesis.
The qualitative method of inquiry used in this study, the interview, provided a means of yielding direct quotations on women's experiences, opinions, feelings, and knowledge of doula care (Berg, 2001; Patton, 2002).

I selected the semi-structured interview, in particular, because it suited the exploratory nature of the study. Berg (2001) explains that in semi-structured (semistandardized) interviews the interviewer poses preformed questions yet also spontaneously poses questions in response to the answers provided by the interviewee. Through semi-structured interviewing, "researchers [can] gain insight into the individual and collective visions, imaginings, hopes, expectations, critiques of the present, and projections of the future on which the possibility of [social change] rests" (Blee & Taylor, 2002, p.95). I also see the selection of the semi-structured interview as the method of inquiry as reflecting a feminist and anti-oppressive approach to research because it can provide room for participants to "embody [their] voices, minimizing... the voice of the researcher" (Blee & Taylor, 2002, p.96). While the use of an interview guide does reflect a researcher's interests and explicitly solicits participant comments on particular questions and issues, the semi-structured use of a guide can provide some space for participants to raise issues of importance to them that may have been overlooked by the researcher.

Recruitment and selection procedures. Birth Companion Program clientele were considered eligible if they were 24 or younger at the time of their baby's birth and if they were 16 or older at the time of the interview. The upper age limit of 24 was selected because it reflects the definition of young mother used in this study; 16 was selected as
the lower age limit in order to adhere to guidelines of the Carleton University Research Ethics Committee regarding interviewing not requiring parental consent.

A first attempt to recruit participants was made through the Birth Companion Program's volunteer list-serve. Two emails were distributed to program volunteers\(^6\) in December 2007 (see Appendixes C & D for Recruitment Emails). Volunteers were asked to share the email for young mothers with any matches (current or past) that were eligible for the study. The Birth Companion Program has contact information for past and current clients but does not have a coordinated email list that can be used to access clients. I was not able to generate an email list for clients or to place calls to clients due to the program's confidentiality policies. As a result, I was dependent on doula volunteers to inform eligible matches about the study; this could have biased the sample as volunteers may have been more likely to inform matches with whom they had a positive and ongoing (post-partum) relationship.

Through email recruitment, I received four responses from eligible doula participants and one response from an ineligible client of the Birth Companion Program. I first interviewed the four doula participants that came forward. The first young mother participant that I interviewed contacted me after one of the doula interviewees encouraged her, as a past match of hers, to also participate in the study. In January 2008, I solicited the help of a community worker at St. Mary's Outreach Centre to inform potential participants about the study, as there is significant overlap in the clientele served by St. Mary's Outreach Centre and the Birth Companion Program. Two additional participants came forward as a result. The last young mother that came forward for an

\(^6\) The program has approximately 50 active volunteers.
interview found out about the study from one of the coordinators of the Birth Companion Program during a routine follow up call.

Of the young mothers who participated in the study, one invited her partner to the interview and they both responded to several of the interview questions. I recognize this as a methodological limitation because the participant’s partner did not meet the eligibility requirements for the study and he was the only non-participant who contributed to an interview. I welcomed him to contribute during the interview largely because the participant that I was interviewing wanted her partner to participate. He was there, in part, to take primary responsibility for their child so that she could more easily focus on the interview. This interview took place at St. Mary’s Home (a residence for pregnant and parenting adolescents). The participant had booked a single visitor’s room for the interview and to be able to care for the baby her partner had to at least be in the room during the interview. I have not counted him among the number of participants but have chosen to include several of his quotations in the discussion because they enriched the analysis on a number of key themes and, in my view, warranted inclusion.

Data collection. Ethics approval for this project was received on September 28th, 2007 from the Carleton University Research Ethics Committee. Prior to conducting interviews, the semi-structured interview guides that I had developed (one for young mothers and one for doulas) were reviewed by the coordinators of the Birth Companion Program and I incorporated most of the feedback that was provided. Data collection began in December 2007 and was completed in March 2008. The interviews varied in length from 45-70 minutes. Interviews took place at locations that were mutually

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7 There was one suggestion made that I was not able to incorporate because it was beyond the scope of the study.
acceptable to the participant and the researcher. Office space at Carleton University and at Canadian Mothercraft were presented amongst possible options. Six of the eight interviewees selected their own homes; as was noted, one of these participants was residing at St. Mary's Home when she was interviewed and in her case she booked a visitor room for our interview. One participant was interviewed at the researcher's home and another was interviewed in a private room at St. Mary's Outreach Centre, a community centre in Ottawa for pregnant and parenting adolescents. None of the participants were reimbursed for their participation. The information sheet was reviewed and both written and verbal consent was secured from each participant before beginning the interview. Each participant was also asked for her permission to record the interview as I wanted to ensure a thorough and accurate recording and transcription of the interviews. All of the participants agreed to recording.

The transcripts from the interviews have provided the data for the study's analysis. All of the interviews were transcribed verbatim by a transcriber who signed a standard confidentiality agreement. None of the participants' names were included in the transcriptions and any identifying information was removed in order to preserve the anonymity of the participants.

Data analysis. In qualitative analysis the data is interpreted with the purpose of discovering concepts and relationships in raw data and then organized into a theoretical explanatory scheme (Strauss & Corbin, 1998). I undertook analysis of the data with the intention of using grounded theory. Through the analysis and writing phases (and through critical reflection) I came to realize that I adopted a slightly different, more deductive approach, but still used an analysis strategy consistent with a grounded theory approach.
(Strauss & Corbin, 1998). The grounded theory method draws on both critical and creative thinking and is a form of qualitative analysis where theory is allowed to emerge from the data. Given that grounded theories come from the data, they are likely to “offer insight, enhance understanding, and provide a meaningful guide to action” (Strauss & Corbin, 1998, p.12).

I began analyzing the interviews by doing line-by-line open coding of the transcripts. As Berg (2001) recommends, I tried to remain open to “multiple or unanticipated results” (p.251). I then listed the categories which occurred in any frequency on a single sheet of paper, and used axial coding to conceptualize how the categories related to one another (Strauss & Corbin, 1998). I assigned these categories into broader and more inclusive categories which enabled me to identify key themes. I pulled coded statements (participant quotes) from the transcripts, organizing each statement or excerpt under each of the key themes (and then into sub-themes which emerged). I prepared a very rough “theoretical statement to explain the relationship between concepts” (Strauss & Corbin, 1998) and organized my data chapters according to this theoretical statement. The analysis carried on well into the writing process as I attempted to strengthen the theoretical statement about how the “axial categories” (Strauss & Corbin, 1998) or key themes were related to one another.

The process of analysis felt both circular and reflexive. Some themes surfaced during the interviews, others were somewhat surprising for me to see emerge during analysis, while still others required re-conceptualizing during the writing stage. For example, I found that my own experiences with witnessing what I have perceived as discrimination toward young mothers in the maternal healthcare system influenced how I
initially conceptualized this theme when it emerged from the data. What I had originally labeled “unfair treatment” came to be re-labeled as “felt discrimination”, given that the data did not warrant such pointed denouncing of the healthcare system. I hope that my process of analysis has done my participants’ contributions justice. In the data chapters that follow I have aimed to not speak “for [the] participants” but to rather enable “them to speak in voices that are clearly understood and representative” (Strauss & Corbin, 1998).

_Credibility and trustworthiness._ Credibility depends on methods that yield high quality data that is systematically analyzed, the credibility of the researcher, and the researcher’s philosophical belief in the value of qualitative inquiry (Patton, 2002). Trustworthiness can be understood as being “balanced, fair, and conscientious in taking account of multiple perspectives, multiple interests, and multiple realities” (Patton, 2002, p.575). The study’s credibility and trustworthiness have been enhanced in several key ways. First, I established an “audit trail” that can be used to verify the rigor of the data collection and analysis (Patton, 2002). An audit trail can be understood as a way of tracking statements that have been made by participants after they have been coded. Each statement is identified using shorthand (e.g., D1 for Doula 1) so that an external person would be better able to follow the logic of the researcher’s analysis. Secondly, in the analysis chapters that follow I have used what Patton (2002) refers to as “thick description” (quotations to elaborate upon and illustrate key themes) with the goal of incorporating sufficient description to provide an understanding of my analysis. Lastly, to better ensure the accuracy of my analysis, I solicited input from study participants at two points: 1) once I completed a content analysis of the data and identified key themes; and, 2) prior to finalizing a summary of the study’s findings. An update on the study and a
summary of key themes was sent to participants via email in September 2008. Two participants acknowledged receipt but none provided feedback in their reply. A summary for general distribution (e.g., national doula care organizations, women’s health organizations) will be prepared in March/April 2009 and participant input will be sought and incorporated at that time. In an effort to increase the likelihood of participant feedback I will contact participants by phone in addition to email. Upon completion, participants will also be supplied with a copy of said summary. I have been available to discuss the study with participants throughout their involvement and will continue to be available upon dissemination of the findings.

Limitations of methodology. Given the small participant sample size, I recognize that the findings of this study only reflect the experiences of the study’s participants and cannot be generalized to all doulas and/or clients of community-based doula programs. Furthermore, because all of the participants were associated with the Birth Companion Program they represent a particular sub-set of doulas and doula care clientele.

For instance, it is possible that the young mothers who participated in my interviews were more stably housed and better networked and supported than some of their peers (i.e., other young mothers who were clients of the Birth Companion Program). I suspect that young women who were eligible to participate in the study but were homeless, struggling with addictions, and/or had lost custody of their child(ren) would have been less likely to contact me for an interview. Therefore, the results of this study may underestimate the support needs of Birth Companion Program clients generally.

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8 All of the doulas are a subset in the sense that they are all from the Ottawa area, have an interest in providing volunteer doula services, and have met the volunteer application requirements of the Birth Companion Program. Similarly, all of the doula clientele are from Ottawa, have met the eligibility requirements of the Birth Companion Program, and have demonstrated a willingness to participate in the program and in the study.
Furthermore, my recruitment e-poster was only available in English which would have made it inaccessible to non-English speakers and a possible deterrent to those who spoke English as a second language. And as was discussed, the involvement of a participant's partner can be considered a methodological limitation because he did not meet the eligibility guidelines and no other participant partners were involved in the study.

The potential impact of my own views, assumptions, and experiences can also be considered a limitation. For one, my involvement with the program may have encouraged participants to share their positive experiences with the program and to withhold negative feedback. I anticipated this potential problem and incorporated several interview questions that explicitly solicited negative feedback. I consider these questions to have been more or less effective as several participants did share negative feedback (e.g., one young mother said that her Birth Companion had forgotten to light incense during her labour and that this had been important to her; another expressed disappointment in the number of postpartum visits from her Birth Companion).

Similarly, participants may have felt pressured to express support for the potential regulation and public funding of doula care. As was discussed, the interviews were initially designed to not only capture a sense of participants' personal experiences with doula care, but to also capture a sense of their political views and motivations regarding regulation and public funding. Many of the interview participants were not very familiar with what regulation and public funding means or with what it would entail. I found myself explaining some of the political processes and concepts behind the questions that I

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9 My only language is English and additional language resources (i.e., translation, interpretation) were not available to me in undertaking a Masters of Social Work thesis.
was asking. In doing so, my bias in favour of mobilizing for the regulation and public funding of doula care was often evident. I tried to manage the influence of my bias during interviews by stating to participants that I recognize that there are both pros and cons to the potential regulation and public funding of doula care, and that I wanted to hear all thoughts that they had on the subject, including any fears or concerns. I would suggest that this strategy was more or less effective because the data contains a range of participant views and, as was also noted earlier, does not indicate explicit support for mobilizing for the regulation and public funding of doula care.

During the process of data collection I also kept an interview journal as a tool for critical reflection. In my journal writing I reflected on my own reactions to the themes that were surfacing at that stage and reflected on the delivery of particular questions. For example, I felt disappointed that participants did not seem enthusiastic about mobilizing around the regulation and public funding of doula care and I began to acknowledge how my expectation that they would be had shaped several interview questions. Similarly, during the analysis phase, I tried to remain open to themes emerging in ways that I did not expect. For example, as key themes became clearer I would re-examine the data to look for exceptions and for quotations that ran counter to an emerging theme. I think that efforts to manage my biases were effective, in so far as is possible.

Key Terms

Young mothers. For the purposes of this discussion young mothers will refer to those ages 24 and under, simply because this is the definition used by the Birth Companion Program. Also for convenience, I will use young mothers to refer to women
in this age range who are pregnant and/or parenting. I use this term with awareness that there is a wide range of ways in which young women experience young motherhood. I agree with Reiger (2000) who, referring to “mothers” as a collective, suggests that it is possible “to avoid simplistic assumptions about shared identities, yet still conceptualize mothers as forming a group or collectivity” for “pragmatic political reasons” (p.319).

At risk. I was reluctant to use the term “at risk” for several interconnected reasons. I will first speak to these reasons and the ways I negotiated them before then defining my intended use of the term. I would suggest that the use of the term implies that I myself am not “at risk” which means that I am exercising power by identifying a collective of women of which I do not consider myself a part. In line with postmodern thinking on the construction of language, I would suggest that the act of labeling a collective of “women who are at risk” implies a division between “us” and “them” and also between “proper” and “unproper” (McLaughlin, 2003). Broadly speaking, language can be seen as constructed within particular social, economic and political contexts that imbue meaning into a term in ways that reflect and reify existing power arrangements. In this particular case, I would suggest that the term “at risk” has been imbued with an “improper” meaning that works to pathologize these women’s struggles and can serve to label the individual as “at risk” rather than pointing to the systemic inequalities that contribute significantly to putting particular women at risk. This discourse, by pathologizing the individual, creates an opportunity to position social workers as the “fix”. Margolin (1997) interrogates power dynamics in helping relationships and in the discourse of social work; he argues that feelings of virtue have often been used to justify a power laden approach where
If the client is apathetic, social work must inspire. If the client is disorganized, social work must provide order. If the client is nonverbal, social work must demonstrate how to speak and what to say. And if clients are passive and will not come to social work, social work must be aggressive and go to them (p.98).

The danger here then, of using the terminology “at risk”, is in implying that social work and community-based doula care must “fix” women who are at risk, are able to do so, and can feel virtuous about the impact of their work.

I do not see women who are at risk as in need of “fixing” and instead aim to draw critical attention to the oppressive dynamics and structural inequalities that operate to put particular women at risk. I have chosen to use this term (women who are at risk) while holding both the problematics and possibilities of its use in mind. While I recognize that my use of this term is by no means wholly “good”, I think that it is possible to take up this term and use it for strategic reasons and in political ways. In an effort to shift attention to multiple and systemic inequalities, feminists have often taken up language as a site of struggle where meanings themselves must change in order for social change to occur (Weedon, 1987).

For the purposes of this discussion, women who are at risk will be defined as women who are socially, financially and/or culturally isolated (e.g., young mothers, new Canadians, incarcerated women, women with addictions). This definition (women who are socially, financially, and/or culturally isolated) is used because it is the same that is used by the Birth Companion Program, and on which their client eligibility is determined. Social isolation, meaning a lack of family, friends or community that one can rely on, or a lack of stable housing, can limit women’s access to social support during pregnancy, childbirth, and the postpartum period. Financial isolation in this context means low income, living in poverty, or living without access to money for one’s own use (e.g.,
some middle-class or upper-class women in abusive relationships do not have access to household income); financial isolation can prevent women from accessing fee-for-service doula support. Cultural isolation, as may be experienced by refugees or new immigrant women, can also limit a woman’s access to social support during childbirth. The Birth Companion Program often provides support to pregnant women who have arrived in Canada alone.

**Woman-centered.** In woman-centered approaches to childbirth the emphasis is on fostering women’s sense of choice and control during childbirth; midwives, as woman-centered care providers, work in direct response to the needs of their clients, and care is meant to serve the emotional and physical needs of the birthing woman (Bourgeault, 2006). Informed choice and access to childbirth options are considered key components of woman-centered care (Bourgeault, 2006). The ethics of woman-centered care create possibilities for responding to the particularities of women's needs, as defined and articulated by women. Ford and Van Wagner (2004) suggest that taking an equity focus in woman-centered care can push its advocates to be cautious about “making assumptions about who that woman is and what she needs” (p.261). I would suggest that both midwives and doulas share a woman-centered approach to birth and aim to provide care that is respectful and responsive to the unique needs of the women they serve.

As was discussed earlier, woman-centered care has roots in the natural childbirth movement and has largely been developed and articulated as an alternative to the medical model. At the same time, I see woman-centered approaches and/or elements of woman-centered care as being taken up by a range of health professionals including, but not limited to, midwives and doulas. It is not the case that all midwives and doulas provide
strictly woman-centered care or that all obstetricians provide strictly medical-model care. Furthermore, while woman-centered care providers may reflect a particular philosophy of birth and a particular approach to birth it does not mean that the care they provide is wholly respectful or wholly responsive to the unique needs of each birthing woman they serve.

The College of Midwives of Ontario (CMO) (1994) has articulated their philosophy of midwifery care in a way that reflects the definition of woman-centered care that is used in this work. The CMO statement includes respect for the diversity of "personal and cultural meanings which women, families and communities bring to the pregnancy, birth, and early parenting experience". Care is articulated as "continuous, personalized and non-authoritarian" and "the mother is recognized as the primary decision maker". The CMO statement also describes midwives as focusing their care on the mother to "obtain the best outcomes for the woman and her newborn" because the interests of the woman and her fetus are viewed as compatible. Supporting a woman’s sense of power and dignity is also articulated as important.

*Relationship-based.* In this work I describe doula care as relationship-based. I use this term to mean that the relationship between a doula and the birthing woman that she is assisting is foundational to the way that she provides care. In my use of the term I mean to imply that these relationships provide a positive foundation (rather than a negative foundation). Abramson, Breedlove, and Issacs (2006) do not define this term but do use it to describe the nature of community-based doula care. I use this term primarily in reference to community-based doula care, as I would consider it to be more relationship-based than private fee-for-service doula care given the length and extent of involvement.
In discussing the ways in which I see doula care as relationship-based I will draw heavily from Bergum and Dossetor’s (2005) work on relational ethics; these authors explore relationships in the healthcare setting between patients and healthcare professionals, between family and clergy, between nurses and doctors, and conceptualize the space in these relationships as a third entity, as an ethical space (or relational space). These authors move beyond “rights” language to suggest that relational ethics are made possible by focusing on the spaces between people (and at the macro level, between the healthcare system and government, for example); that the spaces between are where ethical discussion and thought can be nurtured. Bergum and Dossetor (2005) describe relational space as being held together by respect for difference and suggest that engagement between persons is ethically necessary. Relationships can be about “big decisions” but they can also be about a series of moments and the qualities found therein; namely, how a healthcare professional speaks with a patient and how they use the power they hold in those moments (Bergum & Dossetor, 2005). In this work I will examine participants’ experiences of these moments between young mothers and their doulas and will explore the importance of doula care as relationship-based labour support.

Social support. The term social support is often used broadly to refer to any process by which social relationships can promote health and well being (Cohen, Gottlieb & Underwood, 2000) and this definition reflects my intended use of the term in this work. I do not consider social relationships to be synonymous with social support as one’s family and friends are not always a part of their support system (Oakley, 1992). Rather, social support can be understood as the resources and relationships that individuals perceive to be available to them as these social resources have been found to
act as a stress buffer and confidence builder (Cohen, Gottlieb & Underwood, 2000; Gottlieb, 1988). In addition, social support has often been defined as broken down into emotional (e.g., reassurance), informational (e.g., providing information), and instrumental (e.g., taking care of someone) components (Oakley, 1992) which reflects the emotional, informational, and physical support components that are combined in the doula’s role.

Hartling (2008) comments on and critiques the way that social support is often defined in the literature as a one-way form of relating; namely, something that one gives and another receives. She explains that an emphasis on connection in relationships creates greater possibilities for recognizing the two-way nature of social support. In Harling’s (2008) view, which I share, it is the quality of the connection that makes social support beneficial and not the provision of social support per se. I also agree with authors (e.g., Lundy, 2004; Margolin, 1997) who caution that conceiving of empowerment as something that can be given from one person to another is neither accurate nor ethical as it can exacerbate power dynamics in a helping relationship and deny the agency of the individual receiving support. In anti-oppressive social work practice empowerment is viewed as a means of transforming unequal power relationships between groups and is the “process and outcomes that occur for people when they begin to access various types of power, both internal (such as personal strengths) and external (such as social networks) that they can then use to improve their lives” (Barnoff & Coleman, 2007, p.37).

For these reasons, I conceptualize the social support that doulas provide as creating relational space because I think it more accurately describes and acknowledges the ways in which young mothers are active in accessing their own internal power. In my
view, it is not the case that doulas provide social support that empowers birthing women and gives them control (not that A causes B), but rather that a birthing woman's relationship with her doula can create a relational space where she can experience a greater sense of empowerment and control (that A can create a space where B is more possible).

**Stigma.** Link and Phelan (2001) define stigma in a way that reflects the use of the term in this work. These authors explain that stigma is the co-occurrence of the following components: labeling, stereotyping, separation, status loss, and discrimination.

In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them.” In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination (Link & Phelan, 2001, p.367).

Two of these components of stigma identified by Link and Phelan (2001) warrant further definition given their particular relevance to this work: stereotyping and discrimination. Stereotypes can be further understood as oversimplified conceptions of a particular social group; according to Mullaly (2002), all social groups incur stereotypes but they are often used in a damaging way against subordinate groups (e.g., young mothers are irresponsible). Discrimination can be understood as encompassing day-to-day experiences of being seen as “less than” (Strega, 2007); and, as linked to the exclusion of certain social groups from meaningful social participation and the denial of recognition of their contributions to society (Mullaly, 2002). Conceptualized in this way, stigma can be
understood as enacting sexism, racism and/or classism by reifying the social control of a subordinate group by a dominant group.

In this chapter, I began to situate this study among related research on doula care and have described the theoretical frameworks which have informed this work. I also explained the need to reconsider the study’s social movement research questions in light of participants’ emphasis on increasing the accessibility of doula care rather than mobilizing for the regulation and public funding of doula care per se. I have described the study’s methodology and acknowledged its limitations, began to account for the influence of my own views and biases on the research, and, lastly, have outlined key terms that are used in this work.

In the following chapter, Chapter Two, I will review the literature on doula care and other topics relevant to this discussion. I will describe how doulas can make a valuable contribution to a childbirth team comprised of personal supports and health professionals. I will identify structural barriers to accessing adequate maternal healthcare, will provide an overview of existing services for young mothers, and will draw on literature to suggest that doula care may help to address current inequities. I will then turn to assessing the potential for change. I will first provide an historical overview of the medicalization of childbirth and will then outline midwives’ efforts to increase the availability and accessibility of midwifery in Ontario.

In Chapter Three I will briefly describe the study’s participants and will then draw from participant interviews to discuss young mothers’ experiences with maternal healthcare. I will posit that doulas can enrich maternal healthcare for young mothers by
providing support and helping to facilitate their voices being heard in a maternal healthcare context where some young mothers may feel they are judged and lacking support.

In Chapter Four I will explore the perspectives of the doulas and the young women who participated in the study on the particular benefits of doula care for young mothers. I will point to the centrality of trust and connectedness in a doula’s relationship with a birthing woman. I will argue that young mothers and their doulas can create woman-centered relational spaces within the maternal healthcare setting where it may be more possible for a young mother to access strong social support and experience a greater sense of control over her birth experience.

In Chapter Five I will bring forth participant views on increasing the availability and accessibility of doula care. While in favour of increasing women’s accessibility to doula care, participants were apprehensive about aspects of regulating and publicly funding doula care which might compromise the importance of the relationships between young mothers and their doulas. I will explore participants’ suggestions on how to advance doula care while offering it some protection. I will also discuss participants’ views on professionalization and lastly, the potential for change, pointing to the need for further public education as a possible first step in increasing the accessibility and availability of doula care.

In the final chapter I will offer summative conclusions and will discuss the implications of the study’s findings for social work. I will discuss the limitations of the study and will point to areas that warrant future research. I will also describe how participants’ views emerged in ways that I did not expect, which have challenged me to
explore the tension between their apprehensions and their desire to make doula care more available and accessible. I will close by offering my own recommendations on proceeding with organizing on this issue.
Chapter Two: Literature Review

I will begin this chapter by defining doula care and will then present evidence on its effectiveness. I will discuss the ways that doulas can make a valuable contribution to the childbirth team and will outline doulas’ current status as fee-for-service paraprofessionals. I will then explore the literature on structural barriers to adequate maternal healthcare that are faced by many women who are at risk, and will discuss how doula care can enrich maternal healthcare for these women. I will situate doula care both within existing services for young mothers and within historical changes to maternity care services. I will close this chapter by assessing the potential for change. Based on a review of the literature, I would argue that increasing the availability and accessibility of doula care has the capacity to enrich maternal healthcare, particularly for women who are at risk.

Defining Doula Care

A birth doula is a woman experienced in childbirth who provides informational, emotional and physical support to women during pregnancy, labour, and birth. Doulas provide information to women on topics such as maintaining a healthy pregnancy, the process of labour and birth, and coping with labour pain. The emotional support they provide is as a continuous presence during labour and birth, supplying consistent reassurance and encouragement. Doulas offer physical support by providing comfort

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10 Many different definitions of the term *doula* can be found in the literature. The definition I have used here was selected because it is common, and captures the key elements of a doula’s role. Sauls (2006) points to the need for a consistent definition of the term *doula* in order to improve researcher communication, and data comparison and analysis. Therefore, if a researcher’s definition differs significantly from my own I will make note of the difference and any potential implications.
measures such as massage and positioning. Caregiver support of the birthing woman's partner, family, and/or friends is also an important component of birth doula care.

Doulas who assist during labour are commonly referred to as *birth doulas* and those who provide support during the postpartum period are called *postpartum doulas*; some doulas act as both birth doulas and postpartum doulas yet most specialize in one or the other. In this study I have chosen to focus on the role of the birth doula. I have done so because the Birth Companion Program trains its volunteers as birth doulas, and the services they provide as birth doulas are filling a distinct gap in social supports available in the Ottawa area to pregnant women who are deemed to be at risk. There are a range of social support services that young mothers can access while pregnant and as young parents, yet in most Canadian communities there are no social services that young mothers can access for support during childbirth; the Birth Companion Program is quite unique in this respect.

*Evidence on the Effectiveness of Doula Care*

Continuous labour support significantly decreases length of labour, and rates of intervention and operative birth. The continuous presence of a doula during labour results in fewer cesarean and forceps deliveries, less use of pain medications and shorter labours (Martin, Landry, Stellman, Kennell, & McGrath, 1998). These low-intervention obstetric outcomes are considered by many to be positive because they indicate reduced healthcare costs and a decreased risk of serious complications for both the mother and the baby (Klaus, Kennel and Klaus, 2002). Simkin and Ancheta (2005) also suggest that the above outcomes are related to one another, citing two literature reviews (Leighton, 2002;
Lieberman & O'Donoghue, 2002) that concluded that “epidural use, compared to no epidural use, is associated with longer labours, fewer spontaneous vaginal births, [and] more instrumental deliveries” (p.125).

Klaus et al. (2002) discuss the results of sixteen published, randomized controlled studies on labour support, which considered the experiences of over 5,000 women. The studies, which took place in Belgium, Botswana, Canada, Finland, France, Greece, Guatemala, South Africa, and the U.S., examined whether doula care altered length of labour, the use of pain medication, epidurals, and other obstetric interventions, as well as what effects doula care had on the well-being of the baby and later maternal behaviour. Examining these randomized controlled studies collectively, Klaus et al. (2002) concluded that continuous labour support from a doula reduced the odds of receiving pain medications by 31%, decreased the use of oxytocin\(^\text{11}\) by 50%, forceps deliveries by 34%, and cesarean sections by 45% (p.76).

The effectiveness of doula care was most recently evidenced in a review of studies by Hodnett et al. (2003) on support for women during childbirth. The review assessed the effects, on both mothers and babies, of continuous one-to-one intrapartum support as compared with usual care. Hodnett et al. (2003) explain that women in labour have historically been attended and supported by other women experienced in childbirth; however, in recent decades, continuous support\(^\text{12}\) has become the exception rather than a component of usual care. Their review examined all existing randomized controlled

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\(^{11}\) Oxytocin is a hormone that acts on the uterus stimulating it to contract. Synthetic oxytocin is often given to women to augment a slowly progressing labour; its most common trade name is Pitocin. Many proponents of natural birth think that Pitocin is over-administered and can sometimes increase the chances of experiencing labour dystocia (prolonged labour) and a cesarean section (Simkin & Ancheta, 2005).

\(^{12}\) Continuous support (in contrast to intermittent support) can be understood as attention to a birthing woman that begins early in labour and continues to delivery, with the doula leaving only for toileting.
trials, both published and unpublished, and involved a total of 12,791 women who had participated in 15 trials. Hodnett et al. (2003) concluded that “women who received continuous support during labour and childbirth were less likely to have intrapartum analgesia\(^\text{13}\), operative birth, or to report dissatisfaction with their childbirth experiences” (p.2). In addition, continuous intrapartum support was associated with greater benefits when the provider was not a member of hospital staff, when it began early in labour, and in settings where epidural analgesia was not readily available.

Another review by Zhang, Bernasko, Leybovich, Fahs, and Hatch (1996), looked specifically at those studies that had been conducted among young, low-income, primiparous\(^\text{14}\) women and found that in this population, labour support increased the likelihood of vaginal birth (by 50%), and decreased the use of analgesia, forceps and cesarean births (by 50%). In addition, these authors found that doula-supported mothers in this population group experienced greater satisfaction with childbirth, increased mother-infant attachment, and higher rates of breastfeeding. Zhang et al.’s (1996) review indicates that findings on the effectiveness of doula care are consistent when a subset of studies with young, low-income, primiparous women is examined; the review is worth highlighting because, of those reviews that have been conducted to date, Zhang et al.’s (1996) may be the most relevant to the present work.

Doula care not only significantly improves obstetric outcomes but also affects maternal satisfaction with childbirth, which can lead to positive postpartum effects as well. A comparative trial by Campero et al. (1998) showed that women accompanied by a

\(^{13}\) Intrapartum analgesics are pain medications used to alleviate or reduce pain during labour (e.g., narcotic drugs such as morphine or epidural analgesia).

\(^{14}\) Primiparous women are those who are giving birth for the first time and primigravida women are those who are pregnant for the first time.
doula reported more positive childbirth experiences. Differences included their perceptions of childbirth, how well they understood the information they were given, and the treatment they received from hospital staff. Perhaps most importantly, they expressed a greater sense of control and greater self-esteem (Campero et al., 1998). Simkin's (2001) research demonstrates that this sense of control and self-esteem is often long lasting for women; Simkin compared women's immediate written descriptions of their first childbirths with their descriptions many years later, and found that the memories (both positive and negative) were accurate, vivid, and still laden with emotions, including pride in themselves and enhanced self-esteem. In addition, research on the effects of birth doula care on parenting and attachment in the postpartum period has demonstrated that doula care decreases rates of postpartum depression, while increasing rates of breastfeeding and maternal attachment (Rosen, 2004).

One of the postpartum benefits of doula care that is of particular relevance to work with young mothers is breastfeeding. A 1999 Health Canada review of breastfeeding found that young, less educated, and lower income women were much less likely to breastfeed (Health Canada, 1999, as cited in Horsley & Sippert15, 2006). The percentage of children under two years old ever breastfed ranges from an average of 77% by mothers age 30 or older to a comparatively lower average of 66% by mothers age 24 or younger16 (Health Canada, 2000). While societal views on breastfeeding have shifted over time to reflect market influences and particular social and economic contexts, breastfeeding is currently considered the best method of infant feeding. Breastfeeding

15 G. Sippert, a Birth Companion Program Coordinator, is now named G. Szollos and will be referred to by either name depending on the date of publication or personal communication.
16 These statistics exclude the territories and reflect information gathered through the National Longitudinal Survey of Children and Youth and the National Population Health Survey in 1994-95.
provides nutritional, emotional and immunological benefits, including but not limited to: protection against infant gastrointestinal infections, decreased infant allergies, reduced risk of SIDS (Sudden Infant Death Syndrome), reduced rates of certain cancers, maternal weight loss, enhanced infant cognitive development, and general health and well being (Health Canada, 1998; Health Canada, 2004). In accordance with World Health Organization recommendations, Health Canada advises exclusive breastfeeding for the first six months of life and continued breastfeeding for up to two years and beyond. Doula support can make a significant impact on women’s choices to initiate and continue breastfeeding. With doula support, according to the Birth Companion Program Coordinators, 90% of Birth Companion clients initiate and 53% establish prolonged exclusive breastfeeding (Horsley & Sippert, 2006). This success rate greatly exceeds the national breastfeeding average for young mothers.

Maternal attachment is another postpartum benefit of doula care that may be particularly relevant to work with young mothers. Martin et al. (1998) conducted a randomized controlled trial to assess the impact of doula care on infant development by studying primigravida mothers with uncomplicated vaginal deliveries (1/3 of whom had been randomly assigned to receive doula care). Infant development was assessed at two months postpartum and women who had been provided with doula support during their labours were found to have a significantly more positive level of interaction with their infants. Orenstein (1998) also examined doula support as an intervention that might promote secure caregiving. The Orenstein (1998) study assessed self-esteem in the third trimester of pregnancy, and again four months after the mothers gave birth. Mothers assisted by doulas showed greater security and higher self-esteem than did women in the
comparison group (who had used Lamaze birth preparation\(^{17}\)); mothers in the doula group also rated their infants as significantly less fussy than the mothers in the Lamaze group.

Research clearly indicates that doula care has a significant positive impact on birth outcomes, breastfeeding and maternal attachment. The reasons as to why are less clear and have not yet been studied extensively. Doula care is often credited with disrupting the cycle of “fear-tension-pain” that was observed by Dr. Grantley Dick-Read, an early proponent of childbirth education and labour support:

The theory states that pain and anxiety during labour lead to an endogenous release of catecholamines, which lower uterine contractility and decrease placental blood flow. Less anxiety means decreased catecholamines, improved uterine contractility and efficiency, and a reduced risk of prolonged labour or fetal distress. Women with continuous labour support feel empowered and in control and, therefore, experience less anxiety than their non-supported counterparts (Rosen, 2004, p.24).

Most of the randomized controlled trials on the effectiveness of doula care in relation to obstetric outcomes have been conducted over the last two decades. As was noted in Chapter One, interest in doula care is growing in response to increasing evidence on its effectiveness (Lantz et al., 2005).

**Doula Care as Enriching the Childbirth Team**

Doula care can make a valuable contribution to labour support in addition to care provided by personal supports or others on the childbirth team: nurses, midwives and/or obstetricians. Bowers’ (2002) review of studies on women’s perceptions of professional labour support suggests that one’s capacity to form trust with a woman in labour is not

\(^{17}\) The Lamaze Technique was developed in the 1940s by French obstetrician Dr. Fernand Lamaze as an alternative to the use of medical intervention during labor. Lamaze childbirth classes once focused on breathing techniques, but have expanded over time to also include other ways to manage pain (such as hot and cold packs, changing positions etc.).
dependent on one’s position on the team (whether s/he is an obstetrician, nurse, midwife or doula) but rather, her/his interpersonal communication style and approach to and interaction with a woman in labour. Bowers’ (2002) review focused on women’s perceptions of nurses, midwives, and doulas; a central finding was that professional labour support was significantly influenced by the interpersonal communication style of the caregiver. The personal characteristics of the nurse, nurse-midwife, or doula influenced the mother’s perceptions of the emotional support and caring that were provided. One mother reported that “what you do doesn’t matter as much as how you do it” (Bowers, 2002, p.517). I would suggest that a doula can enrich the childbirth support team, particularly in a busy hospital environment, by providing an opportunity for continuous relationship-based support.

Several aspects of doula care make it unique and enable doulas to enrich the childbirth support team. First, care from personal support persons such as a partner, family member, or friend is not a substitute for doula care. According to research conducted by Scott, Klaus and Klaus (1999), care from a family member has shown to reduce the use of some pain medications, but no studies have reported associations between family support and decreases in cesarean sections, length of labour, or the use of forceps, epidural anesthesia, or oxytocin. Women were found to have lower rates of intervention when supported by a doula and a family member, in comparison to controls who were supported by their family member alone (Scott, Klaus, & Klaus, 1999). In a similar study conducted by Kennel, Klaus, McGrath et al. (1991), mothers supported by both their partners and a doula had a cesarean delivery rate of 14.2%, compared to a rate of 22.5% in the control group of mothers supported by their partner alone.
Scott, Klaus and Klaus (1999) point to prior research on the differences between supportive behaviours of fathers and doulas to explain the corresponding difference in obstetric outcomes. For example, fathers are generally less physically and verbally interactive than doulas and tend to relinquish their place at the mother's side when medical caregivers enter the room. Rosen (2004) explains that birthing women are aware of these differences and cites a 2002 national U.S. survey of women's childbearing experiences where women ranked partners or husbands after doulas, midwives, and other family members in terms of the quality of supportive care (p.29). Childbirth may be overwhelming for someone who is inexperienced in providing labour support; interestingly, there is no other area of medical care where a partner, family member, or friend is given such caretaking responsibilities (Scott, Klaus, & Klaus, 1999).

One of the strengths shared by both doulas and personal support people is that their care can begin early in labour. Labour support from nurses and/or midwives is not generally available until women are in active labour. As stated earlier, the Hodnett et al. review (2003) indicated that continuous intrapartum support was associated with greater benefits when support began early in labour. Establishing supportive routines early in labour can help women to maintain progress and build confidence in their ability to manage labour pain (Simkin & Ancheta, 2005). Rosen (2004) explains that additional support during early labour also enables women to labour longer or more effectively at home, thereby avoiding interventions. Maintaining a continuous presence from early on in labour often taxes the energy of personal support people, and the presence of a doula can help to sustain their energy during long labours. In addition, it is important to note that some women who are at risk are isolated to the extent that they do not have a partner,
family member, or friend available to provide labour support. These women often arrive at the hospital with no labour support.

Another strength of both doulas and personal support people is that they are external to hospital staff. The Hodnett et al. (2003) review indicated that continuous intrapartum support was associated with increased benefits when the support was provided by someone external to hospital staff (p.2). Schroeder and Bell’s (2005) pilot study on doula care with 18 incarcerated women indicates that labour support provided by someone external to hospital staff may be beneficial for this group of women who are at risk. Many incarcerated women receive inadequate healthcare prior to arrest, suffer from addiction problems, have histories of sexual abuse and trauma in childhood, and have experienced male violence (Schroeder and Bell, 2005). In addition, pregnant women in custody are also under a great deal of stress and do not have regular access to their family and community supports (Schroeder & Bell, 2005). The birthing women who participated in Schroeder and Bell’s (2005) study reported unanimous support for doula services and the researchers recommended the implementation of doula care for all pregnant women in custody. Schroeder and Bell (2005) state that the benefits of doula care reported in their study are closely linked to the fact that doulas were able to act as advocates external to both the hospital and the correctional institution. For example, a physician who attended the birth of a study participant stated that “patients need an advocate that is not in uniform... I wish all my patients had a doula” (p.55). Similarly, an inmate participant reported that she “felt like there was somebody on [her] side” and another participant stated that “you need somebody to support you, not just an officer staring at you” (p.56).
Care from a nurse is also not a substitute for doula care. Gilliland (2002) describes the roles of a nurse and of a doula as overlapping somewhat but also differing markedly and she suggests that the two roles are complementary and both critically important. Both nurses and doulas provide labour support; research indicates that labour support provided by nurses is helpful, but not as effective as labour support provided by doulas. A key difference is that doulas are able to provide continuous support whereas nurses are only able to provide intermittent support. Nurses are hindered by a lack of time and staffing models that encourage only intermittent support on the part of nursing staff (Rosen, 2004). Scott, Berkowitz and Klaus (1999) contrasted the influence of intermittent and continuous support provided by doulas during labour and delivery. Continuous support was found to be significantly associated with a reduction in the length of labour, use of analgesia, oxytocin, forceps, and rate of cesarean sections, whereas intermittent support was not significantly associated with any of these outcomes. Nurses also stop providing support at the end of their shift; if delivery has not yet occurred, another nurse takes over the woman’s care. Changing support persons has been shown to be a source of increased anxiety for women in labour as it can be difficult for women to establish communication with someone new once they have begun active labour (Bowers, 2002).

Davies and Hodnett (2002) examined Canadian maternity care nurses’ views about their ability to provide labour support. Labour and delivery nurses that participated in the study reported high self-efficacy and confidence about providing adequate labour support. Despite their perception, when observations were made of the actual care provided, nurses in the study were only found spending between 11.7% and 29.8% of their time providing labour support. Nurses identified inadequate staffing as the main
factor that prevented them from providing labour support effectively. One nurse participant provided the following example: “At 2:00 a.m. it is difficult to increase staffing to meet an unexpected increase in patient demand... lack of nurses is the primary reason for an inability to give one-to-one care” (p.53).

Yet studies that have assessed one-to-one labour support care by nurses have indicated that labour support provided by nurses does not have as significant an effect on obstetrical outcomes as labour support provided by doulas. Gagnon, Waghorn, and Covell (1997) conducted a randomized controlled trial in a Montreal hospital; they found that nurse support was correlated with a 17% reduction in the administration of oxytocin, but had no significant effects on labour duration, rates of cesarean section, use of epidural anesthesia, admission to the neonatal intensive care unit, instrumental vaginal delivery, or perineal trauma. In addition, Hodnett et al. (2002) conducted a randomized controlled trial in Canadian and U.S. hospitals and found that continuous support by a trained nurse did not have any effect on the rate of cesarean delivery. The difference in obstetrical outcomes correlated with labour support provided by nurses and doulas may be because nurses are immersed in a hospital culture that is characterized by policies and norms that encourage intervention (Rosen, 2004, p.28). At the same time, I agree with Miltner (2002) who cautions that dialogue on intrapartum care cannot be reduced to a “high tech versus high touch debate because it negates the complexities of the intrapartum nursing role” (p. 564). The issue of hospital culture and medicalized childbirth warrants further discussion and I will return to this subject later in this chapter.

Lastly, care from a midwife is also not a substitute for doula care. Professional midwives are required to perform two tasks, namely, medical care-giving and the
provision of social support (Scott, Berkowitz, & Klaus, 1999). In the case of fetal
distress, or any medical problem requiring attention, midwives will prioritize their role as
primary medical caregivers for obvious reasons. Yet it is during times of added stress and
uncertainty in childbirth that the calm reassurance of a continuous support person is
arguably most beneficial. According to Scott, Berkowitz and Klaus (1999),

a team approach between medical personnel and lay doulas is likely to benefit
women during childbirth if medical responsibilities interfere with the provision of
social support by healthcare providers; that is, [primary care providers] and nurses
are freed to concentrate on medical tasks that ensure the health of the mother and
infant while a doula is available to provide the emotional and non-medical
physical support essential to successful childbirth (p.1059).

As women’s access to midwifery care is growing, more and more women are
choosing this form of woman-centered care, yet the existing numbers of midwives are not
currently able to meet the demand for midwifery services; only approximately 60% of
women who desire midwifery services are able to access midwifery care (Bourgeault,
Declercq, & Sandall, 2001; Ontario Ministry of Health, 2003). The expansion of
midwifery in some communities is also limited by the politics of hospital privileges18.
Furthermore, women are still becoming aware of what midwifery options entail (e.g.,
many women think that midwives only attend home births). Regardless of the
accessibility to and availability of midwives in a given community, some women will
continue to opt for obstetric care, perhaps because of the way they define and experience
pregnancy and childbirth, what they might be looking for from their care provider, and/or
an interest in obstetrical interventions that would mean a change of care provider if under

18 Post-regulation, hospitals have retained the ability to either grant or withhold midwives hospital
privileges. In Ottawa, for example, The Ottawa Hospital (comprised of General, Civic and Riverside
campuses) does not grant midwives any privileges, which acts as a substantial barrier to the expansion of
midwifery in the Ottawa area. At the time of writing, only the Montfort and Queensway-Carleton Hospitals
were granting midwives privileges. I would suggest that refusing to grant midwives privileges is an
example of the “medical dominance” (Wrede et al., 2001) of the maternal healthcare system.
midwifery care. Young mothers currently tend to fall within this category and the vast majority of Birth Companion Program clients give birth in a hospital and are attended by an obstetrician; currently there are only one or two clients per year (out of approximately 120) who opt for midwifery care\(^{19}\) (J. Dwyer, Birth Companion Program Coordinator, personal communication, September 2008). Women who are birthing at a hospital with an obstetrician are able to have increased access to woman-centered care when they are supported by a doula; in this way, increasing the availability of doula care can serve to increase the options for care that are available to women.

I would suggest that while some aspects of doula care are shared with other members on the childbirth team (e.g., providing verbal encouragement) existing research indicates that obstetric outcomes are unlikely to improve significantly should other members on the team simply provide *more* of the types of support that are provided by a doula. Personal supports, nurses, primary care providers (midwives and obstetricians), and doulas, all hold valuable, yet distinct, roles within the team. As was noted, research on the effectiveness of doula care is growing, but research on *how* and *why* doula care is effective is still, for the most part, lacking; the present study may be able to contribute to existing research by exploring participant views and experiences on this issue. The findings of the present study indicate that the relationship-based nature of doula care with young mothers can explain, in part, *how* and *why* doula care is effective for these women.

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\(^{19}\) Although Birth Companion Program statistics cannot be generalized to all young mothers, this means that 8-1.7% of young mothers who are clients of the Birth Companion Program are opting for midwifery care, in comparison to 6% of women across Ontario (Ontario Ministry of Health, 2003).
Doula Care as a Profession

Doula certification in Canada is available through several certifying bodies. Doulas of North America (DONA)\(^{20}\) is perhaps the most prominent, as it is the oldest (it began in 1992) and largest organization offering doula certification in North America. Similar organizations include the Childbirth and Postpartum Professional Association (CAPPA), the International Childbirth Education Association (ICEA), and the Association of Labour Assistants and Childbirth Educators (ALACE). Certification training and requirements are comparable and usually involve attending an approved training course (which averages 16 hours in length), completing required reading, attending a prenatal class series, writing an open exam and/or completing an essay. Certification also requires attending a minimum of three births which are evaluated by the mother and the primary caregiver\(^{21}\). Most doulas provide their services on a fee-for-service basis. These fees vary greatly across the country; in small rural communities some doulas charge as little as $250 per birth whereas some experienced doulas in Toronto charge upwards of $1,500 per birth. In the Ottawa area, doula fees at the time of writing were in the $400-$600 range. This fee covers an average of two prenatal visits, continuous support throughout labour, and two postpartum visits. Doulas are on call 24 hours a day for their clients, and arrange back up in the case that more than one birth occurs at the same time.

Lantz et al. (2005) conducted a survey with certified doulas across the U.S. to get a sense of their demographics and practice issues. The survey results suggest that doulas

\(^{20}\) DONA website available at www.dona.org.

\(^{21}\) For example, doula skills and qualities that are commonly assessed include the doula’s ability to answer questions and provide good suggestions on comfort measures during labour and birth, and the care and compassion demonstrated by the doula during labour and birth.
are primarily white, well-educated, married women with children. Of the 626 doulas who participated in the survey, the majority worked in solo practice and provided childbirth support services to an average of nine clients per year. Very few of the doulas that were surveyed were earning more than $5,000 per year. Lantz et al. (2005) reported that almost all doulas felt emotionally satisfied with the work yet only a third saw their work as financially rewarding. Doulas also reported challenges in getting support and/or respect from clinicians and in balancing doula work with their personal responsibilities and lives. It is also of interest to note that Lantz et al. (2005) found a quarter of these doulas reporting that they were preparing for a career in midwifery.

In the U.S., a growing number of hospitals and freestanding birth centres have initiated their own doula programs (Meyer et al., 2001). According to Klaus et al. (2002) more than eighty U.S. hospitals have organized in-hospital doula programs. One example, Lexington Medical Centre in West Columbia, South Carolina, has employed doulas since 1994. In Seattle, the Pacific Association of Labour Support has a contract with the Department of Health to provide doula care to Medicaid clients (Meyer et al., 2001). A small number of grant-funded and volunteer doula programs also exist in communities in the U.S. and in Canada. It is one of these existing community-based programs in Canada, the Birth Companion Program in Ottawa, that has served as the focus for this study.

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22 Birth centres generally provide midwifery care in a low-tech, home-like environment. Freestanding birth centres are well established in the U.S. and have their own association: The American Association of Birth Centers (www.birthcenters.org). To date, Canada has a very limited number of birth centres, particularly in urban areas. The only birth centre currently in Ontario is affiliated with the Aboriginal midwifery program and is located in the community of the Six Nations of the Grand River near Brantford, Ontario (www.snhs.ca/BirthingCentre.htm).
Structural Barriers to Adequate Maternal Healthcare for Women who are “At Risk”

Structural barriers to adequate healthcare mean that women who are at risk can experience an inequality of access to public maternal services and unfair treatment within those services. Based on a survey of the literature, I would suggest that some families are receiving a lower standard of care because they fall outside of the socially constructed “ideal” family. Coll, Surrey, and Weingarten (1998) argue that clinical and developmental psychology has historically focused on the development of children, with mothers constructed as an “object” in the child’s story. A “good” mother is likely to be white, married, not working in a job that takes her away ‘too much’ from her parenting responsibilities; she has only one or two children, and they do not have any physical defects or behaviour problems; she conceived her children and is raising them in a heterosexual relationship; and she and her spouse are older than 20 years of age and are of the same ethnic and racial background (Coll et al., 1998, pg.6).

Young mothers are often seen as “bad” mothers and can experience systemic oppression within the maternal healthcare system. According to one teenage mother: “Teens in the obstetrical care system are always told, never asked. They are often treated badly, as if they are being punished for being pregnant... They are afraid of the system and the system is afraid of them” (Ford & Van Wagner, 2004, p.244).

Wilson and Huntington (2005) examined the literature surrounding teenage motherhood and explored the ways in which societal constructions of “normal” motherhood have shifted over the past few decades to position teenage mothers as stigmatized and marginalized. They argue that the view of teenage mothers as problematic is underpinned by social and political imperatives regarding the role and responsibilities of women in Western societies. Seen in this way, marginalization and stigmatization can be understood as a means to control women’s childbearing choices and
behaviour so that they will adhere to an acceptable pattern (i.e., pursue higher education, start a career, then a family). However, “teen mothers do better over time than our stereotypes and political discourse would predict” (Smithbattle, 2003, p.370). Studies have shown that many young mothers have quite positive outcomes; researchers have described adolescent pregnancy as a motivator for positive behaviour change and future planning (Flanagan, 1998; Logsdon, Gagne, Hughes, Patterson, & Rakestraw, 2004) and as life changing and joy giving (Dominelli, Strega, Callahan, & Rutman, 2005). Most teenage mothers do not share the societal view that having a child at a young age ruins a teenage mother’s life or limits a teenage mother’s child’s future (Nelson & Sethi, 2005). Given that many young mothers do not follow the “predictable course of lifelong disadvantage” the stereotypes that abound become largely exposed as “flamboyant rhetoric” (Furstenburg, Brooks-Gunn, & Morgan, 1987, pp.8-9). Stereotypes about young mothers can then be understood as socially constructed and linked to hegemonic notions about who is fit to “mother” and what “family” should look like.

The structural barriers to equitable healthcare faced by women who are at risk can exacerbate the social, financial and/or cultural isolation they are already experiencing. One of the ways in which this happens is that the social, economic, and demographic issues presented by women who are at risk become medicalized; “a woman’s social and economic status, age, and the number of babies that she has had [are seen as] an automatic indicator of risk” (Ford & Van Wagner, 2004, p.254). Oakley (1993) echoes this critique by explaining that unmarried patients are often routinely referred to a medical social worker whereas married patients, who may well be experiencing social

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23 Furstenburg et al. (1987) conducted a 17 year longitudinal study with 300 mothers who gave birth to their first child in adolescence and explored outcomes for them and their child(ren) in later life.
problems, are not likely to be viewed as a “high risk” group. Although Ford and Van Wagner (2004) and Oakley (1993) are referring to two somewhat different categories of “risk” (medical “risk” and social “risk”, respectively) they share a critique of the ways in which “risk” has been constructed, where signifiers, such as being young and/or single, can come to negatively and predominantly shape a woman’s experience of the maternal healthcare system. In this way, societal stereotyping and stigma surrounding young motherhood might arguably be contributing to young mothers experiencing the very risks that have been correlated with their social group. Pregnancy complications that are more prevalent for teenage mothers include premature labor, intrauterine growth restriction, low birth weight and perinatal mortality; these complications are often linked in part to low body mass index, smoking, and young gynecological age (Gilbert, Jandial, Field, Bigelow, & Danielsen, 2004).

Furthermore, the structural barriers that young mothers encounter in the maternal healthcare system intersect with other barriers they face because of their race, culture, class, or ability. Regarding the impact of inadequate funding, Spitzer (2000) suggests that funding cuts in maternal healthcare are borne disproportionately by marginalized women. Spitzer (2000) interviewed both nurses and First Nations, Indo-Canadian and Vietnamese-Canadian mothers about their experiences at three hospital maternity wards in a large Canadian city. Some participants in Spitzer’s (2000) study noted that being both young and a visible minority compounded the differential treatment women received. One participant observed:

...just as I was leaving the desk, there was a Native girl walked in... but she didn’t get like, like I noticed right away, like she wasn’t cared for as much as I was... like those nurses remember me after four... but I noticed that she didn’t get quite as much attention and she was kind of put off...(p.96).
Nurses in the study often spoke of their efforts to understand difference and meet individual patient needs, yet Spitzer (2000) suggests that “women’s cries for assistance are lost in the cacophony of increasing demands placed on nursing staff who have survived institutional downsizing” (p.105).

Hearing from marginalized women about their experiences within the maternal healthcare system is essential to creating change. Midwives made some notable efforts (while undergoing regulation and public funding of their profession) to hear from women about the systemic barriers they face in maternal healthcare. A potential movement to increase the accessibility and availability of doula care can benefit from reflecting on midwives’ efforts in this regard. In particular, an Equity Committee was created at one of the first meetings of the Interim Regulatory Council on Midwifery (which was formed to craft legislation on midwifery) and in the late 1980s and early 1990s the Equity Committee heard from women across Ontario. The Equity Committee spoke to women who are often not consulted in the process of healthcare reform: Aboriginal, Mennonite, immigrant and refugee women, francophones, lesbians, teen mothers, incarcerated women, women with disabilities, and women in northern communities. Immigrant and refugee women spoke about their experiences of racism and reported other barriers in the healthcare system related to immigration papers, health insurance, language, the status of women in their countries of origin, and female circumcision (Ford & VanWagner, 2004).

One participant in the Equity Committee’s consultations with immigrant and refugee women stated the following:

Because we do not speak English, we are forced to be silent—to accept the rules; to accept the methods doctors use during birth; to be without power. Because of the language barrier, we can’t say no or ask questions. Because of the
environment, we are afraid to challenge what the doctors are saying and doing to us. We become the objects of medical intervention (p.247).

The Equity Committee’s reports described experiences of racism, ageism, classism, and abelism in the maternal healthcare system that deprive many women of adequate care and support at a time when it matters greatly. However, the reports were also critiqued as it was suggested that the Equity Committee’s approach

...set up the ‘problem’ of diverse groups with midwifery posed as the ‘fix’. This kind of approach is consistent with the role that midwifery has played in North America. The profession evolved outside the health care system as an approach to childbirth care that would not only act to ‘save’ women from overly medicalized and technologic care but empower women in the process.... This is very different than the British and European context, in which midwifery is seen as part of a system that itself needs to be fixed in order to meet women’s needs (Ford & Van Wagner, 2004, p.260).

Nestel (2004) examines racism within midwifery and argues that the “overwhelming whiteness of the midwifery profession is linked to structural inequities related to race” (p.290). Nestel (2004) suggests that the “story” of midwifery is most often told as a story of liberation, but that when the “point of reference for midwifery identity ceases to be patriarchal medicine and migrates to immigrant midwives of colour” a story of “domination rather than liberation emerges” (p.289). Ford and Van Wagner (2004) add that the North American midwifery movement is rooted in an “alternative lifestyle ideology” that is counter-culture, and I would add predominately white (Nestel, 2004), which can be exclusionary and “offensive to many outside of [this group]” (p.261). Nestel (2004) cautions that any project to eradicate racism and other forms of discrimination is on-going and cannot be considered complete simply when reports such as those produced by the Equity Committee are submitted; this is the current task at hand for Canadian midwives.
I would suggest that the regulation and public funding of doula care can serve to alleviate rather than exacerbate marginalization in the maternal healthcare system that is experienced by women who are at risk, but that its capacity to do so hinges on the social movement (and the resulting profession) taking an anti-racist and inclusive approach. If so, providing universal public funding for doula care has the potential to not only increase access to doula care for women who are at risk (which is in and of itself an equity issue) but could have an impact on decreasing systemic barriers to adequate maternal healthcare. In other words, increasing the accessibility and availability of doula care would likely not, in and of itself, substantially alleviate marginalization in the maternal healthcare system. I agree with Link and Phelan (2005) who argue that health inequalities are fundamentally linked to social and economic inequalities, meaning that people use their social and economic power to promote their health and that, therefore, policies that reduce social and economic inequality are key to fully reducing inequalities in health and healthcare. For these reasons, I would suggest that doula care’s capacity to alleviate marginalization is dependent on hearing from a diversity of women about their experiences in the maternal healthcare system and incorporating doula care into the system in an anti-oppressive way that considers the intersectionality of social, economic, and health inequalities.

Doula Care with Women who are “At Risk”: Addressing Inequities

Doula care may have particular benefits for young mothers and other women who are at risk. According to Rosen (2004), women who are young, single, and of low socio-economic status are less likely to attend childbirth education classes and generally have
poor social supports; as a result, they may have more anxiety in childbirth and may benefit the most from labour support. The Birth Companion Program conducts client surveys\(^\text{24}\) and keeps statistical data on birth outcomes\(^\text{25}\) (reported by doula volunteers) as a means of evaluating program success. Clients report increased confidence in their abilities as parents, an increased likeliness to seek support from the community, and a decrease in emotional stress during pregnancy, childbirth, and the postpartum period as a result of their participation in the Birth Companion Program. In addition, as was noted, Birth Companion Program clients are more likely (than their teenage peers who are not program clients) to initiate and continue to breastfeed, which is a key factor to long-term child health and development (Horsley & Sippert, 2006).

Doula care can also do a great deal to help women who are survivors of early sexual abuse. Sensations and experiences during birth can trigger memories of abuse; common triggers include unexpected touch, nausea and vomiting, bloody excretions, particular positions, being told to “just relax”, and the lack of privacy during labour and childbirth. Even if a woman does not remember being abused her body may (Simkin & Klaus, 2004). Fostering a feeling of being in control is one of the most important supportive measures that can be provided to survivors during childbirth. According to Simkin and Klaus (2004) the following are aspects of control to consider (some of which women can gain more control over than others): control over what is done to her in labour, control over what her own body does, and control over her behavioural reactions

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\(^{24}\) Client surveys have a response rate of 25%.

\(^{25}\) The program has a client caesarean rate that is nearly 50% lower than the regional average (Horsley & Sippert, 2006, p.5) yet obstetric outcomes have been found to vary with age, with rates of caesarean sections lower amongst teenage mothers (e.g., Gilbert et al., 2004; Lao & Ho, 1998; Raatikainen, Heiskanen, Verkasalo, & Heinonen, 2005). Data on obstetric outcomes of young mothers who are program clients as compared to their regional counterparts is not available.
or responses to contractions and procedures. Woman-centered and supportive care from care providers can help to foster a feeling of being in control. Yet in a busy hospital environment many obstetricians and nurses often focus on the clinical aspects of pregnancy and attend less to the psychosocial aspects. A doula can help to make childbirth more manageable for a survivor by providing continuous support, reducing distress and anxiety, maintaining awareness of a woman's triggers, and adapting her care to reduce re-victimization (e.g., she may request that vaginal exams are kept to a minimum and that a care provider of the woman's desired gender perform vaginal exams). In addition, a doula can interact with the staff, helping them to understand and respect the woman's particular needs, informing them of the abuse if requested to do so, advocating for the woman's birth plan, and acting as a “go between” the woman and her caregiver if the woman has a distrust of authority figures (Simkin & Klaus, 2004).

The success of community-based doula programs can be attributed in part to the fact that they are tailored for use with particular populations of birthing women. Providing equitable maternal healthcare services does not necessarily mean providing women with the same services. Williams (1995) states that the "concepts of universalism, equality, and citizenship [must be reconciled] with newer understandings of difference and diversity and the specificities of needs that arise from complex social positionings" (p.129). The importance of tailoring maternal services to the specific needs of particular populations has been evidenced in research on the effectiveness of teen-centered prenatal care clinics when compared with adult-centered obstetric services. A study by Bensussen-Walls and Saewyc (2001) indicated that teen-clinic clients missed fewer appointments, and were more likely to have vaginal deliveries and higher birth weight infants. The
researchers credited the success of teen-centered clinics in part to “clinicians [that are] expert in the unique issues pregnant teen[agers] face and are knowledgeable about the community resources specific to their age group and complex problems” (p.427). Bensussen-Walls and Saewyc (2001) acknowledge that most pregnant adolescents face stigma in the general public and that a clinic designed to meet a teen patient’s perspective can have significant positive effects on her health and well being (p.426).

The few community-based doula programs that are in existence share some key program design elements in common; one of these design elements is the matching of clients with volunteers who speak the same language and/or are of the same ethnic or racial background. Klaus et al. (2002) discuss the positive obstetric outcomes\(^\text{26}\) and other benefits of the Chicago Doula Project, a community-based doula program tailored to meet the needs of its teenage clients. Similar in design to the Birth Companion Program\(^\text{27}\), Chicago Doula Project clients are matched with doulas in pregnancy and doula support continues to six to eight weeks postpartum. Doulas collaborate with home visitors as part of a support team and participants are transitioned to support from the home visitor in the postpartum period. The staff of the Chicago Health Connection (the organizing institution) credit the success of the program to thorough doula training and matching of the project’s predominantly Hispanic clientele with women from the same ethnic community (Klaus et al., 2002).

\(^{26}\) Chicago Doula Project participants were found to have: a cesarean section rate of 8.1\% in comparison to the U.S. average for adolescent girls at 12.9\%; a breastfeeding rate at 6 months of 22\% in comparison to the U.S. average for adolescent girls at 12.2\%; and, a low birth weight rate of 6.6\% in comparison to the U.S. average for adolescent girls at 11.5\%.

\(^{27}\) Birth Companion doulas generally provide support until approximately six-weeks post-partum and then refer matches to the Parent Companion Program at that point. The Parent Companion Program is organized in a similar fashion to the Birth Companion Program; the program’s eligibility guidelines are comparable and volunteers are individually matched with new mothers to provide information and support on parenting infants and young children.
Similarly, the Birth Companion Program has recognized the benefits of matching clients with doulas who speak the same first language and are from similar ethnic communities. The Birth Companion Program has approximately 50 volunteers who come from a diversity of backgrounds and can support women in many languages including: Arabic, Creole, Cantonese, English, Farsi, French, Hindi, Japanese, Mandarin, Somali, Spanish, Russian, and Urdu. In 2005, 51% of the program’s clients spoke English as a first language and 49% spoke a first language other than English; all clients were served in their first language whenever possible (Horsley & Sippert, 2006). The range of languages spoken by Birth Companion Program volunteers is a notable strength of the service as it significantly increases the program’s capacity to reach out to a diverse clientele. The potential benefits of matching as a component of doula care were recently discussed in a National Aboriginal Health Organization Report; the author claims that “having a First Nations doula can... assist women to incorporate traditional practices into their birthing experience, and creates a space where the understanding of these practices is acknowledged and understood” (First Nations Centre, 2008). The report suggests that doula care may be especially beneficial for mothers who are evacuated for birth from remote communities into urban centres. The author calls for research on doula care in First Nations Communities and on the role of social support in pregnancy and childbirth for First Nations people.

In contrast to the diversity of women served by community-based doula programs, clients of fee-for-service doula care are predominately white, middle-to-upper class, well-educated women. Lantz et al. (2005) surveyed doulas across the U.S. and found that doulas’ recent clients were an average age of 30, 84% were married, and about

28 French and Arabic speakers represented approximately one half of these clients.
one-half were giving birth for the first time; regarding ethnicity, “doula clients were 84% white, 6% African-American, 7% Hispanic, and 3% other ethnicities” (p.112). To my knowledge there is no demographic research available on the clientele (or doulas) of fee-for-service doula care in Canada, yet it warrants investigation.

One of the key ways in which doula care can support women in achieving equitable maternal healthcare is through practicing the principle of informed choice. Informed choice has been articulated as a principle of midwifery care and can be understood as providing birthing women with comprehensive information about their care and respecting their right to be the primary decision makers about their own care (Shroff, 1997). As a woman-centred model of care, informed choice is often articulated as an important component of doula care as well. The principle of informed choice is considered fundamental, as a doula aims to provide information, convey respect for a birthing woman’s choices, and act as an advocate in support of her birth choices. The Birth Companion Program teaches the practice of respecting women’s choices by training its volunteers that decision making is the sole terrain of the woman in labour; it is “her body, her baby, her birth” (G. Sippert, Birth Companion Program Coordinator, personal communication, January 2005).

When working with women who are at risk, a doula may be able to support a woman’s right to informed choice in her maternal healthcare. This is a one of the ways that incorporating doula care into the healthcare system could work to alleviate systemic oppression encountered by women who are at risk. According to Sherwin (1998), it is not only the social and economic conditions of women’s lives that shape their health, but also their “society’s organization of health services [which] has great potential to either
deepen or relieve existing patterns of oppression” (p.3). Even if “informed choice” is recognized by some hospitals in their policies, as The Ottawa Hospital does (Sprague et al., 2006, p.770), there are many structural barriers that prevent putting this principle into practice. Sherwin (1998) suggests that when informed choice is provided, it is inherently limited by the medical model of care and existing relations of power and oppression, such as feelings of social inferiority:

by focusing only on the moment of medical decision making, traditional views fail to examine how specific decisions are embedded within a complex set of relations and policies that constrain (or, ideally, promote) an individual's ability to exercise autonomy with respect to any particular choice (p.32).

Options can be limited by the model within which they are being offered and there can be a strong social pressure to accept a certain option. However, the illusion of choice is maintained, which can be understood in effect as a mechanism for controlling behaviour (Foucault, 1979, cited in Sherwin, 1998). In Sherwin’s (1998) words “the paradigm offered for informed consent is built on a model of articulate, intelligent patients who are accustomed to making decisions about the course of their lives and who possess the resources necessary to allow them a range of options to choose among” (p.24). In this way, systemic discrimination and stereotypes about women who are at risk can undermine their credibility and authority in healthcare contexts (Sherwin, 1998). For example, young mothers’ rights to informed choice may become influenced or compromised by stereotypes surrounding young motherhood (e.g., being seen as too young to make rational or competent decisions about their own health and the health of their baby).
Teenage Pregnancy and Existing Services for Young Mothers

According to Health Canada (1998), the birth rate among teenage girls aged 15-19 is 25/1000, ranging from 14/1000 among those 15 to 17 years of age to 40/1000 among 18 to 19 year olds. Rates of teenage pregnancies and births decreased in Canada during the last quarter of the 20th century and the rate of teenage pregnancies in Ontario remains below the national average (McKay, 2004). Young mothers exhibit an increased incidence of smoking and alcohol and drug use which can negatively affect obstetric outcomes. In addition, many young mothers are living in poverty or have low incomes which directly affects their access to social support, food availability, and access to health and social services (Health Canada, 1998). Low birth weight is one of the key concerns associated with teenage pregnancies; the national average for low birth weight is 5.7% whereas for adolescent mothers the low birth weight rate is 6.5%. Low birth weight is associated with neonatal morbidity and mortality and developmental problems, among other illnesses (Health Canada, 1998). The association between young maternal age and preterm birth is less clear as some studies have found an association and others have not (Da Silva et al., 2003).

Health indicators, such as those noted above, contribute to the dominant cultural construction of teenage pregnancy as quite negative. However, it is important to note that some ethno-cultural communities do not necessarily see teenage pregnancy as negative, including First Nations communities in the far north (McKay, 2004). Perceptions of teenage pregnancy have also changed historically. In Canada, in 2003, the average age of women at first birth was 28 with almost 50% of all births occurring to women age 30 and over; whereas in 1971, the average age at first birth was 22.8 (Whitley & Kirmayer,
2008). Such changes greatly influence the dominant discourse on what is considered "normal" and "deviant" in women's fertility behaviour. When viewed in this way, stigmatization of young mothers can be seen as serving "a penological function to affirm and maintain dominant Anglo-Canadian middle-class cultural norms emphasizing the importance of education, careers and delayed childbearing for women" (Whitley & Kirmayer, 2008, p.339). I would suggest that it is possible that the stress of young mothers' experiences with discrimination, stigma, and social exclusion may in fact contribute to some of the negative obstetric outcomes associated with teenage pregnancy. There is a strong correlation between stress and lack of social support during pregnancy and negative obstetrical outcomes such as preterm birth (Rogers, Peoples-Sheps, & Suchindran, 1996). Similarly, Ruddick (1993) argues that economic and social problems associated with adolescent mothering are largely because of economic and social policies, and not because of the sexual and procreative behaviour of young women. For these reasons, I would suggest that discussions focused on decreasing rates of teenage pregnancy may be less constructive than those focused on initiating and supporting policies and practices that address inequities among young women and increase young mothers' access to supportive services.

Two key federally funded community-based programs for young children are in place to provide services for young mothers and their families (among other target groups): the Canada Prenatal Nutrition Program (CPNP) and the Community Action Program for Children (CAPC). There are 748 CAPC and CPNP projects represented in 500 communities across Canada; projects include resources such as family centres,
parenting programs, and nutritional counseling. For example, Buns in the Oven\textsuperscript{29} in Ottawa is a well-respected CPNP funded program that combines cooking groups with prenatal and postnatal information and support.

Existing social services make many valuable contributions to the health and well-being of young mothers and their families. However, there is a virtual absence of social supports available to young mothers during labour and delivery. The community-based doula programs in existence are only able to service a small percentage of young mothers in approximately five communities across Canada. When examined collectively, the evidence suggests that regulating and publicly funding doula care would significantly improve obstetric outcomes and maternal and infant health and well being for women who are at risk. Many researchers on doula care have called for maternal health services to be reorganized to ensure that all birthing women have access to continuous emotional and physical support during labour (Scott, Klaus, & Klaus, 1999). And if all women were to have access to doula care then women who are at risk stand to benefit significantly. According to Pascali-Bonaro and Kroger (2004) in times of “intense personal emotional, social, or cultural stress... the benefits of doula care are likely to be especially powerful... although this hypothesis has not yet been well studied, early reports are promising” (p.23). The current study contributes to studying these benefits by exploring doula care as it is experienced by young mothers and doulas at the Birth Companion Program.

\textsuperscript{29} www.ottawayoungparents.com/BOmore.htm
Integrating a Woman-centered Care Model into the Maternal Healthcare System

Aboriginal forms of woman-centered maternity care existed in First Nations communities in Canada for thousands of years prior to colonization (Bourgeault, Benoit & Floyd, 2004, p. 4). In the 1800s and early 1900s, the arrival of European immigrants and a number of social, cultural, economic, and political factors led to a massive shift in the way that birth was understood and managed. Most notably, the history of childbirth in Canada is characterized by the demise of the midwife. Biggs (2004) argues that the decline of midwifery was directly linked to allopathic medicine’s attempts to gain a monopoly over all realms of healthcare. Midwives were seen as a threat to establishing the medical model of healthcare and needed to be discredited in order to secure its legitimacy. Birth became socially constructed as a medical event and the “risks” of non-medicalized birth were emphasized in order to establish the “safety” of obstetric care. Few would argue that medical technology has not afforded advances in obstetric care; however, many birth activists believe that the pendulum of “technological progress” has swung too far and that elements of medicalized birth are unsafe (e.g., that rates of caesarean sections are unnecessarily high).

Growing skepticism about the efficacy of the medical model and women’s desires for positive birthing experiences have long been fueling a “rebirth” of woman-centered models of care (Shroff, 1997). According to Shroff (1997), the medicalization of women’s bodies and of birth was linked to the broader “medical takeover of reproductive healthcare, growing social and economic support for technological medicine, patriarchal domination of healthcare, [and] colonial oppression which propped up Western medical

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30 A recent national survey of Canadian women’s maternity experiences found that 26.3% of births are by caesarean section (Chalmers, Dzakpasu, Heaman, & Kaczorowski, 2008).
practices” (p.16). In response, the North American natural childbirth movement began in the 1960s and 1970s and recognized birthing women’s need for social and emotional support; most significantly, the movement fought for the right of partners to enter the delivery room (Meyer et al., 2001). More recently, the resurgence of midwifery culminated in its regulation in Ontario in 1994. Midwifery’s woman-centered philosophy is characterized by three main elements that are also shared by doula care: informed choice, choice of birth place and continuity of care (Shroff, 1997).

An examination of the midwifery movement and its incorporation into the maternal healthcare system can offer insights on the potential challenges and successes that regulated and publicly funded doula care could present. The movement for midwifery came a long way in a relatively short amount of time. In the 1980s, Canada was the only industrialized nation where there were no formal provisions for midwifery practice. By the mid to late 1990s midwifery was legalized and incorporated into provincial healthcare in Ontario, Quebec, British Columbia, Alberta, Manitoba, and Saskatchewan. It is anticipated that most if not all of the provinces and territories will soon have midwifery care integrated into existing provincial maternal healthcare services (Bourgeault, Benoit, & Floyd, 2004).

During regulation in Ontario, one of the primary concerns of many midwives was that the regulation and public funding of midwifery care would open it to co-optation by the mainstream medical system. When the lobby for midwifery swelled in the early 1990s many midwives argued that the “bureaucratization of reproductive services” could serve to separate midwives from the women they serve and result in depreciation in the quality of care (Benoit, 1997, p.94). Midwifery was regulated on the premise that the benefits
outweighed the sacrifices and measures were therefore taken to “protect” midwifery from the larger medical system through self-regulation, legal protection, and specialized research and education forums (Benoit, 1997). A prominent midwife in the struggle for regulation, Vicki Van Wagner, stated that

although we did not want to be controlled by the system, we wanted to become a part of it... it seemed to many of us that involvement with regulation could create pressure for midwifery to conform to medical standards of practice and create hierarchical models of training and practice that would undermine women’s choices (as quoted by Bourgeault, 2006, p.72-74).

I would suggest that midwives’ fears of co-optation by the medical system were situated within a broader discourse surrounding the medicalization of childbirth, the alternative birth movement, and midwifery care that often positions woman-centered care as separate from and/or in opposition to the medical establishment. O’Reilly (2004) argues that the “fight against the medicalization of childbirth” has been “waged in language” (p.220). She suggests that childbirth has been constructed as a “medical event” through medical discourse and that the natural and alternative birth movements have challenged this by reconstructing childbirth as “natural” (O’Reilly, 2004). In other words, the discourse of the alternative birth movement has built on the medicalization of childbirth rather than focusing on deconstructing it; and, as a result, the construction of childbirth as “natural” positions the birthing woman in control of her labour, rather than as being controlled by hospital practices. Similarly, Layne (2003) argues that feminists’ efforts to wrest control of birth from biomedical obstetrics produced a rhetoric that in effect can work with biomedical obstetrics to relay the idea that “happy endings” can be controlled for (whether by medical intervention, or by women’s “natural” power to birth). Layne (2003) describes this effect as an unintended consequence and argues that, as a
result, maternal blame (and self-blame) can arise when pregnancies are not "perfect"; she also links this pressure that women feel to achieve the ideal birth with a broader "culture of meritocracy" (p.1881).

While childbirth is ultimately an experience that is beyond anyone's control, a woman's sense of control (e.g., over decision making) is important. Research has indicated that a woman's sense of control can improve obstetric outcomes and/or can increase maternal satisfaction with childbirth (e.g., Campero et al., 1998; Rosen, 2004; Simkin & Klaus, 2004). A woman's sense of control during labour can occur in a context where childbirth is both "natural" and "medical" and where it is the expertise of both obstetricians and midwives; viewing it as such may produce greater possibilities for increasing women's access to woman-centered forms of care. Referring to women's healthcare reform more generally, Armstrong (2000) argues that:

It is possible to be in and against the state; to support public care while seeking to change it; to resource communities while working to alter institutional care for those who need it; to critique the medical model while recognizing the need for expertise; to provide continuity without limiting access through a single point and to a single service; to seek both equity and equality; to struggle for women's collective interests while accommodating differences among women (p.14).

In line with the thinking of many pro-regulation midwives, I would argue that the benefits of regulating and publicly funding doula care are likely to outweigh the sacrifices. At worst, it is conceivable to imagine that once instated as part of the mainstream healthcare system that doula care could be reduced to the provision of comfort measures (e.g. massage, positioning) and stripped of some of the woman-centered principles which are arguably central to its effectiveness. In other words, the process of integrating doula care into the mainstream healthcare system may relegate a doula's role to the tasks she performs rather than the less tangible, but arguably
fundamental, relationship-based and woman-centered elements of her care. Yet if doulas can integrate into the maternal healthcare system in a way that retains these fundamental elements of their care, then doulas could become an option for more birthing women and the benefits of doula care that have been identified (e.g., lower-intervention births, increased maternal satisfaction with childbirth, greater maternal attachment, higher rates of breastfeeding etc.) could be made available to a greater number and diversity of women. If doula care does integrate into the maternal healthcare system then I would suggest that measures be taken to protect the relationship-based and woman-centered elements of doula care in order to ensure its effectiveness post-integration. I will examine participant views on this issue in Chapter Five.

Assessing the Potential for Change

The current political climate may present a great deal of ideological resistance to policy change regarding the provision of labour support within maternal healthcare. Government policies in all areas are in accordance with what Richmond and Shields (2004) refer to as “a new funding regime built on neoliberal foundations” (p.53). The current funding regime favours fee-for-service models and increased privatization of government funded services. Private doula services as they currently exist are effectively a form of two-tiered healthcare. In addition, the downloading of responsibilities onto families is considered beneficial because it “relieve[s] state fiscal burdens and increase[s] efficiencies” (Richmond and Shields, 2004, p.58). Over the past two decades, the issue of inequities in maternal healthcare has been increasingly brought to the attention of federal and provincial governments; yet unfortunately, the current political climate is not only
curtailing the development of progressive health policies, but is retracting prior gains made by the equity and women's health movements (Ford & Van Wagner, 2004). McQuaig (1998) states that this period is characterized by “a failure of will on the part of governments” where powerlessness in the face of capital markets is fronted by governments that are guarding their political reluctance (p.26). I would suggest that the current political climate may pose challenges to increasing the availability and accessibility of doula care.

At the same time, the potential cost savings associated with doula care may serve as a financial incentive for government. In the U.S., some hospitals employ their own doulas. A U.S. based research and consulting firm that represents hospitals, health systems and physicians, hypothesized that a single hospital can expect to save $100,000 to $180,000 per year by offering doula care; this projection was based on 2,000 deliveries per year with a 3%-5% reduction in cesarean section rate and a 30%-50% reduction in epidural rate (Meyer et al., 2001). Another 1992 study conducted by a U.S. hospital projected that providing continuous doula support throughout every delivery would reduce annual maternity healthcare costs in the U.S. by more than $2 billion (Meyer et al., 2001). This potential cost savings to the healthcare system may provide a strong incentive for government and public health administrators to consider providing financial support to increase the availability and accessibility of doula care.

Based on this review of the literature I would suggest that doula care can be of benefit to young mothers and other women who are at risk, and secondly, that it would be advantageous to increase the availability and accessibility of doula care. Regulating and
publicly funding doula care may be a viable means of increasing women’s access to
doula care; as emerging paraprofessionals, the current fee-for-service way in which doula
care is organized limits many women from accessing their services. The regulation and
public funding of midwifery in Ontario has laid groundwork on the challenges, tensions
and successes of integrating a woman-centered model of care into the maternal healthcare
system. Authors on the integration of midwifery care largely tout its success (e.g.,
Bourgeault, 2006; Daviss, 2006; Ford & Van Wagner, 2004); and, in the decade that has
passed since the first class of midwives graduated from McMaster University in 1996,
midwives have been able to provide woman-centered care to an increasing number, and
increasing diversity, of women across Ontario (Ford & Van Wagner, 2004). The
regulation and public funding of doula care could provide another avenue for improving
women’s access to adequate care, informed choice, and woman-centered options within
maternal healthcare services.

While existing studies are limited in number, growing epidemiological evidence
on the effectiveness of doula care is compelling. As well, preliminary reports on and
investigations of community-based doula care with young mothers, and other women
who are at risk, are promising. The fee-for-service way that doula care is generally
available serves as a significant barrier to many women accessing this option in maternal
healthcare. Increasing access to doula care may help to alleviate the marginalization that
women who are at risk can experience within the maternal healthcare system. Doula care
can increase opportunities within maternal healthcare for young mothers and other
women who are at risk to receive relationship-based and woman-centered social support
that is responsive to the specificity of their individual needs at a pivotal time in their lives.

In the remaining chapters I will turn to examining the views and experiences of the participants in this study. I will begin, in Chapter Three, by briefly describing the study’s participants before turning to exploring young mothers’ experiences with doula care.
Chapter Three: Enriching Maternal Healthcare for Young Mothers through Doula Care

The Participants

Young mothers. I interviewed four young mothers who had been clients of the Birth Companion Program. They ranged in age from 16-23 when their baby was born. All had been matched with a doula in pregnancy, with the time of matching ranging from the first trimester to the last trimester. All had given birth in an Ottawa area hospital; three had an obstetrician as a primary caregiver and one had a midwife. One identified as Native and Canadian, and the rest as European-Canadian or Canadian.

Doulas. I interviewed four women who are volunteer doulas with the Birth Companion Program. They had all volunteered for the program for a minimum of one year, and three also took on private doula clients in addition to their volunteer doula clients. They all identified as European-Canadian or Canadian and they represented a range of ages and income levels.

Pseudonyms. I have provided each participant with a pseudonym that I will use throughout this data chapter and those that follow. I have named the doulas Christine, Sonya, Anne and Marisa and the young mothers Jennifer, Amy, Natasha and Catherine. As was discussed, a participant had invited her partner to join us for the interview; that was Amy and I have named her partner David.

In this chapter I will draw from participant interviews to discuss young mothers’ experiences with maternal healthcare. I will posit that doulas can enrich maternal healthcare for young mothers by providing support and helping to facilitate their voices being heard in a maternal healthcare context where some young mothers may feel they
are judged and lacking support. I will begin by analyzing participant comments that indicate that societal stigma and stereotypes surrounding young motherhood can create anxiety for some young mothers as they navigate the maternal healthcare system. I will then discuss the ways in which participants point to a need for improved communication between young mothers and their healthcare providers in order to make information more accessible to these young women. Lastly, I will draw on literature on the medicalization of childbirth to look at how participants narrate the “choices” that are made during birth and how a young mother’s sense of control over her birth experience can become diminished.

*The Impact of Stigma*

Jennifer, one of the young mothers that I interviewed, felt that she was treated differently in the maternal healthcare system because she did not fit the profile of a “good” mother. She felt that assumptions were made about her at the hospital because of being unmarried and pregnant at a relatively young age. At one point in her pregnancy she went to the hospital because she suspected something was medically wrong. She received the impression that she “worried too much” and was referred to a hospital social worker. Similarly, on a visit to emergency, a hospital staff person said to Jennifer that she looked “depressed”. The referral to the hospital social worker and the comment about looking “depressed” may have been intended as supportive but Jennifer experienced them as judgmental. Jennifer did not feel heard or respected by hospital staff and stated that she felt that this was because of her age and marital situation: “in the hospital they just may
not understand you...some of them seem to be... against younger people having kids that aren’t married”.

Jennifer’s narrative may provide insight into how societal stigma surrounding young motherhood can create anxiety for some young mothers as they navigate the maternal healthcare system. As was discussed in Chapter Two, societal constructions of “good” motherhood have shifted over time and contemporary views stigmatize and marginalize teenage mothers (Wilson & Huntington, 2005). Ruddick (1993) explains that the adolescent mother has become a symbol of “sexual and social disorder” and she argues that young motherhood (even more than teenage pregnancy) has become a representation of “the causes as well as symptoms of intergenerational cycles of poverty and despair” (p.126). Ruddick’s (1993) claim is reflected in the work of Fraser and Gordon (1994) who trace historical shifts in the usage of the term “welfare dependency” in the U.S. They argue that this term serves to “enshrine certain interpretations of social life as authoritative and to de-legitimate or obscure others, generally to the advantage of dominant groups in society and to the disadvantage of subordinate ones” (p.311). These authors argue that the ultimate contemporary expression of welfare dependency is the “young black single mother” and explain that she “simultaneously organizes diffuse cultural anxieties and dissimulates their social bases” (Fraser & Gordon, 1994, p.327). Through interlocking dominant discourses such as these, the adolescent mother as a symbol of social disorder (Ruddick, 1993) and the young black single mother as welfare dependent (Fraser and Gordon, 1994), normative notions of motherhood are raced, classed, and gendered (O’Reilly, 2006).
Young mothers’ experiences of pregnancy, childbirth, and motherhood are arguably impacted by these pervasive social discourses and related notions about “good” and “bad” mothers. Kulkarni (2007) conducted ethnographic interviews with 30 young mothers and two of the key themes that emerged were “pressure to be with their children’s fathers” and “stigmas associated with teenage motherhood”. This later theme was quite prevalent, with more than 60% of the participants sharing experiences with discrimination due to stigma. I would conclude by suggesting that Jennifer’s narrative may reflect the impact of societal stigma surrounding young motherhood and how such stigma can produce anxiety and experiences of felt discrimination in the maternal healthcare system.

Participants indicated that one of the stereotypes about young mothers is the notion that young women are less able to handle physical and emotional challenges than older women. This may influence the way that care providers treat young women in labour. Anne, a doula, told a birth story about advocating for her match and being open to seeing through stereotypes:

I got the call at around 11 o’clock at night and I asked her how far apart she was and she said she was three minutes. Normally I wouldn’t worry too much about it but then I asked her if she was feeling pressure and she said yes, she was feeling pressure in her bottom and I immediately thought—ah oh, a light went off.... So I went to get her to bring her into the hospital and I got her in the car and in the car she was having contractions and was talking [through them]... it wasn’t the picture of someone in labor. [I thought] she’s either really early in labor, like barely started, or she’s really far along. So we got to the hospital and the staff kind of took their time and then the pain became very intense. I wasn’t sure if it was a fourteen year old being a fourteen year old and not dealing well with the contractions. But there was something... my instincts kept telling me... I thought she was farther along, 8-9 cm kind of thing. I really had to convince the doctors to check her. They thought she was just very early in labor and not coping very well. So I finally convinced them to check her and she was 8-9 cm. So that was a situation where I really had to advocate on her behalf.
Anne acknowledges, and seems to criticize, the doctors’ assumption that her match was not handling the labour pain well, yet indicates that the pervasiveness of this stereotype affected her own assessment of her match’s stage of labour as well. Anne herself states “I wasn’t sure if it was a fourteen year old being a fourteen year old and not dealing well with the contractions”. Anne’s narration of her match’s birth story also suggests that her match displayed some contradictory or confusing behaviour. For example, she states that “it wasn’t the picture of someone in labour”. Fortunately, Anne acknowledged that she “wasn’t sure” and focused on “advocat[ing] on her behalf”. Anne does not include any clear indicators of what her match was requesting at this point (i.e., was Anne’s match wanting to be checked?). It is unknown precisely what factors motivated or enabled Anne to advocate for her match. She reports that her “instincts kept telling [her]” that her match was farther along in labour. It seems that Anne was able to minimize the influence of a stereotype and advocate for her match to be assessed.

Research indicates that when care providers and support people themselves draw on the stereotype about young mothers not being able to handle pain in labour, it can negatively affect a young woman’s experience of pain. According to Lowe (2002), the element that best predicts a woman’s experience of labor pain is her own level of confidence in her ability to cope with labour. And her confidence in her ability is affected by those attending to her in labour. Lundgren and Dahlber (1998) found that a woman’s experience of pain is related to the context (e.g., setting) and “especially to the people with the woman... women need to trust the people around them and they need to be affirmed in their efforts... security, support and encouragement [are] described as important” (p.107). In other words, conveying confidence in a young mother’s ability to
manage labour pain and affirming her in her efforts can have a positive impact on her experience of labour pain. Conversely, displaying a lack of confidence in a young mother can negatively affect her experience of labour pain. In this way, an alternate discourse (of young mothers as capable of managing labour pain) may improve the effectiveness of labour support for these women.

An analogy can be drawn to caregiver attitudes towards young mothers and breastfeeding, as alternate discourses on young mothers and breastfeeding may be able to open up a young mother’s sense of her options for infant feeding. All of the doula participants described providing information and support on breastfeeding as an important part of their role in working with young mothers. A participant and young mother, Natasha, made reference to a conversation with her doula on breastfeeding:

The funniest thing is that when I was pregnant I didn’t know about breastfeeding... I didn’t really know about it until I started seeing breasts popped out everywhere. But it was [my birth companion] who asked me if I was going to nurse or if I was going to bottle-feed and I said, “bottle feed” and she said, “Well are you going to try it?” and I thought well I might as well try. So she’s actually the one that introduced me to nursing. So when [my baby] was born I just did it and he was hooked.

Natasha does not indicate whether or not she had been subject to any stereotypes about young mothers as non-breastfeeders. She does indicate a lack of familiarity with breastfeeding and credits her Birth Companion with “introducing” her to nursing. While the question posed to Natasha (i.e., “Well are you going to try it?”) does not indicate that her Birth Companion provided information or support specifically, it is possible that her Birth Companion helped to open up an alternate discourse by not assuming that Natasha would be bottle-feeding.
In training for the Birth Companion Program, doulas are encouraged to discuss societal stereotyping of young mothers as non-breastfeeders with their matches, to convey their own confidence in their match’s ability to breastfeed, and to challenge their matches to defy the stereotype (G. Sippert, Birth Companion Program Coordinator, personal communication, January 2005). I would suggest that this alternate discourse (young mothers as capable of defying the stereotype) is arguably more supportive, and can help to encourage a behavior that is considered healthy. At the same time, it is important to recognize that it is still somewhat coercive in its delivery in that it works by substituting one narration of young mothers and breastfeeding with another. I think it is possible for this approach to be taken up in ways that can increase a young mother’s sense of her own capability (and her options) while also supporting the particularity of her views on, experiences with, and choices regarding breastfeeding. The program’s approach to breastfeeding appears to be effective, with 90% of Birth Companion clients initiating and 53% establishing prolonged exclusive breastfeeding; a rate that greatly exceeds the national breastfeeding average for young mothers (Horsley & Sippert, 2006).

Conversely, researchers Dykes, Moran, Burt, and Edwards (2003) have found a connection between stereotyping by health professionals who often assume that young mothers will not be breastfeeding and teenagers’ views on and experiences with breastfeeding. According to one participant in Dykes et al.’s (2003) study: “I wasn’t asked how I was feeding. I was asked how many ounces is he having... then when I said I was breastfeeding they like looked and said “oh you’re breastfeeding” and I was like “yes” and they said “oh...that’s good” (p.394). Adolescents reported that they felt watched and judged by older people. Dykes et al. (2003) draw a connection between this
feeling of being watched and young women's lack of confidence in their ability to carry out breastfeeding effectively. In Dykes et al.'s (2003) study the feeling of being stereotyped as a likely bottle-feeder is explored in relation to age; similar results have been reported by Dracup and Sanderson (1994) in relation to socioeconomic status (as cited in Dykes et al., 2003) which, I would add, may intersect with and intensify the impact of stereotyping for the many young mothers who have low incomes or are living in poverty (Health Canada, 1998).

Participant comments and related research indicate that there are a multiplicity of ways in which young mothers’ experiences of being stereotyped and judged can be affected by dynamics surrounding other aspects of their identity and background. Anne, a doula, tells this story:

She had a history of drug abuse and it became very clear that the nurse was not treating her very nicely because of it and she kept asking her about it and she’d say, you know I got off the drugs very early on in the pregnancy I got clean and all that, and she was just not being supportive of her, and kept asking about the father in a very impolite way. So she was not treated very well through the whole thing and unfortunately when the baby did come out, she was white and the baby was a darker colour, the nurse did make an unfortunate comment about the baby and the colour of the father.
Heather: You mean a racist comment?
Anne: Yes.

This excerpt offers an opportunity to explore multiple readings of the issue of drug use during pregnancy from the varied perspectives of the women involved (Anne, the nurse, and the birthing woman). Anne, by expressing criticism of the nurse’s treatment (e.g., “[the nurse] was just not being supportive of her [the birthing woman]”), may be illustrating that she holds a view that women in labour deserve unconditional support. From the nurse’s perspective, it is possible that she saw drug use during pregnancy as a sign of irresponsible parenting given that many street drugs can cause harm to the foetus;
her concern for the baby's health may have affected her view of the mother. For the birthing mother, it appears the pregnancy may have served as a catalyst for getting off of drugs. Anne reports that “[she] got clean and all that” and that she “got off drugs very early on in the pregnancy”. I would suggest that rather than there being one “true” story about a birth, it is possible to see in this excerpt how each of these women’s perspectives may have shaped and influenced their interactions with one another.

The excerpt above can also highlight the multiple ways in which women can be classified and marginalized as “good” and “bad” mothers. While there may not be one “true” story about a given birth, I think it is possible to critique and mobilize around the ways that some mothers have more social power to exercise in creating their own birth experiences. In this mother’s situation, I would suggest that the racist comment that Anne says was made by the nurse about the baby and the skin colour of the baby’s father can be seen as an illustration of the intersecting oppressions that are arguably experienced by many young mothers. Coll et al. (1998) explain that the more a mother deviates from the prototype (of white, married, middle class etc.) the more likely that she and her mothering practices will be marginalized. Furthermore, research with young women of colour found that one in five reported that they had encountered racism in the Canadian health care system; these experiences included cultural insensitivity from their doctors (8.6%), name-calling or racial slurs (2.5%), and receiving an inferior quality of care (6.2%) (Ali, Massaquoi, & Brown, 2003). In this way, marginalization due to racism, classism, and/or other forms of discrimination may intensify a young mother’s experience of felt discrimination within the maternal healthcare system.
Stigma surrounding young motherhood is pervasive (Ruddick, 1993) and affects both doulas and hospital staff. For example, recall Anne’s statement about young mothers not being able to handle the pain of labour: “I wasn’t sure if it was a fourteen year old being a fourteen year old and not dealing well with the contractions.” Many hospital staff and doulas alike are open to seeing through such stereotypes about young mothers and providing care that is respectful and supportive. Participants in this study spoke positively about the care they received from hospital staff. For example, Catherine, a young mother, said:

They [the nurses] were really nice... I had one nurse who, I wasn’t sleeping that well at night and she had to give [the baby] her test. She actually took [the baby] for the full three hours so I could get some sleep and brought her back when it was time to feed again.... I had a second night [and] the nurse I had when I came into the hospital, she was like, “you’re still here?” and she sat in the room with me ‘cause the floor wasn’t busy... she sat in the room with me and did her paperwork.

Similarly, David (the partner of Amy, a participant) said that the nurses who attended to Amy were “amazing”, “very kind”, “very knowledgeable”, and “really good”. I would conclude that doulas can enrich young mothers’ experiences in the maternal healthcare setting by working collaboratively with other health professionals on the childbirth team to achieve a shared aim of providing respectful and supportive care.

Doulas can make a unique contribution to the childbirth team by providing continuous, woman-centered care and encouraging women’s positive birth experiences. Anne states:

I think that regardless of their income level, their life experience or whatever, whether it’s their first baby or their eighth baby this is a time when women need support and in the reality of our medical system...it really is a crap shoot of the quality of nursing and medical care that they will get at the hospital, most of the time it’s really good but I think that...it’s important to know that one person is going to be there regardless of what else happens... you’ve got one person who is
known to you, is familiar with your birth plan and what you want and knows what the issues are, what your concerns are and can help address them as early as possible, as they become issues and just to be there and aware of what you want and what’s important to you and who you are and see you as an entire person as opposed to the medical system. They have a different job in this and a different role and it doesn’t always connect with what women need. It’s good to have the [doula] that’s focused on the whole person rather than just getting the baby out.

Anne’s narrative may reflect a broader discourse of the alternative birthing movement as she positions woman-centered care as separate from, and fundamentally different than, medical approaches to care. In practice, I would suggest that the lines between woman-centered approaches and medical approaches to care are less defined than they have been put forth here. For example, it is not universally the case that medical personnel are focused on “just getting the baby out” and many medical personnel would likely report that they are also concerned with factors such as what’s “important” to the birthing woman and with providing support regardless or irrespective of a woman’s “income level [etc.]”. Conversely, some doulas may also be focused on “getting the baby out” and doula care can also be considered a “crap shoot”. At the same time, Anne’s narration captures some of the realities of the various roles on the childbirth team; obstetricians, midwives and nurses do hold clinical and medical responsibilities that are their first priority, while doulas are able to focus on providing continuous support to the mother and attending to her emotional needs. Nurses carry a busy patient load and regularly assess women in labour, whereas a doula’s role is defined by her continuous support. A doula’s attention to a woman in labour often begins in early labour and continues to delivery, with the doula leaving only for toileting. Anne’s comments highlight the mother’s birth experience as a central priority in the doula’s approach to care.
Barriers to Communication with Healthcare Providers

Societal stigma surrounding young motherhood may create barriers to young mothers accessing adequate information and support during pregnancy, childbirth, and in the postpartum period. Jennifer, a young mother, said during our interview that she was reluctant to apply for subsidized child care because she thought applying for child care might make it look like she was not competent to care for her baby: “I just don’t want them to think that I can’t take care of her on my own, ‘cause I can”. I would suggest that Jennifer’s reluctance to apply for subsidized childcare may possibly be linked to particular societal notions about “good” motherhood (e.g., good mothers can pay for childcare) and related fears about child welfare involvement.

Phoenix (1991) argues that stigma surrounding young motherhood can prevent some young mothers from seeking help with their children. Young mothers may fear being perceived as irresponsible (Greene, 2006), particularly in a social context where notions of “good” motherhood can invite CAS scrutiny for some young mothers (Dominelli et al., 2005). O’Reilly (2006) suggests that the expectations that have been set for good mothers are continuing to rise. She argues that notions of good motherhood have expanded to further regulate women and now include what she calls “intensive mothering”. According to O’Reilly (2006), intensive mothering, among other things, dictates that “children can only be properly cared for by the biological mother... [and that] mothers must lavish excessive amounts of time, energy, and money in the rearing of their children” (p.43). For young mothers, it is possible that such rising expectations for good motherhood would exacerbate the barriers they may face in asking for help with their children.
When young mothers do ask for help, there can be a pressure to “look promising” or be considered “deserving” which can affect young mothers’ behaviour and make them complicit in “(self)policing their own condition” (Dominelli et al., 2005, p.1130). Pressure on young mothers to appear responsible can be intensified by a fear of CAS involvement. The young mothers that I interviewed all had custody of their baby at the time of our interview and none of them disclosed any experiences with CAS. It is unlikely that this was a coincidence; I assume that mothers whose babies had been apprehended by CAS would be less likely to respond to my call for participants because it would be emotionally challenging to discuss their pregnancy and birth. However, research indicates that young mothers are often afraid of losing their baby to CAS. Dominelli et al. (2005) conducted focus groups with Canadian child welfare workers and interviews with young mothers and found that young mothers’ fears of losing their baby to CAS are warranted as young mothers’ failure to live up to notions of “good” motherhood invites a “process of scrutiny that is stigmatizing [and] unhelpful” and can result in child apprehension (p.1130). Another study by Rutman, Strega, Callahan, and Dominelli (2002), which also involved focus groups with Canadian child protection workers, found that social workers tend to reflect prevailing middle class values, including norms about good and bad parenting and, of particular relevance to this discussion, the belief that adolescent pregnancy is, in and of itself, “bad”. In addition, Rutman et al. (2002) claim that “policy and practice informed by middle class values serves to punish those who are not white and middle class, as evidenced by disproportionate rates of child investigation and removal” (p.158). Dominelli et al. (2005) found that some young mothers feel that social workers and/or child protection workers
have even directly conveyed to them their belief that young mothers are not good mothers in order to encourage them to give up their babies. And according to Rutman et al. (2002) young mothers who were raised in CAS care are particularly vulnerable to stigma and bias as a result of their “age, class, race and family history... this stigmatization segues into systematic and often relentless scrutiny and surveillance” (p.158).

When examining young women’s experiences of social exclusion, Sanders and Munford (2007) found exclusion to be a product (at least initially) of the excluding actions of others: social institutions and individuals with power. When exclusion occurs across the major domains of a young woman’s life then this view can become “the dominant one and, through processes of mutual reinforcement” their behaviours and actions can come to reflect this dominant view of them as unacceptable (Sanders & Munford, 2007, p.191). I would suggest it is possible that young mothers’ experiences with societal stigma can foster behaviours and actions on the part of young mothers that reflect the sense of exclusion they may feel. I would conclude that experiences of feeling stigmatized and/or under surveillance may act as a barrier for some young mothers in forming trusting relationships with, and receiving adequate information from, healthcare and social service professionals.

Several of the young mothers and doulas that I interviewed indicated that young mothers tend to receive a lot of information about pregnancy and birth from the media and/or from their peers. These information sources are not always reliable. For example, Catherine, a young mother, shared that she was surprised that during her own birth she had not screamed; instead, her doula had coached her to breathe through her contractions. She said that “on TV, you see them screaming away” which had indicated to her, prior to
her own birth, that screaming was an inevitability. Similarly, while living at a residence for young mothers during the later part of her pregnancy, Amy got a lot of her information about birth from other young moms at the residence who had just had their babies: “It [birth] [was] different from what I was expecting... all the girls were telling me their stories of giving birth and I was so scared... all of their stories were of excruciating pain, it was all bad stories.” After Amy’s own birth experience she asked herself “is that all?” as she had been expecting worse.

Marisa, a doula, offers her perspective (which is limited, given that she is not a young mother herself) on why young mothers might be more likely to access information from sources like the media and/or peers. She said that she thinks that older women are less apt to use such sources because they have the wherewithal to ask the questions and expect... appropriate answers.... [they’re] able to get the answers from appropriate resources... not just [a] girlfriend but from doctors and books and pharmacists, things like that, whereas when you’re younger... a teenager, you’re more apt to ask your girlfriend who may or may not have had children before or someone online... where information isn’t necessarily accurate and reliable.

I see the lack of “wherewithal” that Marisa refers to as possibly due, in part, to the felt discrimination that participants reported young mothers can experience. Felt discrimination may create anxiety, put young mothers “on guard”, and diminish their capacity to form trusting relationships with healthcare professionals. The dynamic that results might then hold some young mothers back from asking all of the questions they would like to ask, or from asking for help, which creates a barrier to their accessing adequate healthcare information and support.

Power dynamics may contribute to hindering communication between medical personnel and young mothers in healthcare settings. Regarding communication between
young women and healthcare providers, Dougherty (1999) reports that some studies have found that adolescent women want to discuss issues more than their healthcare providers do and others find the opposite, but most have reported unsatisfactory communication between providers and adolescent patients. Adolescents and their care providers often have different perceptions of what should be discussed during a healthcare visit (Dougherty, 1999). Fears that confidentiality will be breached appear to hold some young women back from discussing particular issues (e.g., feelings of depression, sexually transmitted infections) with healthcare providers (Dougherty, 1999) which, I would suggest, points to the importance of healthcare professionals fostering trusting relationships with young mothers. Adamson, Ben-Shlomo, Chaturvedi and Donovan (2003) examined the relationship between access to health care and ethnicity, socio-economic position and gender (in the UK) because of evidence that patients of ethnic minority descent, in lower socio-economic positions or women are less likely than white people, middle and upper class people, or men, respectively, to access secondary and tertiary medical care. These researchers found that patients were attempting to access healthcare services and that barriers to adequate healthcare must therefore be occurring at the level of healthcare provision; they also point to "communication problems between doctors and patients" as a potential barrier (p.903).

The limited availability and accessibility of teen-specific settings may serve as another barrier to young mothers receiving adequate information from healthcare professionals. One of the study’s participants, Catherine, lived too far from the Vanier neighbourhood where the teen-specific prenatal education class in Ottawa is offered and so she attended a class for the general public. When asked how she found the class she
said “Good, except I was the only single mother there.” Catherine continued to attend the class but I suspect that some young mothers may be deterred from accessing general community programs and information for fear of being the only young mother or, if single, the only single mother there. In addition, I would suggest that teen-specific settings can invite the use of more casual language, which some young mothers may feel more comfortable using when asking questions about pregnancy, birth and their bodies. The young mothers that I interviewed often used casual language when describing their experiences during pregnancy and birth. For example, Natasha describes the tears she experienced during delivery: “Most girls if they rip they rip between the butt... I didn’t tear there. I tore up by my clit.” I suspect that the use of more casual language by other attendees of teen-specific programs may increase the comfort level of some young women in asking questions.

Research indicates that there is a sense of inclusion that young mothers often feel in a teen-specific program or healthcare setting that can help to increase their access to information. As was discussed in Chapter Two, teen-specific antenatal care results in improved obstetric outcomes. Quinlivan and Evans (2004) determined that teenage pregnancy clinic patients were significantly less likely to present with threatened preterm labour, prelabour, prolonged rupture of membranes or deliver preterm compared with those from general clinics. Bensussen-Walls and Saewyc (2001) draw a connection between the physical spaces in the maternal healthcare system and contrast it to the spaces in teen-specific care. They explain that the presence of younger women in the waiting room can make a teen patient feel more comfortable, and, secondly, that posters and pamphlets that picture adolescent women instead of adult women can increase the
accessibility of the information that is provided (Bensussen-Walls & Saewyc, 2001). To my knowledge, existing research on teen-specific prenatal care has not explored the use of casual language in such settings. I would add that the use of casual language may also be a factor in making young mothers more comfortable and in increasing their access to information.

I see the Birth Companion Program as providing a community-based service that is, to some extent, teen-specific. Doulas with the Birth Companion Program regularly work with young mothers, and program volunteers are required to undergo training specific to working with young mothers. In addition, I would suggest that the relatively informal and connected relationships that can form between young mothers and their doulas may provide a space that can facilitate an easier sharing of information. I will return to, and elaborate on, the informal and connected nature of these relationships in Chapter Four.

Participant comments indicate that doulas can work with other healthcare professionals to increase young mothers’ access to information. Catherine said about her doula: “If I didn’t have her there I wouldn’t have known what to do. You can only read so many books. And with the birth companion at least you’ll know someone in the room other than ‘hey I’m your nurse and hey I’m your doctor’”. Catherine seems to indicate that her doula filled a gap in the information that she was able to access and that having her doula also helped to put her at ease in the hospital. Similarly, Amy, a young mother, talked about the information that her doula was able to provide:

They [doulas] know the newest drugs and the newest techniques, anything my mom doesn’t know... [maternal healthcare practices] are different now. [The doula] was very nice. The first couple times we met before giving birth she went through all the drugs that they offered at the hospital and the side effects and what
to do with the breathing and stuff and she gave me a lot of good information about birth.

Comments such as these were made by each of the young mothers that I interviewed and participants who were doulas also identified providing basic information about pregnancy, childbirth, and infant care, as an important part of their role. I would conclude that doulas in this study can work with other healthcare professionals on the childbirth team to enhance the availability of information for young mothers, like those in this study.

**Diminished Control and the Compromising of Informed Choice**

Of the four young mothers who were interviewed, all had given birth at an Ottawa area hospital. Three were attended by an obstetrician and one by a midwife. Some striking contrasts were evident in the way that the midwifery birth and obstetrical births were narrated by these women. Natasha, who was attended by a midwife, used language like “offered me” and “I declined” when referring to a decision to not receive stitching for tears incurred during delivery. Her language seems to demonstrate a positive sense of her own agency. This is an excerpt from Natasha’s birth story:

Then we went back to the hospital and they showed me... my room and my staff and stuff and I needed to pee so I went into the bathroom and I peed like fully clothed, we’d just gotten to the hospital and I went pee and then I opened my door and I was completely naked, like buck naked, and I opened the doors wide open and my birth companion, and my midwife just stopped and looked at me and one of them asked, “Do you want to get back in the Jacuzzi?” and I was like, “Yeah, I do”. We were walking, she was completely dressed, boots and everything, and me buck naked going, “Which way to the Jacuzzi?” It was hilarious.

Natasha expresses a sense of ownership over the space and her birth experience when referring to “my room and my staff”.

In contrast, the rest of the mothers spoke about feeling as though decisions were pushed on them or described their birth experiences without discussing choice at all. Regarding a discussion about medication for postpartum depression, Jennifer describes medical personnel as “pushy”:

...they thought that because I have mild depression that I’m automatically going to get postpartum, or whatever it is called. I think there are some people that might not get it even though they’ve had depression and people that don’t have depression that get it. Like, I wasn’t on my medication at that time so they kind-of wanted me to go back on my medication. They said “oh it’s not that strong, you might still have to be hospitalized”, or this or that, they were just like, really pushy and I felt like they were telling me, that “oh if you don’t get on some medication you’re going to get this and you’ll most likely get it and need some stronger medication...” I was like, “well how do you know that I’m going to get this?”

Jennifer implies that “some people” are exceptions to what statistical likelihoods indicate may occur. Her comment “I think there are some people that might not get it even though they’ve had depression” suggests to me that she wants to be seen as an individual, to be seen as having a unique situation, and not necessarily reflecting a statistical likelihood. She implies that currently experiencing depression does not mean that she will develop postpartum depression. She tests the staff’s reading of her situation by saying “...how do you know that I’m going to get this?” She seems to be challenging the staff because she does not assume they are correct, yet she also clearly expresses that she felt pushed. Jennifer does not indicate whether or not she discussed this issue with her doula; yet it is possible that relationship-based support could have provided an alternate avenue for Jennifer to feel affirmed in being seen as an individual.

In the following excerpts Catherine also describes medical staff as “pushy” regarding pain medication:
Catherine: ...they were pretty much like, yeah, “you want the epidural, you want the epidural... you need your rest, you need the epidural”. They pushed the epidural like a lot...
Heather: What did you say when they were pushing?
Catherine: Well I didn’t really want it but then my mom... they figured [not having the epidural] would be a bad choice for me. They gave me Demerol just to like, it takes the edge off, but it’s not going to help that much. Like you’ll need to rest and you’ll need to save energy to push and if you don’t have the epidural then you’ll be really tired and your labour is not going to go as well.

Heather: What were the hard parts [of childbirth] and what were the easy parts?
Catherine: The long wait. That and I didn’t like needles. I didn’t want the epidural. I didn’t want to get an IV in me.

Here, Catherine conveys that there was a sense of choice around whether or not to get the epidural but she indicates that the choice was up to her mom and the medical personnel at her birth (e.g., “they figured [not having the epidural] would be a bad choice for me”). Catherine does not explicitly indicate whether or not she includes her doula amongst the “they” who were pushing the epidural. Catherine’s description of the extent to which the attendants at her birth (both medical and personal) pushed the epidural indicates that she resisted the “pushing” and did not comply right away. Yet, the way that she narrates the choice to have an epidural indicates that she saw the medical personnel and her mother as having the bulk of the control.

As was discussed in Chapter Two, critique of the medical management of labour and delivery has been prominent in the alternative birth, midwifery and women’s health movements. Many critics argue that the medicalization of childbirth has (re)constructed labour and delivery as hazardous and has resulted in unnecessary interventions during childbirth (Fox & Worts, 1999). Fox and Worts (1999) argue that the medical management of birth can disempower, and decrease the control of, the birthing woman, fail to improve the physical and emotional outcome of the birth, “and even alienate the
Simonds (2002) argues that it is in large part the conceptualization of time in medical discourse which affects a woman's experience of control during her birth. She argues that the medical discourse and system is "obsessively time-focussed" whereas woman-centered discourse focuses on women active in time, rather than against it (p.559). She claims that by institutionalizing rigid time standards (e.g., for labour progress) the medical system uses fear of the potential for danger to exercise power over women's experiences of control. She further argues that there have been a wide range of improvements in the medical management of birth due to feminist and consumer activism but contends that the "ideology of medicine" remains patriarchal, technocentric, and interventionist and that none of the changes that have been made have altered the "fact of masculinist medical authority" (Simonds, 2002, p.561).

It is possible to be critical of such elements of medicalized childbirth without positioning "the medical system" as diametrically opposed to "women's needs and interests". For example, obstetricians do not always subscribe to masculinist ideology and midwives do not always represent a rejection of this ideology (Simonds, 2002). I would suggest that elements of medicalized childbirth or an "ideology of medicine", to use Simonds (2002) language, has set a stage where the politics of choice and decision making during childbirth play out. Women's needs and interests during childbirth are constructed and articulated in a broader cultural context that places great value on medical technology. As a result, many other factors that may influence a woman's choices and her sense of control during childbirth can also be traced back to, and/or are interconnected with, an ideology of medicine. To illustrate this idea, I would suggest that
the views of family members and personal support people are significantly influenced by an ideology of medicine and that their views, in turn, can be a factor in women’s decision making during childbirth.

The issue of personal support people influencing a woman’s choices during childbirth surfaced in the stories of the participants in this study. This excerpt is from David, Amy’s partner:

The whole time I was like baby, come on, just take the epidural, even before the pain got really bad ‘cause I was like, I don’t want to see you in that much pain, I couldn’t stomach it. I would come over and say would you please take it. She was like, I don’t want it, I don’t want it and then finally she broke down and said I want it which just relieved me ‘cause we had people in the room next to us screaming and stuff, all you could hear was screaming, and she didn’t even groan or moan or anything... she was just contained.

David indicates that he wanted Amy to have an epidural because he did not want to see Amy in that much pain, that “[he] couldn’t stomach it”. I think that it can be difficult for personal support people to watch those they love in pain and this difficulty can be compounded by not necessarily having an understanding of the birth process and the nature of labour pain. What stands out to me in David’s excerpt is that he is aware that having an epidural is not what Amy wanted (i.e., “she broke down”) but that he continued to push her to have one. Family members and personal support people can often influence women in labour to make the choices that they see as “good choices”. Although well intentioned, this influence can greatly affect a woman’s own sense of choice and control during labour.

Earlier in Amy’s interview, she said that she knew that her doula was “against” the epidural because she had given a “long speech on the side effects of the epidural”. I asked Amy about this:
Heather: It’s interesting for me to hear you say that you knew that she [the doula] wanted you to do things a certain way.... Did you feel a pressure to?
Amy: No because I told her [the doula] that I wanted the least drugs as possible.
Heather: So that was something you said was important to you.
Amy: She was like, okay...she wanted to respect my wishes, so she was like there are signals we can work on and if you give me that signal I’m going to ask you to repeat it twice so that you are really sure of what you are doing.... well I was like what if I’m in labour and I don’t remember what the signal was? And she was like ask me once then wait five minutes and then if you ask me again I’ll go get the doctors....
David (Amy’s partner): I think that was definitely smart on her behalf because I would never have thought of something like that. I keep thinking well if I was by myself I don’t know what I would have done ‘cause she would have said I want the epidural now and I would have been like okay, I don’t know how to talk to you about this. I’m so glad she was there.
Amy: Yeah...she made me feel so relaxed that I actually had the chance to experience natural childbirth before the epidural so I had a long time to know what it was like.

I think that the labour support Amy received from her doula may have helped her to navigate the pressure she received from her partner to have the epidural. While Amy says that she perceived her doula to be “against” epidurals, Amy also conveys that she felt her doula established the communication plan because “she [the doula] wanted to respect my [Amy’s] wishes”. I have already argued that the broader maternal healthcare system tends to medically manage birth in a way that can decrease the control of the birthing woman (Fox and Worts, 1999). In this setting, regardless of whether a woman’s birth plan involves a high degree of intervention or a low degree of intervention it is important to elicit her views and support her choices. In Amy’s case, I suspect that Amy’s doula likely defines birth as “natural” and that her own views may have aligned well with Amy’s desire to have “the least drugs as possible”. Conversely, it may have been more challenging for her doula to provide respectful support to Amy had her birth plan involved a high degree of intervention.
Jennifer wanted more interventions and she narrates this aspect of her birth story in this way:

They told me to push and I was demanding a c-section...they told me to push and I wanted more pain medication...they told me I had to push it out that I wouldn’t be able to push it out unless (inaudible) and so finally going through some painful contractions they gave me more pain medication and then they told me that the vacuum would help to get her out and I kept saying cesarean and they kept trying to talk me out of it and tell me why. And then the head doctor came in and told me the vacuum would probably help with this.... I got help and with three pushes she was out.

Jennifer’s narrative may speak to her sense of who held the control in the delivery room. Jennifer is assertive in “demanding” a c-section. She positions herself in opposition to her care providers (likely including her doula); “they” are not narrated in a supportive way but are described instead as telling her what is going to happen (e.g., “they told me that the vacuum would help to get her out and I kept saying cesarean”). Her reference to the “head doctor” coming in also speaks to her awareness of the medical hierarchy in the room, implying that the “head doctor’s” position is superior to hers because s/he gets the last word. Some of Jennifer’s additional comments suggest that she sees her doula as a supportive member of the childbirth team. Earlier in our interview Jennifer said: “I was really nervous and scared but my birth companion made me realize that I can” and “she was with me at times like at the hospital with the nurse...actually when she was and they knew I had her help they weren’t on my back as much, they kind-of saw, like you know, she has this help and she seems good and stuff”. When speaking about her doula at these times she seems to emphasize her own capability (i.e., “I can”, “she seems good”). She also seems to suggest that her doula’s presence sometimes acted as a buffer between herself and her nurses; this echoes her earlier positioning of herself in opposition to her care providers. At the same time, she seems to acknowledge that the nurses may have
been "on [her] back" out of concern and a desire to help because they were less so when they saw that she had her doula's "help". This differentiation on her part suggests to me that she may have been more receptive to the labour support provided by her doula.

I think that all women who birth at the hospital are affected by hierarchical and interventionist hospital policies and practices to some degree; yet women’s expectations and views on childbirth vary widely and this setting reflects some women’s interests better than others. In addition, I would suggest that a woman’s social location is also a factor in their hospital experience. Some mothers may be shielded from hierarchical and interventionist hospital practices by constructed signs of a “good” mother such as age, whiteness, middle-class status, and marital status. As has been noted, many authors who discuss the medicalization of childbirth focus on a woman’s experience of control during childbirth (Fox & Worts, 1999). Women’s expectations regarding, and experiences of, control are influenced by their varied social locations (Fox & Worts, 1999) and can represent “complex negotiations via the body that are produced by different class and work experiences” (Martin, 1990, p.311). For example, Davis-Floyd (2006) points out that the middle class are used to exercising choices which may predispose them to feeling entitled to a sense of choice and control during childbirth. Furthermore, recall from Chapter Two that, according to Sherwin (1998), systemic discrimination and stereotypes about women who are at risk can undermine their credibility and authority in healthcare contexts. I would conclude that from their social location as young mothers, participants’ birth stories may reveal the ways in which control of their birth experiences can be diminished, and their experience of informed choice can be compromised.
Participants spoke about how doula care can support young mothers in the hospital setting. Anne, a doula, explains how she sees her role:

I think for someone to come in that’s really neutral and doesn’t have their own opinion on whether they should give the baby up for adoption or whether they should have aborted the baby and is just concerned with the woman and her interests and getting her connected with the right programs and just being there to talk to her and have all her concerns voiced and being able to listen to them and also give her the option, present her with various options for the birth itself so that she doesn’t have to feel disrespected and make sure that her voice is heard in the delivery room.

When asked “What do you think are the basic principles and values of doula care?” Marisa, a doula, said:

Support. I think some of the moms in the program are alone and they don’t have healthy relationships with other individuals that can give them that unbiased support. That unconditional helping hand so to speak that regardless of their situation that there is someone there that really wants the best for them and for that child—no agenda. And for a lot of women at risk, they don’t have that in their life.

Marisa suggests that a doula can be “that unconditional helping hand” for women who may feel alone. And Anne positions the doula as an important support person and advocate, whose role is to help ensure that the woman in labour “doesn’t have to feel disrespected” and “make[s] sure that her voice is heard in the delivery room.” Both Marisa and Anne speak about the importance of remaining “unbiased” and “neutral” when providing such support. Although doulas will inevitably have their own views on a woman’s childbirth choices, these excerpts from Marisa and Anne suggest that doulas try to put boundaries around their views in order to facilitate informed choice and provide support in a less biased way. It is not clear, however, whether or not these attempts are effective. I would suggest that the provision of informed choice is inevitably subjective despite the best efforts of any doula or health care professional to put boundaries around
their biases. Even many subtleties, such as tone of voice, can convey approval or disapproval of the options that are being presented. At the same time, I do think it is possible to minimize the influence of biases. Amy's perception that her doula was "against" epidurals, discussed earlier, indicates that it is not universally the case that doulas are able to put boundaries around and effectively minimize their biases. I agree with Mills and Sprenkle (1995) who explain that a postmodern emphasis on subjectivity necessitates attention to the personal biases and influence that a helper brings into their relationships with clients. I would suggest that doulas' capacity to put boundaries around their biases is important and may warrant further development as a component of the practice in order to enhance their potential to facilitate young mothers' voices being heard.

In this discussion I have drawn from existing research to discuss the ways in which participants' experiences in maternal healthcare can be been influenced by societal stereotypes and stigma surrounding young motherhood. I have also pointed to the related barriers that young mothers may face in communicating with healthcare professionals. I have argued that doula care can enrich maternal healthcare services for young mothers by providing valuable support and additional information. In the next chapter I will expand on the nature of the support that doula care can provide and I will argue that young mothers and their doulas can create relational spaces in the maternal healthcare setting where it may be more possible for birthing women to feel respected, establish trust, and experience greater control over their birth experiences.
Chapter Four: Understanding Doula Care with Young Mothers

In this chapter I will analyze participant experiences with doula care, including the perspectives of both the doulas and the young women who participated in the study. I will explore the ways that participants articulate and understand the support provided by a doula: what motivates the doulas in this study, and the centrality of trust, rapport and connectedness in a doula’s relationship with a birthing woman. Within this connected and trusting relationship it can be possible for a young mother to access strong social support. I will argue that it is in this way that a young mother and her doula can create a relational space within the maternal healthcare setting where it may be more possible for the birthing woman to experience a greater sense of control over her birth experience. I will begin by sharing participant comments on the close connections that can form between young mothers and their doulas and will make use of available research to suggest that relationships that are informal and personal in nature are an effective way of providing social support to young mothers. I will draw on participant descriptions of the impact of doula support to argue that, for the young mothers in this study, empowerment during pregnancy, childbirth and as new mothers can be strengthened by the relationship-based support that doulas can provide.

**Doulas as Encouraging a Positive Birth Experience**

Doulas who participated in this study indicated that they believe that every woman has the right to a positive birth experience, meaning that women are entitled to informed choice and a sense of control in creating the birth experience they want. The doulas reported that this was their primary motivation for doing doula work; namely,
providing support and empowering women to help ensure positive birthing experiences. Sonya states: “I believe that... every woman should have the right to have that [doula] support there”. Anne echoes this idea: “Every woman deserves to have a good birth story and deserves to have healthy children in this century, to get off to the best start possible”.

This excerpt from Anne is rich, as she speaks to the interconnections between access to information, respect, choice, and support:

Heather: What makes doula care what it is? 
Anne: I think it’s respecting the person that you’re dealing with, it’s their birth, finding out in a very respectful way what they want, finding out where they’re at in life, what has brought them to this pregnancy? What do they want for this pregnancy? How do they feel about this pregnancy? So you are really tapping into them and it’s all about them, it’s not about you and your birth and your experiences and your feelings about epidurals or anything like that. You try to give them very objective information and try to find out what they want and make sure they have the proper decisions. And at the end of the day it’s about respecting them and being there to help them and making sure they have the best birth possible. Give them a sense of confidence that they can mother well and to make sure they have the resources so if they have any questions or concerns they know there are people there to help them and they don’t have to do this all by themselves. It’s about respecting the person and their experience and what they are going through and trying to help them in any way you can.

Anne speaks to several components of doula support that many participants described in their interviews and which are discussed throughout this chapter: respect for the birthing woman, a woman’s sense of ownership of her birth experience, and a woman’s sense of control over her birth. This particular excerpt from Anne resonates with me because she underlines the importance of viewing a woman’s birth experience in the broader context of her life (i.e., “what has brought them to this pregnancy?”). Anne also acknowledges the importance of restricting bias (i.e., “you try to give them very objective information”) yet uses the phrase “proper decisions” which seems to imply some sense of “right” versus “wrong” decisions. At the same time she describes the importance of “really tapping
into” the needs of a birthing woman and setting one’s own experiences and biases (e.g., “your feelings about epidurals”) aside. Anne also seems to acknowledge the arguably inevitable influence of biases by saying that “you try to give them very objective information”. In addition, it also stands out to me that Anne makes room for her matches to discuss a range of feelings about their pregnancy (i.e., How do they feel about this pregnancy?). Societal notions about “good” mothers often constrain women from exploring a wide range of feelings about motherhood as some emotions are considered more acceptable than others (e.g., selflessness and maternal love are “normal” while doubt or fear are “abnormal”) (Wolf, 2003). Yet many young mothers can experience a range of emotions about their pregnancy and talking through their feelings may help them to navigate a pivotal time. Sharpe (2004) links the application of a postmodern feminist framework in healthcare settings to an ethic that encourages reciprocal and open relationships; similarly, I would suggest that relationship-based care may provide a means of affirming the particularity and subjectivity of a mother’s own experience of motherhood.

Fahy and Parratt (2006) have posited a theory that they call “birth territory” which clarifies the connections between the components of doula care that Anne spoke to in the excerpt above: information, respect, choice and support. The birth territory theory predicts that emotional empowerment affects birth outcomes positively while emotional disempowerment affects birth outcomes negatively. Taking a critical post-structural feminist perspective, their central proposition is the idea that “midwifery guardianship” (rather than “midwifery domination”) can create and maintain the ideal birth territory where the birthing woman feels respected, empowered and in control of her birth
experience; in this environment she is more likely to give birth naturally, to be satisfied with the experience, and to adapt with ease in the post-birth period. I would suggest that doulas can help to create the positive sense of birth territory that Fahy and Parratt (2006) describe.

Research by Fox and Worts (1999) lends support to Fahy and Parratt's (2006) birth territory theory. Fox and Worts (1999) investigated the relationship between social support and a woman's experience of control over her childbirth experience. They found that "women's autonomy (i.e., their ability to give birth without 'submitting' to medical control) rests on their access to strong social support; that is, it occurs in a context of "heightened dependency" (p.329). The study involved qualitative interviews with 40 Canadian mothers, all of whom had given birth in a hospital. Fox and Worts (1999) focused their research on features of the immediate context and environment in which women give birth: the types of support given labouring women by hospital staff, the nature and quality of support women received from loved ones regularly and during childbirth, and the prenatal and postnatal services provided by the hospital and the community. Fox and Worts' (1999) findings suggest that a young mother's empowerment during labour and control over her birth experience can be positively impacted by strong social support, which is precisely what a doula can provide. I would argue that the relational space that can form between a young mother and her doula can provide a context of "heightened dependency" (Fox & Worts, 1999) where she may experience a greater sense of control over her birth experiences. It is in this way that I conceptualize the empowerment the mother-doula relationship can provide; that doulas do not empower young mothers and give them control (not that A causes B), but that a young mother's
relationship with her doula can create a relational space where she can experience a
greater sense of empowerment and control (that A can create a space where B is more
possible).

I also conceptualize the creation of relational space in maternal healthcare as
being possible in various relationship configurations (e.g., mother-partner, mother-health
professional etc.) yet I see particular opportunities and strengths for relational space in
doula support with young mothers. I would argue that the continuous woman-centered
support provided by a doula, and the relationship-based way in which such support is
provided, may be of particular benefit with young mothers. As was discussed in Chapter
Two, for example, women who are young, single, and of low socio-economic status, are
less likely to attend childbirth education classes and generally have poor social supports;
as a result, they may have more anxiety in childbirth and may benefit the most from
labour support (Rosen, 2004). It is worth noting that all of the women in Fox and Worts’
(1999) study had partners who also participated in a larger project, of which the study
under discussion was a part, and these couples were recruited through childbirth courses.
I would suggest that the participants in Fox and Worts’ (1999) study may have been more
likely to have access to existing and ongoing social supports, it is possible that their
results underestimate the potential effects of social support for young mothers.

Marisa speaks about the support that a doula provides and she claims that there is
“something that happens” between a woman and a doula:

How do you explain in words how a woman feels after they have had a doula with
them? I think it’s an answer that all doulas struggle to find. People come and ask
me, so what is the benefit of having a doula? How do you put into words that
[in]tangible feeling? It’s a difficult thing, I still struggle explaining the importance
[of doula care]. I mean it’s more than just rubbing your back and telling you that
you are going to be okay and helping you to breathe through the contractions.
There is so much more that goes on in those moments. How do you put that into words? Even the moms afterwards say thank you that support, and I’ve asked them—what was it? There is something that happens, every woman that has that support will tell you something happens, there is a connection. I still have moms, of the 21 moms that I’ve supported that I’m still in contact with, that I’m still involved in their lives. It has changed and grown and all of those things. But I don’t know if you can ever really find the right words to explain the importance of that and what it is—but something, it’s definitely something.

While Marisa speaks of experiencing “a connection” with “every woman”, I would suggest that such connected relationships are possible in mother-doula matches but are not inevitable. The knowledge, skills, values and qualities that a helper brings to a helping relationship may be among the factors that influence the quality and connectedness in a relationship (Trevithick, 2003). What stands out to me in this excerpt is Marisa’s description of “something that happens”; I read this as being about the creation of a relational space where the birthing woman can feel in greater control of her birth experience. I agree with authors (e.g., Howe, 1998; Jordan & Walker, 2004; Sudbery, 2002) who conceptualize the relationship in social work and helping professions as providing a medium for clients to ameliorate their own problems and facilitate their own growth. Yet Marisa implies that the “definitely something” that happens is about more than connection in relationship. The work of Bergum and Dossetor (2005), on ethical or relational space, enhances the ways in which other authors have understood the importance of connection and relationships. These authors conceptualize the space in between two persons in relationship as a third entity and claim that it is in this space that greater ethical responsiveness and responsibility becomes more possible. I would suggest that connectedness is valuable in and of itself but that it is particularly significant because it can facilitate the creation of a relational space.
Most of the doula participants said that they are motivated to create positive birth experiences for other women because of their own personal experiences with birth. I would suggest that this motivation could have positive effects on a doula’s care (e.g., help to foster and convey empathy) yet at the same time it may also present dangers (e.g., a doula’s transference of her own emotions and issues around her own experience). Of the doulas that I interviewed, two had given birth to their own children and two were planning to have children in the near future. When asked what motivates Marisa, a doula, to volunteer for the Birth Companion Program, she responded in this way:

My own experience with the birth of my daughter. Although I had really adequate support and all of that I realized at the time that what I was really wanting was the support that was provided by a doula. And ten years ago I would not have known what that even meant—I had never even heard that word or known that that care was available out there. But I knew after the birth of my daughter that there had to be more... additional support. After her birth I did some research and came across doulas.

Similarly, Christine, a doula, shared the following:

I had two children and my first birth experience was really bad and my second birth experience was very good but that was no fault of the hospital, they, in those days it was not very patient-friendly, it certainly wasn’t very mother friendly... I still feel that pain in my heart remembering how sad.... So my first motivation is I want the mother to have a really good birth experience and that is my focus... it’s about the birth experience... [so that] anybody that is under my care as a doula doesn’t have to suffer what I did but that was many years ago. So that’s probably what motivates me.

Sonya, a doula who does not yet have children, connected her desire to have children to her motivation to do birth work and her passion for the “whole idea of it”:

I’m a woman at an age where I’m hoping to have children in the near future. It [birth] interests me.... As I did the [Birth Companion Program] training I realized how much more there is to it than I ever thought in my life. And once I started being at births, being there, seeing it, I just loved the whole idea of it.
These excerpts from three doulas, at a range of ages and life stages, illustrate a common link: that their motivation to do doula work is tied to their own personal experiences with birth. In contrast, in the excerpt that opened this chapter, Anne stated that doula support is *not* about a doula’s own experience with birth (i.e., “it’s all about them [the mother], it’s not about you and your birth and your experiences”). I would suggest that, as is the case in many helping relationships, there is a tension here between drawing on one’s personal experience as a “helper” in a relationship and holding the experience of the individual who is being “helped” at the center of the relationship. Rather than thinking of the “helper” as *either* distinct *or* merged, I agree with Jordan (1991) who claims that in practice “clear boundaries and appreciation of differentness… can exist alongside … self and other overlap” (p.72). Many authors on feminist therapy (e.g., Brown, 1994; Costigan, 2004; Jordan, 1991) hold the view that when a therapist (or “helper”) expresses her/his own experiences and is as genuine as possible that this can foster a more egalitarian relationship. At the same time, many feminist therapists exercise caution around making overgeneralizations about their gendered experiences as women to the experiences of other women clients, who may differ in terms of race, class, sexual orientation, and age, as well as in terms of needs, skills, and resources. I would conclude that some doulas may be drawn to the work by their own experiences with birth and that focusing on the particularity of their clients’ own experiences is both possible and also necessary to the work. I will return to the issue of boundaries in relationship-based work later in this chapter.
Several of the comments from doulas, on the nature of the social support they provide, reflect a broader cultural narrative on empowerment that purports that qualities like courage can be given from one person to another. For example, Sonya states:

It’s great to have someone there to give them [women who are at risk] that courage and support so they’re able to give their wants and needs in such a special time, in the birth of their child which is an event that is going to affect them the rest of their lives, and their children’s [lives].

Another doula, Christine, said:

I feel that parenthood is the most important job in the world.... I’m honoured to be a part of that for some of the lives that are coming into the world. I may have given some young mother the courage to go on.... I’m making a small difference in the world to help a very vulnerable population.

This narrative of “giving courage” does not often consider the power dynamics at play between the giver and the receiver and does not make much room for acknowledging the constraints that oppressive dynamics can put on one’s capacity to exercise their own courage. Margolin (1997) suggests that the “rhetoric of empowerment” can provide a discourse for the “helper” to “claim the moral imprimatur of client self-determination, continuously describing their interventions as ‘empowering’, but retain their prerogative to plan and strategize, direct and control” (p.122). Viewing doula support as creating relational space may more accurately describe and acknowledge the ways in which young mothers resist the stereotyping and stigma they can experience and exercise their own courage in their birth experiences; I would suggest that this may be a more accurate and supportive way for doulas to speak about their work.

In the excerpt from Sonya, above, she also describes doula care as impacting “an event [childbirth] that is going to affect them [women who are at risk] the rest of their lives, and their children’s [lives]”. Sonya seems to suggest that doula care may have lasting impacts. Breedlove (2005) attributes the effectiveness of doula care with young
mothers, in part, to the modeling of a caring relationship within which they can learn about caring for their infants. Although a young mother’s relationship with her doula is time-limited, the modeling of a caring relationship is occurring at what is a critical time in her life and some effects may be long lasting. This may also be reflected in the responses of the young mothers in this study to the question “On a scale of 1-10 with 10 being ‘I am just bursting with love’ and 1 being 'I have no positive feelings towards my baby at all', where do you think you are?’; all of the young mothers responded with an eight or above. This finding, although quite limited, is consistent with those of Zhang et al. (1996); as discussed in Chapter Two, these authors reviewed studies that had been conducted among young, low-income, first-time mothers and found that doula-supported mothers experience greater mother-infant attachment, among other benefits.

Many of the doulas who participated in this study expressed confidence in their ability to contribute to creating positive birth experiences.

Christine: I guess it seems all but self evident but I will say I certainly feel that I have been sometimes able to provide enough support so that the young mother didn’t end up with a caesarean, provide enough support so that the young mother may have been able to get breastfeeding more established, and then provide enough support so that even emotionally they were more prepared for the birth.

Christine articulates birth outcomes in a rather dichotomous way, suggesting that the support that she provides is intended to achieve particular outcomes which appear to reflect her own values. While research has indicated that vaginal birth (Klaus et al., 2002) and breastfeeding (Health Canada, 2000) can support maternal and infant health, it is not clear that these outcomes also reflect all of Christine’s matches’ values or their own definitions of and expectations for their childbirth experiences. At the same time, Christine indicates that she thinks doula care can make a concrete difference in obstetric
outcomes and enrich young mothers' birth experiences. She seems to convey a belief in
the positive impacts that support and empowerment can have on young mothers while
acknowledging that doula support is limited in its impact (e.g., "sometimes able to
provide enough support..."; "more prepared...").

Anne also speaks about the ways in which a doula's support can be mediated by
factors that are outside of her control:

With the teens you don't always get the thank-yous... but you can tell they do it
in their own little way... you know your time has been appreciated and you've
connected them with resources and everything won't be perfect but [things] are
better than if you hadn't been there and... you know that you've done the best
you can and they know you were there and they didn't have to give birth alone
and that's a good thing.

Anne states that "everything won't be perfect"; she suggests that she is confident that her
presence has made a difference (i.e., "things are better than if you hadn't been there") but
she acknowledges that a doula's support has a limited impact. Anne conveys the
awareness that she cannot create a positive birth experience for every woman that she is
supporting, but rather that by having an impact during a pivotal time she may make it
more possible for a young mother to have a positive birth experience.

Trust and Connectedness in Young Mothers' Relationships with their Doulas

Participants reported close, connected and trusting relationships between doulas
and young mothers. The definitions of close, connected and trusting varied but included
notions of emotional involvement, feeling understood and respected, being able to rely on
someone, and being able to speak openly about personal experiences and challenges. In
this discussion, I use the terms closeness and connectedness in related and overlapping
ways. Closeness refers to the intimacy in a relationship and connectedness refers to one's
personal investment and engagement in a relationship. It is evident in many participant comments that young mothers were more likely to describe their relationships with doulas as “close”; whereas, the doulas tended to describe their relationships with young mothers in ways that demonstrated that they felt “connected”. This may be because doulas are likely to consider themselves helpers in what are informal but semi-professional relationships which would arguably affect the way that they narrate these relationships and the boundaries that they establish within them.

In this sense, doulas can be presented with challenges around maintaining boundaries within the connected relationships that often form between young mothers and their doulas. The challenges that these connected relationships present are also linked to the benefits they bring. I see the connected nature of these relationships as important to the effectiveness of community-based doula care with young mothers. I think relationship boundaries can be more complicated in community-based doula care relationships than in fee-for-service doula care relationships because, for one, these relationships are “helping” relationships and involve broader social support that extends beyond labour and delivery and, secondly, there is no payment exchanged. Some doula participants spoke about their efforts to maintain relationship boundaries with their matches. Christine said:

I can only do so much... I really have to set limits, otherwise, I wouldn’t be able to do this work... I can do what I can, hope that people’s lives are touched, that they’re a little bit stronger and then go on to somebody else. If I had to stay with everyone I was referred to I’d never be able to take on new cases.

Christine seems to hold the view that boundaries are not only beneficial but also necessary as not having “limits” would prevent her from being able to “do this work”.

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31 Although these volunteers are not staff, during volunteer training they are encouraged to consider themselves representatives of the Birth Companion Program (Birth Companion Program Coordinators, personal communication, January 2005).
Interestingly, while at other points in our interview she referred to “matches”, here, when discussing boundaries, she refers to “cases”. Christine has an educational background and many years of work experience in a helping profession and may be drawing on a particular understanding and way of talking about boundaries that has developed in part through her professional work.

I see boundaries and engagement as both necessary to providing relationship-based support. Boundaries are not a matter of separating “the relationship” from “the work”; rather, as noted earlier, the relationship can be understood as the medium for the work (Sudbery, 2002). I think it is possible for relationships to be engaged, connected and supportive while at the same time being limited in the degree to which they are all of these things. I see such limits as not only possible, but necessary, in a doula’s relationship with a client. For example, doulas may need to contact CAS with concerns regarding a match’s capacity to parent and a relationship without boundary definition would make it more difficult to make such a decision. Sudbery (2002) speaks to the tension between boundaries and connectedness in this way: “The ability to do what is right in the social work role requires the ability to enter into... subjective experiences whilst thinking, making judgments and behaving appropriately in the more objective world of outside reality and organisational procedures” (p.155). While Christine’s comment provides some insight into her own view on boundaries, I do not think there is evidence in the data to suggest that doula participants share a particular conceptualization of boundaries in their relationships with their matches. The differences which emerged in how doula participants narrate their relationships with their matches (as connected) as compared to how young mothers narrate these relationships (as close) may indicate a lack of
communication between doulas and matches regarding boundaries and/or a blurring of boundaries. I would suggest that this may be an element of the practice that could benefit from further attention and development.

Natasha, a young mother, spoke about having a particularly close connection with her birth companion:

We instantly clicked 'cause we’re both open bubble type personalities, so we clicked well.... she was there—open—just being a support. She even drove me home from the hospital, her, her husband and her son with me, my boyfriend and my son.

She also later says of her doula “[we] were pretty close”. And this second excerpt from Natasha is a particularly compelling example of the impact that her doula had on another young mother who Natasha knew from her workplace:

There was another girl that worked with me and her name was [Amanda] and she [my birth companion, Claire] delivered [Amanda’s] baby a month, a month and a half maybe before mine, well she didn’t deliver, she was there. And then [Amanda] got pregnant again and now she has a new daughter and she [Claire] was there for her birth, and [Amanda] even gave her [Claire’s] name, as a middle name.... Yeah, she named her daughter Sarah Claire and I asked, why Claire? I was confused and she was like well she did help me bring both my children into the world and I was like, good point!

This young mother gave her daughter her birth companion’s name as a middle name; a gesture that seems to illustrate the significance of the relationship.

Preliminary research on doula care suggests that connectedness in young mothers’ relationships with their doulas may be central to doula care’s capacity to provide strong social support. Breedlove (2005) found that young mothers appreciate the emotional aspect of doula support and differentiate it from other types of assistance. And Abramson et al. (2006) see young mothers’ trusting and connected relationships with their doulas as
foundational to the success of the Chicago Doula program; in this program community-based doulas are engaged in one-to-one relationships throughout pregnancy and over an extended period of time. The [community-based doula] model extends the intensive intimate support during birth into a long-time trusting supportive relationship with a pregnant woman and her family, which encourages strong connections and ultimately helps to build a nurturing environment for the newborn. The model makes the best use of the powerful time around birth to engage underserved families in an ongoing framework of support that optimizes outcomes for the mother and baby (p.18).

Abramson et al. (2006) also identify the negotiation and maintenance of boundaries as a challenge in these long-time trusting and supportive relationships; they suggest that regular supervision meetings can help doulas to address this challenge.

The connectedness in these one-to-one relationships was also felt by doulas who participated in this study. Marisa shared that one of her matches had immigrated to Canada from Somalia well into her pregnancy and had been “filled with fear and depression” when she first arrived, “new country, new everything, on her own, expecting”. Marisa continues:

She has gone back to school, she has awesome marks. She’s going to have her own apartment soon…. I’ve had a second hand store donate clothes to her. So she has been able to get clothes without it being a cost on her. I’m proud of her…. I’d like to see her write her story because she has overcome so many fears…. she’s accessing all of the resources and she has such drive, such drive… being able to support her and be a part of that is awesome.

The sincerity of Marisa’s connection to her match was quite evident during our interview as Marisa became teary and emotional at this point. She also shared that being a part of the changes that have taken place in her match’s life is what motivates her to continue to volunteer for the Birth Companion Program. This excerpt from Marisa and her demonstration of emotion highlight several important issues. First, Marisa suggests that
there are notable benefits of these connections for the doulas who participated in this study as well. I think that many of the connections between young mothers and their doulas are based on what feminist therapists Miller and Stiver (1997) call “mutual engagement and empathy” which they define as “a joining together based on the authentic thoughts and feelings of all the participants in a relationship” (p.29). Miller and Stiver (1997) discuss how feeling that one is having a positive impact on someone can make one feel empowered and worthy.

Secondly, and at the same time, doulas’ connections to young mothers are likely complicated by power dynamics common to helping relationships. A helper may narrate and conceive of the support they provide in a heroic way where they are constructed as “saving” those who they are helping. Marisa expresses admiration for her match and her own emotion about being a part of the changes in her match’s life (e.g., “she has overcome so many fears.... being able to support her and be a part of that is awesome”). Margolin (1997) suggests that social workers’\textsuperscript{32} approach to practice is characterized by tension between two agendas; the first, to help others and generally do “good”, and the second, to impose society’s values on those who they are helping. Margolin (1997) applies a critical lens to helpers’ awe for those they are helping, arguing that the helping relationship can form a “frenzy of benevolence”, where “the difference between patronizing and sympathizing... becomes nondefinable” (p.61). Earlier, I commented on Marisa’s emotion as “sincere”; Margolin (1997) encourages critical reflection on “sincerity”, suggesting that it can often be substituted for self-awareness of the power dynamics at play in a helping relationship. I would conclude that helping relationships

\textsuperscript{32} Margolin (1997) is not speaking strictly of the profession of social work but is defining social work broadly, as “a type of power, a way of seeing things that traverses every kind of institution or profession” (p.2).
(such as a doula’s relationship with a young mother) can simultaneously empower and disempower and would suggest that they are more apt to do the former if they are subject to inward investigation. Furthermore, I would suggest that encouraging self-awareness of such power dynamics in helping relationships could be further developed as a component of the practice (e.g., discussed in current certification trainings and/or built into future regulated training programs).

Participants also indicated that trust was an important part of the connections that form between young mothers and their doulas. While talking about the benefits of doula care for women who are at risk, Sonya, a doula, said:

...my matches have been very insecure [and] for them to be able to trust in somebody that’s going to help them get where they want, it’s what they need... that extra stuff that they need that I can provide.... I find that being able to listen, for someone to be listening to them instead of telling them what to do, because when you’re a teenager you’re often told what to do and I know that being a teenager that is the last thing you want... so, just to have someone to listen to you and try to do something that you want. I think with teenagers you need to be with them a little bit longer just to get that trust as well. It’s hard for them, I think, for them to trust anybody older and with more power really than them.

Sonya conveys an awareness of societal wide ageism when she says that it can be hard for young mothers to “trust anybody older [who] has more power”. She also describes herself as being able to provide what her matches need, which speaks to the power that she herself holds in relation to her matches (i.e., “my matches have been very insecure [and] for them to be able to trust in somebody...it’s what they need... [and] I can provide”). She suggests that trust can be earned by taking an egalitarian approach of listening rather than providing advice (e.g., “listen... to them instead of telling them what to do”). This idea is reflected in Bergum and Dossetor’s (2005) claim that, in the context of relationship, “the hearer has, with listening, power to enable the speaker to say what
needs to be said; in fact, to enable the speaker to discover what needs to be said” (p.130). Egalitarianism in helping relationships has also been written about extensively by feminist therapists who have sought ways of acknowledging and addressing power dynamics. For instance, Brown (1994) explains that a feminist ethics of practice is tied to both social change and interpersonal relatedness; she claims that the question of power must be addressed in the therapy relationship itself because the therapist (or helper) is “accorded authority, expertise, and wisdom in both real and symbolic ways by clients and by the larger culture” and must seek ways of creating egalitarianism (Brown, 1994, p.52). While Sonya implies that her approach to clients can help to offset the relative lack of power that young mothers hold in society, it is not clear that she has negotiated the power that she herself holds in the helping relationship; she points to listening, rather than giving advice, as one potentially effective means of fostering egalitarianism in relationship.

Sonya later compares the nature of the connection between young mothers and their doulas to a trusted friendship, saying that she thinks that her matches are “looking for some kind of friendship, obviously not a true friend or something, but to be able to [have] honesty, to be able to honestly tell you things and get honest answers”. This quote from Sonya conveys a tension between the close and connected nature of these relationships and the boundaries that are established; she uses “not… true” and “honest” in her description of the same relationship. It is important to note that Sonya is describing these relationships from her perspective as the “helper” in the relationship. It is possible that some young mothers are in fact looking for a “true friend”, which, again, highlights the importance of negotiating the tension between boundaries and engagement in these
connected relationships. Again, I would suggest that it is likely not possible to simply separate the relationship from the work. Abramson, Breedlove and Isaacs (2006) describe community-based doula's relationships with their clients as both personal and professional and explain that it may be the intimacy in the relationship that is responsible for the profound effect of community-based doula support. While such engagement can present challenges, Bergum and Dossetor (2005) suggest that it can bring about a more ethical approach to healthcare; that a re-conceptualization of relationship where the exchange is circular rather than linear can cause patients/clients to be seen more justly as subjects.

Abramson, Breedlove and Isaacs (2006) explain that there are significant “limits [to] what professionals can do to influence... such personal areas of health” (p.17). As a result, a Chicago Health Connection breastfeeding program that preceded the doula program has become peer-based, which Abramson, Breedlove and Isaacs (2006) report is substantially more effective; they credit the success of the program to an awareness that “the messenger is as important as the message and that the advice of a trusted family member, friend, or peer is sometimes much more powerful than information from a nurse, doctor or dietician” (p.18). Research has demonstrated that young women appreciate informal and personal relationships and are most likely to access those they feel close to for support and information. Nelson and Sethi (2005) researched teenage mothers’ experiences with breastfeeding and one of their findings was that teenage mothers viewed health care professionals as important sources of breastfeeding support, but wanted them to be more personal in their approach. In addition, Sarri and Phillips (2004) interviewed young mothers in shelters, community-based agencies and alternative
schools, and one of their findings was that adolescents tended to prefer informal help from friends or mentors, and sometimes from family, depending upon family relationships.

Some of the young women that I interviewed spoke about how easy it was to talk openly with their doulas. Jennifer conveys the sense that her doula was approachable: “I talked to her about how the pregnancy is going, if I had any issues with the pregnancy that I needed to talk about, like if I thought something was wrong or this or that, I could talk to her.” And Natasha also said that she talked openly with her doula: “I opened up to her a lot, she knew a lot of things as opposed to the counselors [at a social service program for young mothers] that I didn’t really know that well.” It may be that the connectedness and trust that can develop between a young mother and her doula provides a supportive relationship space where she can talk about issues of importance to her. Miller and Stiver (1997) explain that people develop a sense of worth when others convey that they recognize and acknowledge their experience. SmithBattle (2000) applies the notion that self grows through connection (Miller and Stiver, 1997) to young mothers and claims that positive recognition by close others can be particularly empowering for young mothers.

Strong social support may be beneficial, but rapport and connection are not always easy to establish. Christine, a doula, talked about some of her program matches with young mothers that had not worked out and had ended prematurely.

The young moms that I’ve been referred to have tended to be the ones that have fallen though, whether it’s my age—maybe they’re looking for a younger doula and they find I’m just too much of a mother figure for them and they already have enough in their life... or things have changed in the family.... I trust that other people are better matches.
Christine's comment that "other people are better matches" suggests that the process of pairing a particular doula with a particular young mother is important. Natasha, a young mother, also speaks briefly about the importance of being "matched properly":

[Doulas] really help. They help with our self-esteem [and] our confidence in birthing. They reassure. They're just great. Well, especially if they are matched properly, they really have to be matched properly because not every personality is going to match but if they are matched properly then it will make a better birthing experience and postpartum and prenatal period.

These comments from Christine and Natasha indicate that young mothers and their doulas will not automatically develop a connected and trusting relationship and that a pair's potential to form a close relationship depends in part on being well matched by the program. As was noted in Chapter Two, community-based doula organizations often try to match clients with doulas who speak the same language and are of the same ethnic background. To my knowledge there has not been any research into the merits or drawbacks of matching young mothers and doulas in any particular way, yet these comments from participants suggest that "proper matching" may help a pair to form close and connected relationships. It is interesting that they both use the word "proper" as this suggests that there might be only one way of matching or one key aspect that should be considered in matching; yet Natasha suggests that "personality" is important, while Christine focuses on the importance of age.

I would suggest that what young mothers are looking for in terms of matching is likely as varied and diverse as young mothers themselves. Research by Rogers et al. (1996) provides evidence that is somewhat contrary to Christine's assumption that her younger matches have "tended to...fall through" because of her age (e.g., "maybe they're looking for a younger doula and they find I'm just too much of a mother figure for..."
The study by Rogers et al. (1996) was designed to evaluate the effectiveness of a social support program on teenage pregnancy outcomes and, interestingly considering Christine’s comment, it was “resource mothers” who were employed to deliver social support services to adolescent mothers through home visiting. The resource mothers formed informal and connected relationships with the young mothers in the program, they provided “expressive (e.g., sharing of friendship, acceptance, understanding), instrumental (e.g., giving of educational information, assistance with transportation) and social support” (Rogers et al., 1996, p.139). Rogers et al. (1996) found that the effects of stress on preterm birth can be modified by the provision of strong social support. Teenagers in the program were less likely to have a preterm birth than those not in the program and one of the conclusions made was that the development of a warm, trusting relationship can be critical in modifying the effect of stress on preterm birth (Rogers et al., 1996).

*The Impact of Social Support*

Participants unanimously shared the view that the support provided by doulas is beneficial for young mothers. The young mothers spoke about how their doulas supported them during pregnancy, labour and birth, and/or during the postpartum period. For Natasha, the nature of the support provided by her doula was at first difficult to articulate:

She drove me to my appointments, which was helpful and, I don’t know..... She did more than drive me I swear! I do appreciate her for more than that! I don’t know, I don’t know, I just found that we bonded really well, everything flew, I don’t know, I don’t remember, because even in the car, driving to places we would just talk about everything.
Talking “about everything” on the way to and from prenatal appointments may have helped to establish the kind of supportive relationship that later benefited Natasha during the postpartum period:

Heather: How do you think that your pregnancy, labour and post partum period would have been different without a birth companion?

Natasha: It would have been different because after I gave birth I found that [partner], his father, became like ‘oh my god I’m a parent’, like he had a reality check and that scared him a little so I was forced to take care of [baby] on my own—he was just hanging out with his friends and acting like a fool. And I think I would have had postpartum depression or something, did I get that word right? I did have supports here, I had friends and stuff... [but] my family moved away, they live in [another city] so I don’t get to see them very much. Yeah, she [birth companion] really helped me stay on track and tell me that everything is going to be alright and eventually [partner] like matured, he’s much better, he’s there you know. It wouldn’t have been that easy, it wasn’t easy but it would have been harder if I didn’t really have anyone to talk to because I opened up to her a lot, she knew a lot of things as opposed to the counselors [at a social service agency] that I didn’t really know that well. She really helped me feel productive. It was good that she was there, very good.

Natasha was able to “open up” to her birth companion who she indicates provided her with valuable support, helping her to “stay on track”. Individualized and ongoing support in the context of close and connected relationships appears to be of value for young mothers. Regarding healthcare provider care, Ginsburg, Menapace and Slap (1997) found that teens identified caring and respectful providers and continuity with the same providers as two of the components most likely to encourage them to seek and continue healthcare (cited in Bensussen-Walls and Saewyc, 2001). SmithBattle (2003) emphasizes the need for individualized support for young mothers and suggests tailoring public health nursing practice to the meanings, context and complexity of teen mothers’ lives. In earlier work, SmithBattle (2000) cites the merits of relationship-based health care practices as a form of individualized support; she reviews research on young motherhood and argues for “strengthening relationship-based health care practices”, suggesting that
engaging young mothers in “respectful relationships [can] validate their struggles, strengths, and aspirations” (p.37). Resilience in adolescents in general has elsewhere been positively associated with social connectedness and support (Resnick et al., 1997, cited in Logsdon et al., 2004) and social support has also been associated with long term positive outcomes for young mothers and their infants (Logsdon et al., 2004).

Broader social support (not directly related to pregnancy and childbirth) such as assistance with housing, relationships, schooling, child support or social assistance was also described by doulas as an important part of community-based doula care. Marisa distinguishes between her paid clients and her Birth Companion Program clients in this way:

A paying individual is typically a couple with two incomes. They’re educated, older—let’s say in their late twenties, late thirties, sometimes their even older than that. They’ve been working in the work force for quite some time and there is education behind them whether it’s college or university... there is education behind them, more than just high school. They are in positive relationships [and] they’ve also lived in this country for many years.... The moms in the program tend to need more encouragement and ideas on how they can eat healthier on a budget and how they can take care of themselves on a budget and the importance of healthy relationships.

Christine talked about how she surveys her matches’ needs and then does “whatever needs to be done”:

I talk to them about their own parenting, about what expectations they have for the birth, about Buns in the Oven and some of those groups. Do they need information about power of attorney? [I] check on their layette. Do they have questions? Do they need information about this? Do they know where the storage cupboard is? Can they get a car seat? Some of them already have children, so helping them problem solve, think through... Have you asked CAS or social services for this? They may not be aware, so you make sure they get all that they are entitled to for services. Plus just being somebody who really really cares and wants to nurture them through a time when we’re all feeling very vulnerable. Are you eating well? Can I get you this? You’re looking tired... you need boots? Doing that kind of stuff, whatever needs to be done—that is what a doula should
do. Again, with the aim of having a good birth, a healthy mother who is eating well, who has got what she needs, and who is feeling grounded for the birth.

Christine clearly indicates that she sees these broader social supports as integral to having a good birth. Breedlove (2005) identified a similar range of supportive care being provided by doulas working with young mothers through a community-based doula program: the provision of prenatal, childbirth, and parenting education, continuous emotional and physical support during labour and birth, and “assistance in defining and establishing pathways to success for a brighter future” (p.18). The young mothers in Breedlove’s (2005) study placed the value of doula support above all other supports, including and despite the availability of social workers, home visitors, childcare, and assistance with basic needs within the same agency as the doula program.

Community-based doula care is unique in the way that it provides continuity of support (i.e., relationship-based social support during pregnancy, labour and delivery, and in the postpartum period). This approach can serve to link supports in the community with supports in the maternal healthcare setting and may help to ensure that young mothers have access to resources that can better facilitate a positive birth experience and adjustment in the postpartum period. Fox and Worts (1999) found that the social support that women receive during pregnancy has the potential to modify the impact of hospital practices that erode women’s control over their birth experiences. Fox and Worts (1999) specify that a woman’s particular “immediate social context... options and resources” (p.329) affect the nature of the constrained choices she is making in the hospital environment; and claim that the type and amount of support that a birthing woman receives during pregnancy, labour and delivery can shape her needs and expectations during childbirth. I would posit that providing broader social supports and a continuity of
support throughout pregnancy, childbirth, and in the postpartum period may in fact have the potential to bring about a more ethical approach to birthing. Bergum and Dossetor (2005) call for a shift of thinking beyond rights, to speaking about ethical commitments by using “a richer language [that] calls for responsibility and responsiveness—a language that remembers that moral responsibility, itself, is the precious human right” (p.36). I see the broader social support that is offered through community-based doula care as integral to encouraging a positive birth experience and to supporting a young mother in a way that is responsive to the larger context of her life.

In this chapter I have drawn from participant comments and existing research to answer a key research question on the particular benefits of doula care for young mothers. Findings discussed in the previous chapter suggest that doula care can enrich maternal healthcare for young mothers and here I have argued that its capacity to do so can be attributed, in large part, to the creation of a relational space between young mothers and their doulas. Within the context of the relationships that can form between young mothers and their doulas it becomes more possible for young mothers to access strong social support and to experience a greater sense of control over their birth experiences. In the next chapter I will turn to participant views on the potential of regulating and publicly funding doula care and will suggest that in proceeding with organizing on this issue measures should be taken to protect the importance of the relationship in doula care with young mothers.
Chapter Five: Advancing and Protecting Doula Care

In this chapter I will bring forth and analyze participant views on the potential for the regulation and public funding of doula care. Participants expressed a desire to integrate doula care into the maternal healthcare system in order to increase the accessibility and availability of doula care. Despite the benefits of this potential move, it seems that participants were apprehensive about regulating and publicly funding doula care largely because of concerns that increased professionalization would compromise doulas' capacity to provide relationship-based care. Participants made the following suggestions that would arguably help to protect the relationship-based nature of doula support: 1) safeguard the doula's position as independent from and external to the hospital system; 2) match women during pregnancy; and, 3) ensure that women retain control over the choice of their doula. I will also discuss participants' views on the potential for change and the need for further public education as it was identified as a means of organizing on this issue.

Increasing the Accessibility and Availability of Doula Care

All of the participants expressed support for the idea of increasing women's accessibility to doula care. Jennifer, a young mother, expressed appreciation for the existence of the Birth Companion Program: “I think it’s [doula care] a really good service and just that they offer this to people because normally doulas are really expensive”. And when discussing the potential of regulating and publicly funding doula care, Jennifer suggests expanding the Birth Companion Program eligibility requirements to help ensure that more women can access doula care:
I think that Gill [Birth Companion Program Coordinator] told me some people are at the cut off, they aren’t considered low-income but they don’t necessarily have a lot of money, and the money they have they need to spend on things like food and clothes and necessities. So they would like a doula but they get told “Well you have all this money so you should be able to afford one”—but then they have all these other expenses so I think they should be able to be allowed to have the service too.

In this comment Jennifer points to a group of women who may have difficulty accessing doula care in Ottawa: those who are not eligible for the Birth Companion Program yet cannot afford a private doula. Participants’ belief in increasing women’s accessibility to doula care may be linked to a broader belief system, about one’s right to have equal access to adequate healthcare, that is arguably an important part of the Canadian political landscape. Universal access to healthcare services was considered one of the five fundamental principles of the Medicare plan when it was first created, meaning that “provincial governments had to ensure medical services were reasonably accessible, were provided on universal terms and conditions and were free of... barriers to access” (Wrede et al., 2001, p.42). Prominent women’s activist Marilyn Waring (1997) has explicitly argued for the extension of women’s human rights to include their embodied experiences of childbearing (cited in Reiger, 2000, p.312). Because doula care has shown to improve obstetric outcomes and because many women who have low-incomes or are living in poverty are not able to afford a doula, the current fee-for-service way in which doula care

33 The Birth Companion Program recently started up Mothercraft Birth Support, an initiative that provides doula services to low and middle income families who would otherwise be unable to afford a doula. The initiative operates as a social enterprise; clients of this program receive doula support according to a sliding scale fee system (i.e., contributing $0-$400 based on their family income). All revenues from Mothercraft Birth Support are used to support the ongoing work of the Birth Companion Program. At the time of writing, the initiative was just beginning and had been in an initial testing phase for approximately six months. The Mothercraft Birth Support initiative has two main goals: 1) to increase access to doula support for women who are low and middle income and who would not have been considered eligible for the Birth Companion Program, and 2) bring in some monies to support the Birth Companion Program which does not have stable and reliable funding. Mothercraft Birth Support uses the same staff, same volunteer training, and same volunteers as the Birth Companion Program (J. Dwyer, Birth Companion Program Coordinator, personal communication, October 2008).
is organized can be seen as a form of two-tiered healthcare; participants’ motivations to make a doula available and accessible “to every woman who wants one” suggests that they may view it in this way.

Many participants viewed regulation and public funding as a beneficial means of increasing the availability and accessibility of doula care. David, Amy’s partner, says that he thinks all women should routinely be offered a birth companion (he uses the word “mandatory” but then clarifies that he means they should be “automatically offer[ed]” a doula):

I think it should be mandatory. For father and mother alike. Having someone there with that knowledge and the sense of calm that she brought to it. She just walked around like it’s nothing, second nature. I just looked at her in awe—“How can you be so calm!” She just brought calmness to the room. So I just think it should be mandatory..... Yeah, for your first child and that... when you go to a doctor when you’re pregnant and they automatically offer a birth companion.

Similarly, Sonya, a doula, also said that it would be “ideal” to routinely offer women a doula, covered under OHIP:

I think if it were to be regulated by OHIP then it would be easier for women to experiment and try it out... The ideal situation would be for it to be covered under OHIP... every labouring woman has a nurse—it would be great to be able to have a doula at the same time.

Many participants suggested that public education would be the first step toward regulating and publicly funding doula care (which I will discuss in more detail later in this chapter). However, Sonya implies that regulation and public funding itself might also provide an avenue for women to become more familiar with doula care and to explore it as an option. This appears to have been the case for midwifery, as more women, and a greater diversity of women, have accessed midwifery care since it was regulated and publicly funded. Ford and Van Wagner (2004) conducted a survey of Ontario midwifery
practices in the spring of 1999 and found that most practices reported that they were better serving low-income women; ethnic, cultural, or religious minorities; immigrant women; and visible minority women. In addition, about half of the practices reported that they were better serving teens and refugee women (Ford & Van Wagner, 2004). Ford and Van Wagner found that these practices identified funding of care as the most critical factor in increasing women’s access to care, while other factors that were considered important included: hospital privileges, outreach activities, the increased credibility of midwifery since regulation, and increased diversity of midwives within the practice. Public education could be a key part of organizing a movement for the regulation and public funding of doula care, but Ford and Van Wagner’s (2004) research suggests that increasing the accessibility and availability of doula care would depend on regulation and public funding.

All of the participants responded affirmatively when asked if they could see themselves “working with other women to try to convince the government to make doulas an option for every woman”. Anne, a doula, claimed that the regulation and public funding of doula care “just makes sense”:

I mean it just makes sense, it comes down to common sense. Who would not do this, this is about mothers, this is about babies, this is about families. It could become a new women’s rights issue... So I think you just need the right person to run with the right tone to it—all the passion behind it is there.

Anne calls for a broad movement; she implies that those who care about “mothers”, “babies” or “families” would all rally behind a push for increased availability and accessibility of doula care. She implies that strong leadership would be important (i.e., “the right person to run with [it]”) yet this is balanced by her call for many people to be involved, and her suggestion that it could be framed as “a new women’s rights issue”. 
This attention to framing doula care as a women’s rights issue is reflected in the organizing efforts of pro-regulation midwives. According to Bourgeault, Declercq and Sandall (2001), midwives’ efforts to regulate and publicly fund midwifery care were also framed as a feminist issue of women controlling their reproduction and this resulted in sustained support from midwives and consumers as well as women’s health and feminist activists. This approach was successful; midwifery became a feminist issue which kept it on the policy agenda and helped to garner wider consumer support (Bourgeault, Declercq and Sandall, 2001). Midwives focused on women’s right to choice of birthplace when framing midwifery as a feminist issue of women controlling their reproduction; this issue is not relevant to a movement for regulated and publicly funded doula care but issues of accessibility to doula care could be framed in a similar way.

Anne also underlines the importance of framing the movement to resonate (i.e., “with the right tone to it”) with those who could become involved. Framing can offer strategic interpretations of issues with the intention of mobilizing people to act (Noakes & Johnston, 2005). Noakes and Johnston (2005) explain that understanding framing is central to understanding social movements; they describe the frame as the subjective component (or the element of perception) and suggest that “successful frames must not only analyze events and identify who is responsible but also ring true with an audience—or resonate” (p.2). According to Snow and Bedford (1988) frames accomplish several basic tasks: frames are diagnostic, meaning that they explain what is “wrong” and why; they are prognostic, meaning that they present a solution to the diagnosis; and they are motivational, meaning that they compel people or give them a reason to support an action
or social movement. Anne suggests that framing the movement effectively would harness the interest and "passion" of many women.

Several of the young mothers said that their own positive experiences with doula care would be motivational for them, and would encourage them to contribute to a movement to increase the accessibility and availability of doula care. For example, Catherine, a young mother, said:

I guess knowing how it helped me would make me want to make the government realize how much of a help it is. Especially the young women who are alone and scared, I bet it would help them a lot too. If I didn’t have one there I wouldn’t have known what to do.

I think it is striking that Catherine refers to "the young women who are alone and scared"; she implies that she is outside of such a collective of women and that birth must be harder for them, yet she also indicates that she can empathize with their situation by referring to her own (i.e., "if I didn’t have one there..."). It is often the case in feminist organizing that women are motivated by private/personal experience to contribute to a political effort, and that their experiences become re-situated in public ways. For example, a private experience of feeling alone in childbirth can become presented publicly as an injustice experienced by a collective of women. Reiger (2000) compares political efforts to reform birth practices to women’s mobilizing around violence against women, suggesting that both push "so-called private sphere issues on to the public agenda" (p.311). Furthermore, Mullaly (2002) explains that anti-oppressive approaches elaborate on the feminist claim that the "personal is political" by pointing to dynamic interactions between individual, cultural, and structural levels; he claims that "just as structural forces affect people, so, too, do people affect structures.. this insight is behind all social change movements" (p.49). Catherine’s concern for women who may feel
“alone and scared” during childbirth is not likely to be readily taken up by policy makers. Women’s experiences with childbirth are often left out of assessments of the quality of maternity care that is provided; moreover, as a marginalized group, young mothers may struggle for legitimacy in a political arena where marginal behaviour is often “constituted as a problem, and efforts therefore focus on eliminating it” (Munford & Sanders, 2005, p.320).

According to Daviss (2006), an “overhaul of the value system” is what is required to redefine quality of care and to value caring labour in maternal healthcare as “non-intervention is a hard sell in a society increasingly obsessed with the modus operandi that important tasks require technology” (p.417). Daviss (2006) calls attention to the “big business” of birth and argues that the maternal healthcare system resists change because it does not stand to benefit from lowering interventions and decreasing healthcare costs. Grinspun (2000) argues that the shift from what was formally a cure-care paradigm to what is now a business paradigm in hospital management is not only detrimental to the quality of care provided but also fails to achieve cost effectiveness. For example, structural conflicts of interest between physicians’ remuneration, hospitals’ needs, and patient health can increase the use of invasive procedures (such as cesarean sections) over less invasive and less expensive interventions (Grinspun, 2000). Given that one of the main “selling points” of doula care is its potential to decrease obstetric interventions, the big business of birth could present significant challenges to a movement for the regulation and public funding of doula care. If women were to organize for the regulation and public funding of doula care then they may be operating from core assumptions that are contrary to socially entrenched ideas about technology and caring labour; and
secondly, that are in opposition to the medical system’s economic reliance on obstetrical interventions. However, more optimistically, there is arguably a larger push underway to re-orient the healthcare system; the potential for further change to childbirth practices may be advanced by critics of the healthcare system who point to its inefficiencies and costly approaches, calling instead for increased attention to health promotion and illness prevention (Wrede et al., 2001).

Professionalization and Integration into the Maternal Healthcare System

Participants expressed apprehensions about the potential regulation and public funding of doula care; there were mixed thoughts about which aspects of professionalization would be negative and why. Many participant comments on regulation and public funding seemed to reflect concerns about integrating a relationship-based and woman-centered approach into a maternal healthcare system that is based on a medical model. Participants frequently referred to what might be “lost”, how doula care might be “reduced” or have things “taken away” if it were to undergo regulation and public funding. Similarly, participants conveyed wariness about placing too many parameters on doula care (e.g., “as long as they don’t infringe on how we do things”; “as long as it doesn’t come with too many strings attached and take away from what it means to be a doula”) and fears about not being understood (e.g., “I think it’s good as long as the government still understands the essence of it…”).

The two aforementioned approaches to childbirth (i.e., relationship-based/woman-centered and medical-model) are not separate, entirely different from one another, or inherently incompatible. Rather, I consider them to be always interacting with and
influencing one another, both embedded, at any given point in history, within a broader
cultural, political and economic context. Weisman (1998) claims that simply thinking of
the “male-dominated medical profession that oppresses women” ignores the development
of what are actually a number of gendered institutions and socially constructed beliefs.
Witz (1992) describes the ways in which a range of institutions have exercised patriarchal
control over women’s labour. She identifies three modes of control: inclusionary (control
within sites), exclusionary (preventing women from entering male-dominated
professions), and segregationary (characterized by a hierarchical gendered occupational
order). Regarding midwifery, Witz (1992) explains that as the medical division of labour
emerged, gendered demarcationary strategies were often used to constrain the
professional projects of midwives. I would suggest that participant concerns about
professionalization become clearer when one considers their views in this context of
gendered occupational relations in maternal healthcare.

Several doula participants expressed that they saw formal certification and
training of doulas as beneficial; yet at the same time, participants expressed the concern
that regulated professional training may not capture the importance of “rapport”, the
“essence” of doula care, or the “non-tangible things” that they see as central to doula
care. Sonya states that how to be a “good doula” is not something that can necessarily be
taught through a certification process: “…just because you are officially certified doesn’t
necessarily mean you are a good doula, that you know the stuff, or have the experience.
A lot of things are going to need to be considered”. Anne also expresses the concern that
regulation and public funding may “take away from what it [doula care] is and what we
do”:
A lot of it [doula care] is just experience and very non-tangible things that you can’t put your hands on. It’s the rapport, just the way that you talk to people—and you can’t give that through education. So as long as they don’t infringe too much on doulas. I know that saying you have to take X amount of courses and you have to do X amount of births and you have to attend this and do this and that, I think that would be good. But you don’t want to take away from the way doulas do things; you don’t want to regulate it too much. I really do think that the part that makes a good doula is not tangible, it’s totally about the rapport. It’s not about education, not about how many books you’ve read... it’s just something you can’t learn from a textbook.

Participants seemed to indicate that they see a doula’s personality, experiences and approach to the work as important components of a doula’s care. Participants’ comments may also suggest that these factors are less measurable than knowledge-specific training and therefore may not be adequately considered in post-regulation perceptions of the quality of care a given doula can provide. Malka (2007) suggests that while professionalism is about legitimacy, standards and knowledge it is at the same time also about “exclusivity, elitism, gatekeeping and a monopoly on knowledge” (p.6). These less desirable qualities of professionalism that Malka (2007) identifies may well pose challenges to a professional project for doula care. I would suggest that if the intention of a professional project is to provide relationship-based doula care then the components identified by participants, such as a doula’s personality, experiences, and approach to the work, would need to be emphasized in the development of professional standards and training requirements.

Many midwives shared similar concerns about how to teach elements of woman-centered care through a regulated training program. Ontario midwives now have a specialized undergraduate degree program (offered jointly through Laurentian, McMaster and Ryerson Universities). Midwives in Quebec and British Columbia have followed a similar path whereas midwives of Manitoba have preserved multiple educational options,
including the traditional apprenticeship model (Benoit & Davis-Floyd, 2004). Although it remains to be seen how formal midwifery education will fare in the long run in Canada, initial reports are promising. Benoit and Davis-Floyd (2004) suggest that midwifery education is two pronged and involves education as well as socialization, the latter referring to the “shared culture” of a group and “often unstated ideology” that underlies... ideals and behaviour patterns” (p.170). Benoit and Davis-Floyd (2004) argue that the philosophy of care must remain woman-centered lest a move into the university represent co-optation of midwifery’s principles and values; writing that

The kind of midwives a given program produces will have as much to do with how they are taught as with what they are taught. Midwives who are trained in a humanistic manner and in a nurturing atmosphere will find it easier to become woman-centered caregivers when they go into practice than midwives who are trained according to techno-medical norms (p.184).

Doulas who participated in this study also expressed more general concerns about how relationship-based elements of doula care may become compromised if doula care were to become more professionalized. Sonya suggests that professionalization would create a barrier to a doula’s emotional involvement with her clients:

Once it becomes more regulated it would be like everything else, it would be more regulated, the things you can say and the things you can do, so that might prevent you from becoming that emotionally involved with your clients.

It is interesting that Sonya suggests that regulation would make doula care “like everything else”; she seems to imply that doula care is more effective when positioned outside the medical system. Although Sonya is not stating that she is opposed to the potential regulation and public funding of doula care, her concerns reflect those expressed by many midwives in the early days of organizing for the regulation and public funding of midwifery. Van Wagner (2004) writes that “many of us felt that women and
midwives together were creating a kind of care that could only grow outside [italics added] of institutions... [its] basic principles seemed at the time antithetical to a system that was often authoritarian, fragmented and routinized” (p.73). Anne similarly expressed concern that doulas’ reliance on intuition may become compromised by professionalization:

...as long as the government doesn’t interfere with it and say this is what you can and can’t do as a doula. Every situation is different... what you do and how you proceed. So you have to go with your intuition and sometimes going with your intuition isn’t very well factored in regulation. You’ve got to understand that there is a lot of gray in these issues, in dealing with these particular clients [women who are at risk]. And regulation is a lot of black and white so you’ve got to figure out a way to deal with the gray without interfering too much... you’ve got to kind-of trust the doulas to do what they do best and let them be. Intuition guides them quite a bit and usually they’re right about things.

It is possible that these comments from both Sonya and Anne reflect concerns about subjecting doula care to a hierarchical form of control (e.g., “as long as the government doesn’t interfere with it and say this is what you can and can’t do”; “it would be like everything else... the things you can say and the things you can do”). Anne suggests that doulas are guided by intuition and that forming helping relationships with women who are at risk requires a fair degree of flexibility. Anne focuses on the particularity of women’s experiences (e.g., “every situation is different”) and seems to be critical of measures and/or professional standards that she perceives as restricting her capacity to respond to women’s unique needs. I would suggest that the line between being inside the system (and subject to control) and being outside the system (and free from control) is not entirely clear or fixed. Women’s professional human service work is characterized by limited control (Fisher, 1990) yet women’s work can be controlled by institutions in exclusionary or inclusionary ways (Witz, 1992). While I think that doula care’s current
position, external to the maternal healthcare system, does grant independence and flexibility, I would suggest that it is not entirely free of the influence of institutional forms of control (e.g., hospital policies that affect when a doula can be present).

I would further suggest that this institutional control over women’s work (both inside and outside the medical system) is dependent on and closely connected to a cultural devaluing of caring labour. Canada’s healthcare system arguably relies on unpaid women to be able to provide quality of care to the degree which it does. There is an assumption that women will provide caring services for little or no remuneration (Shroff, 2000) and, as Gustafson (2000) argues, this assumption regarding women’s time can be understood as the appropriation of women’s personal property for the common good. Emotional support work is not easily quantified (Gustafson, 2000) and as a result is often under-considered in determining quality of healthcare. The medical model largely adheres to business principles and “caring, a central aspect of nursing practice, suffers from the race to the bottom line... the fragmented and rushed approach to nursing care promoted by the business paradigm does not allow for the human connectedness which is necessary for caring relationships to flourish” (Grinspun, 2000, p.25).

More optimistically, I would suggest that women’s labour roles within the medical system have shifted significantly and continue to evolve, evidenced in part by the success of midwifery’s integration (Bourgeault, 2006). I agree with Sharpe (2004) who suggests that regulations can be flexible and that woman-centered forms of care can be integrated into the healthcare system; she claims that “direct experience, intuition, and work with relationship have a valid place in the... professional world” (p.151). Furthermore, access to paid work can strengthen women’s positions in both the private
and public spheres (Fisher, 1990). Efforts from within the system to revalue caring labour have also experienced some success. Malka (2007) traces the impact of second-wave feminism on nursing and argues that feminism offered nurses a language and strategies they could use to reconstruct their work, resolve their subordination to medicine, and gain increased autonomy. In addition, I would also suggest that it is possible that doulas may have an easier time than midwives of factoring relationship-based elements into regulatory measures; as non-clinical labour support providers, doulas would likely contend with less concern about professional liability and may be able to create more flexible regulations.

Marisa seemed concerned with how regulation and public funding might reduce doulas’ sense of control over their income and/or business:

There is still, as much as we are caring for other women and we’re supposed to be open and all of those things, when it comes to fellow doulas there is still an element of protectiveness over what we’ve invested our money into and our time into.... [It is]...sort of that feeling of ownership of your business and your experience and being somewhat reluctant to share that information with other doulas with the idea that they could be taking away from your business. So I don’t know how it would fly across Canada. I mean even just thinking in Ontario—you’d have the doula that is charging $2,000 in downtown Toronto suddenly not making that kind of money, and the doula in some remote city who is only charging $300 because that’s what the community can afford—is suddenly making $800. I can see there being lots of people saying, well I feel I’m worth this amount. That can really cause a lot of conflict... It is a very fine line because as much as this is a calling and I feel so fulfilled, I have to put food on the table for my family.

Marisa’s concern about decreasing doulas’ sense of control over their income and business were not reflected in the comments of other doulas, but stood out for that reason. Of the four doulas that were interviewed for this study, Marisa takes on substantially more paid births than the others and is most reliant on doula care as a source of income. She suggests that the fee-for-service model may have some clear benefits for those
doulas, including herself, who are currently making a business of doula care. Lantz et al. (2005) reported that, in the U.S., the gross income average of doula work during 2002 was $3,645, with almost one-half of doulas reporting that they made less than $1,000. A mere 10.3% of certified doulas reported making $10,000 or more during 2002. To my knowledge, there is no comparable Canadian data available. However, these figures suggest that public funding for doula care would likely increase doula work related income for most doulas. However, Marisa seems to be placing an emphasis not strictly on income, but on the potential loss of control that doulas might experience over the way that they manage their businesses (e.g., “protectiveness of what we’ve invested our money into and our time into…. that feeling of ownership of your business and your experience”). I would further suggest that a fee-for-service model offers more constraints than possibilities and does not provide as much “choice” and “control” for patients, or care providers, as proponents of privatized healthcare tend to suggest. According to Oakley (1993), being a “consumer” of healthcare is not an appropriate way to conceptualize using services for “it embodies the capitalist assumption of a free-market society... but in practice, capitalism is a means of ensuring that people’s right to choose is unevenly distributed in the population” (p.55). Viewing Marisa’s comments alongside the concerns of other doulas, I would suggest that control over one’s doula care business also affords control over the nature of care that is provided; the concerns she has articulated may well be related to broader participant concerns about how regulation could compromise a doula’s capacity to provide relationship-based care.

Another comment of Marisa’s also offers further insight into the complexity of doulas’ views on professionalization. She suggests that doulas are often described in a
way that is not representative of her experience ("as much as we are... supposed to be open and all of those things"). In this statement Marisa may be providing an example of what Benoit and Davis-Floyd (2004) describe as an "often unstated ideology" that underlies the ideals of a group and produces a "shared culture" (p.170). Following this line of thinking, I would suggest that a group can construct a particular narration of itself which may be a simplified representation of the experiences and realities of group members. Marisa seems to suggest that doulas describe themselves as "open" but that the values and behaviour of doulas are actually more mixed and varied. This is useful to consider when examining doulas' views on increasing the accessibility and availability of doula care as the concerns that doulas express may be constructed in part within the "shared culture" of the group, where dissenting views may have less room to develop.

To elaborate, some doulas seemed to indicate that the low remuneration (or no remuneration in the case of volunteer births) that doulas currently receive serves as a screening factor. Sonya expressed concern that professionalization would result in doulas choosing to do doula work "for the money". Whereas, in the excerpt above, Marisa states that she does doula work for the love and the money: "as much as this is a calling and I feel so fulfilled, I have to put food on the table for my family". Christine shares Sonya's concern that doulas may become laissez-faire in their attitude toward work that they currently "just do for love":

That's another thing, when you get into regulation you get into stuff that people just do for love... [Right now] they aren't saying "When's my shift over?"... I would never want doulas to become that and isn't that happening with midwives now... so, you know, why would we be any different.

Christine indicates that she thinks that midwifery has experienced negative changes as a result of regulation and public funding. Professionalization has undoubtedly changed
midwifery; what Christine suggests is that these changes may not be for the better. Midwives made extensive efforts to anticipate negative outcomes of professionalization and to account for these. For example, midwives fought for an alternative funding model because they were critical of the fee-for-service way in which doctors were reimbursed by the province for medical services (Bourgeault, 2006). In the words of Vicki Van Wagner, midwives acknowledged that “the system of payment creates incentives and disincentives to kinds of care... we went in with our eyes wide open. The basic principle was that the model must drive the funding system, not the funding system drives the model” (Bourgeault quoting Van Wagner, 2006, p.195). Davis-Floyd (2006) claims that midwives have managed to maintain their principles and values “even as they professionalize... [they] are simultaneously striving to maintain themselves as...woman centered, family-serving, intuition-honouring, birth-trusting, and system-flouting” (p.196).

Furthermore, I would suggest that it is also difficult to extract the process of professionalization from the broader social context; I think that midwifery can be better understood if seen as having always been changing, ever since the role of midwife first emerged. For example, it was not actually until the turn of the 20th century that midwifery was even linguistically labeled as such for prior to that point the terms “obstetrics” and “midwifery” were used interchangeably. Gross (1984) argues that this was a strategic move made by the medical system in order to communicate the superiority of obstetrical care. Benoit and Davis Floyd (2004) describe midwifery as not simply traditional, but transforming in response to changes in the wider socio-cultural context in which it is embedded. Regarding the professionalization of midwifery in Ontario, Bourgeault (2006)
claims that midwifery had to change for “the same forces that helped propel midwifery forward as a professional project—namely the HPLR—could have quashed community midwifery in favour of another form or the status quo—no midwifery” (p.279).

Should proponents of doula care choose to pursue regulation and public funding, doulas who participated in this study suggested that the government would be reluctant to embrace change.

Heather: What challenges do you think the movement might face?
Marisa: The government. That’s a problem, a tiny tiny problem. [laughter] I think that is the best way to sum it up, it’s the government. You’re talking about bureaucracy, you’re talking about boys. They’re not going to understand the importance of that mom being in power, that single mom being in power to make healthy choices and the importance of all those things. I don’t think the boys in the big chairs are going to realize the importance unless you can show it to them in dollars.

Marisa indicates that she sees bureaucratic reluctance to prioritize maternal healthcare as being a significant barrier to regulating and publicly funding doula care. Integrating doula care into the maternal healthcare system would likely necessitate organizing a significant and sustained movement around the issue. For even if women and communities do push for the regulation and public funding of doula care then they are likely to face deeply entrenched barriers to change. Despite evidence-based research and a strong consumer movement in support of midwifery, the maternal healthcare system remained resistant to its integration for some time. Daviss (2006) comments on the influence of money in these matters, writing that “accessing funding for research into therapies that use less technology proves difficult in a health-care system in which increasing technology use represents financial gain” (p.424).

34 The Health Professions Legislation Review was established by the provincial Conservative government in 1983 and was put together to make recommendations to the Minister of Health regarding which health professions should be regulated (among other aims). Many authors on the regulation of midwifery credit the HPLR with inciting midwives to seek regulation and public funding.
Anne, a doula, spoke about a potential reluctance to embrace change on the part of the general public, and the majority of people who are not familiar with the benefits of doula care:

I think that for the uneducated, or the people that don’t have experience with this, they don’t see. I think they would say “Well women have the choice of what they want to do”. I think this is because they don’t see the reality of what is involved in the hospital system. So they’d say “Well you’ve got a doctor and nurses there—why do you need a doula?” I think women can understand about a doula but I don’t know if a 50 year old politician would understand the need for doulas, cause their response is—“Well my mother didn’t have a doula and my wife didn’t have a doula”. I don’t think there is a real understanding of how it [maternal healthcare] could be improved. I think they want to look at the healthcare system and say it is fine the way it is and not see that extra piece of the puzzle. Maybe... they see the difficulties in regulating the issue and subsidizing and that... and just wouldn’t want to touch it.

Anne suggests that education on the value of doula care may make a difference (e.g., “for the uneducated, or the people that don’t have experience with this, they don’t see”). Yet at the same time, Anne questions whether or not education is enough to create change; she suggests that one’s social location may affect one’s perception of the value of doula care. Anne suggests that politicians want to guard the status quo (e.g., “look at the healthcare system and say it is fine the way it is”). She states that “women” can relate to and understand the need for a doula but describes the prototypical “50 year old male politician” who might not understand the need for a doula because he cannot see the need reflected in his own experience (i.e., “my mother didn’t have a doula and my wife didn’t have a doula”). While some groups of people may be more likely to see doula care as valuable it is not the case that all older male politicians would not value doula care or that all women would. And while education on doula care would likely increase the public’s familiarity with and awareness of doula care it would likely only influence the opinions of those whose values are already well aligned with those associated with doula care.
Bourgeault, Declercq and Sandall (2001) credit the success of the midwifery movement in some part to the fact that the provincial ministers of health during the push for the regulation and public funding of midwifery were women who were personally supportive of the midwifery initiative; it was possible for these ministers to advocate effectively on the issue because it could be presented as a cost effective form of care and the government of the day was also keen to be publicly viewed as supporting women’s issues and rights. Unfortunately, the current political climate may be less favourable to women’s issues and rights; Rebick (2005) claims that the last fifteen years in Canadian politics have brought about a significant shift to the right, including cutbacks to the funding of the women’s groups who might lend their support to a new women’s health movement. However, more optimistically, as the prevalence of midwifery is increasing, more people are becoming aware of what a woman-centered approach to childbirth entails, meaning that Canadians on a whole may be more welcoming of doula care. Weisman (1998) writes that social movements can emerge together in clusters or “movement families” and in periods of “heightened collective activity” which are known as “cycles of protest” (p.27). The regulation and public funding of midwifery may have “paved the way” for integrating doula care into the maternal healthcare system in more than one way; not only has it “given us a sense of our strength” (Adamson, Briskin, & McPhail, 1988, p.247) but it may also have increased public awareness of woman-centered approaches to childbirth.

Most of the participants in this study identified public education as an important first step in a potential movement for the regulation and public funding of doula care. David, Amy’s partner, said:
I think we could have workshops just to kind-of put it out there. You know, this is available... if you are interested in something like this... do a session just for information, just to let people know that this is available to them. I think that would be a really good idea.

And Natasha, a young mother, said “I don’t think birth companions are well known, I think they need more exposure or advertising, for girls to know”. Anne, a doula, states:

Getting the stories out of how there are very practical benefits involved, the personal stories of what a doula does, what a doula contributes and how much of a difference they can make in terms of the birth, but also the long term benefits of having the doula there.... education—just making it known. The more people see the benefits of it... it’s not hard to convince them. It’s just educating them on what a doula is and what they are not. Just showing real stories of doulas and clients and how it comes to be.... [getting] personal stories out which I think would be good with an education campaign.

Anne mentions a strategy of sharing anecdotal evidence; I would add that personal stories could provide an avenue for emphasizing the particularities of women’s needs in their birthing experiences. Sonya, another doula, said that public education could familiarize women with doula care and that they would then be more open to trying it if it became available under OHIP. Research by Goer (2004) suggests that public education strategies are popular amongst grassroots birth activist groups and I do think that public education could achieve some aims identified by participants (e.g., increasing the public’s familiarity with doula care). At the same time I would argue that deeply rooted societal ideas about health, healthcare, and social change might limit the effectiveness of public education as a primary strategy for increasing the accessibility of doula care. Regarding women’s healthcare reform, Gustafson (2000) states that Canadians hold deeply rooted beliefs about the nature of health and healthcare that are shaped by “social practices [regarding] gender, age, race/ethnicity and social class that are firmly embedded in our healthcare institutions, political processes and legislative policies” (p.18). For example, as discussed earlier, one of these deeply rooted beliefs about health and healthcare is the
idea that caring is the ultimate responsibility of unpaid women in the home, family and community (Grinspun, 2000; Shroff, 2000). I do not think these sorts of deeply rooted beliefs would be apt to change much in response to a public education campaign designed to increase awareness about the benefits of doula care. I would suggest that public education may be more effective in combination with other strategies, particularly policy oriented activism. Despite the hurdles presented by the project, improvement to the organization and delivery of healthcare to women has been one of the main goals of the women’s movement (Weisman, 1998) and women have made significant strides in advocating for informed choice in their reproductive healthcare, homebirth and midwifery care, “baby friendly” hospitals, and breastfeeding.

Protecting the Relationship-based Nature of Doula Care

Locating services in the community. If doula care were to become regulated and publicly funded, participants clearly expressed that they would prefer to see it based in the community, rather than in the hospital. Most of the young mothers who participated in this study indicated that they saw community-services as having more time for their clients or as being more “young person friendly”. For example, Catherine, a young mother, said “If they [doulas] worked at a community agency they would probably have more time to meet with you beforehand [during pregnancy] than if they worked in the hospital. If they worked at the hospital they’d be pretty busy”. Jennifer, a young mother, also said that she would prefer for doula care to be housed in the community:

Sometimes I find services in the community, especially if you are a younger person, they are more young person friendly than the hospital... In the hospital they just may not understand you as well. There were times in the past when I thought I was pregnant and I went to a clinic and the doctors were saying, “Oh
what are you doing trying to get pregnant at your age?” [In the community] they
don’t judge you or anything... I saw a big difference in the kinds of support for
younger people....everything is confidential and they are there to support you in
your decision instead of being, oh you know, what are you doing at this age, blah
blah blah.

Jennifer makes it clear that she felt less judgment in the community. Jennifer’s comments
may be linked to Catherine’s as it could be possible that the time constraints in the
hospital environment sometimes intensify feelings of being judged. In addition, services
in the community may be more teen-specific in their approach (e.g., Planned Parenthood
tailors many of its services to youth); if so, this would reflect the findings of Bensussen-
Walls and Saewyc (2001) who credited the effectiveness of teen-centered clinics in part
to “clinicians [that are] expert in the unique issues pregnant teen[agers] face and are
knowledgeable about the community resources specific to their age group and complex
problems” (p.427).

Other participants spoke about wanting to keep doula care in the community in
order to preserve its autonomy. For example, Anne, a doula, said:

I definitely think that being in the community is the better option. I think that if
you put it in the hospital it takes away the whole option of midwifery care and
home birth. Whereas, if you put it in the community it allows for all options for
where you birth and it doesn’t necessarily associate it with the hospital. I think
there would be strengths in associating it with the hospital but I also think there
would be a lot of disadvantages with associating it with the hospital. It needs to
be on it’s own as doula care—it’s not associated with midwives, it’s not
associated with obstetrics, it stands by itself, alone.

Participants were unanimous in calling for doula services to be community-based should
they undergo a process of regulation and public funding. For one doula, however, this
was not expressed as a key priority. Marisa said:

In terms of hospital base vs. community base, well, it’s wherever they are willing
to put us up I guess. I’d say that I’d still like to see it in the community where we
have access to the resources and the community around. Like, for myself, I’ve
got donations from the second hand stores around to help my matches with clothing and snowsuits, things like that, so I’d like to see it stay in the community. However, sometimes hospitals have better accessibility—a mom might be coming in for a test or something and then she could pop into her doula’s office. Say hello and touch base... I think it could work in either environment, however, staying true to the whole doula thing... I think I’m more of a modern doula in the sense that if you have that connection it’s going to work no matter where you are. If there is a home base in a hospital then the doulas could travel to the moms’ houses in order to maintain that intimacy and that relationship. Wherever the home base is I don’t think is very important as long as those connections are being made in the woman’s home. So where home base is, I don’t think that really matters.

Marisa’s comments seem to suggest that she sees a range of possible ways to integrate doula care. And Anne, in contrast, seems to call for autonomy (e.g., “stands by itself, alone”). I would also suggest that the comments of both of these doulas may reveal different perceptions of the medical system as opposed to, or separate from, woman-centered models of care. Anne seems to refer to a division between the hospital and midwifery by suggesting that placing doula care in the hospital would “take away the whole option of midwifery”. And Marisa seems to emphasize the potential compatibility of doula care and the medical system (she refers to being a “modern doula in the sense that if you have that connection it’s going to work no matter where you are”). She does not specify her intended use of the word ‘modern’ but it stands out to me because her comment and the language she has chosen may indicate that she is referring to a division between “hospital base vs. community base” as a “traditional” way of thinking about woman-centered models of care. Yet at the same time she then quickly adds “as long as those connections are being made in the woman’s home”. This may possibly reveal a tension for her between “modern” and “traditional” ways of thinking about woman-centered care (as integrated with the hospital or separate from the hospital, respectively).
It also stands out to me that Marisa makes reference to how a physical space may affect the formation or connectedness of a relationship. I would suggest that this may reflect an aspect of Fahy and Parratt’s (2006) birth territory theory as they describe the physical space of a hospital room as a “surveillance room” and posit that the design of the space may contribute to some birthing women’s feelings of disempowerment. This line of thinking reflects Foucault’s (1975) analysis of the power constructed and conveyed through physical space, where institutional spaces (such as a hospital) can facilitate institutional control. While Marisa says that she thinks that doula care could work in either the hospital or the community she seems to be suggesting that the relationship-based elements of doula care (“that connection”) would be more easily facilitated in a woman’s own home.

Matching women during pregnancy. All participants also shared the view that doulas should be matched during pregnancy, preferably early in pregnancy, for two key reasons: to be afforded the time to develop a good connection and relationship, and to provide broader social supports (such as assistance with housing, relationships, schooling, child support or social assistance) for women who are at risk. All of the young mothers that I interviewed spoke about the benefits of developing rapport and relationship with a doula during pregnancy. For example, Natasha underlines the importance of having people that are trusted, rather than strangers, with a woman in labour:

[Doulas and birthing women should] definitely [be matched] prenatally.... I liked having a midwife because I knew who was going to deliver my baby whereas with the obstetrician it’s just whoever is on call. When it’s a birthing experience, first or not even first, it’s something sacred to you, it’s memorable, you’re giving birth, so of course you’re going to want people you know and trust around you, not just strangers. Especially if they are occupying the room, if you can only have
two people in your room, you don’t want strangers occupying something that your mother could be otherwise\textsuperscript{35}, so you definitely need time.

Doulas also spoke about the importance of establishing rapport and relationship during pregnancy. Anne says:

Yes, I think you’ve got to do the matching [in advance]. I think it’s very important to establish that rapport before the birth. I’ve done births where I’ve just walked into the hospital room and met the woman for the first time. I think if it is possible women should be matched up beforehand so the doula can establish what she [the birthing woman] wants, how she wants it, address any concerns, get a sense, get a rapport building so she knows what you look like before you come in and it’s a familiar face, even when things are difficult.

And Marisa claims that “...for ‘it’ to really be there it has to come in advance.... There can be times where even though you haven’t met beforehand it can work but I think a doula’s role is to be with you and empower you and support you and all that stuff”. Sonya adds:

I think the relationship of trust needs a bit of [time for] development.... if a person comes that is unknown to you then it right away creates an uncomfortable situation and increases stress. The more comfortable the better it is. If you didn’t get one before the birth and you want to get one now that should be made available. But ideally I would say [matching should occur] about two months or so before they deliver.... you want to be on the same track, on the right track with the pregnant woman.

These comments from participants about the importance of matching women in advance can be understood as an extension of the discussion in Chapter Four on the close and connected relationships that form between young mothers and their doulas. Participants seem to suggest that matching women in advance is necessary in order to form these close and connected relationships (e.g., “the relationship of trust needs a bit of [time for] development”; “for ‘it’ to really be there it has to come in advance”; “you’re going to

\textsuperscript{35} Hospitals set their own policies regarding the number of support people that are allowed to be with a woman during labour and delivery. Some hospitals count a doula amongst the number of personal support people permitted and others do not.
want people you know and trust around you, not just strangers... occupying something that your mother could be otherwise”). Similarly, several doulas also spoke about how being matched in advance would enable the provision of broader social supports (such as assistance with housing, relationships, schooling, child support or social assistance).

Anne states:

It’s a chance to discuss not just the birth, but also things like their housing issues, what they plan on, like the bigger picture. When you are matched late in pregnancy the birth becomes your focus. Whereas earlier in the pregnancy you can focus on the whole woman, what she’s doing, housing, schooling, community centers, if the father is involved then getting him involved in different ways. You can attend pre-natal classes with them. You can attend pre-natal appointments with them.... Just a chance to get to know the person a bit more and maybe some family members, you get to know their dynamics, if they are going to play a role in the birth and they often do. If it’s not just the client, you’ve got the mother and the boyfriend so you can get a sense of the family dynamic, what the issues are going to be, and how you are going to get through this and how you are going to make it a better situation if needed.

Anne seems to describe how doula care can help to create linkages between a mother’s birth experience and other facets of her life during what is a pivotal time (e.g., “if the father is involved then getting him involved in different ways”). Anne also seems to imply that assisting with broader social supports can better enable a doula to provide effective labour support. By focusing on the “whole woman” Anne seems to suggest that doula care can bring in-depth continuity by providing consistent support that begins in the community, is provided throughout the maternal healthcare experience, and is carried back into the community.

Most of the participants were careful to note that being matched late in pregnancy or during labour would be far superior to not being matched at all. For example, Natasha, a young mother, said:
...say you didn’t have any family or the father involved, it would have been nice to have had the other person [doula] before [during pregnancy]... In most cases I’m sure a girl would have liked some pre-natal support but at least having someone there to support her during labour to show support for that moment might be just as good for her.

It seems that participants believe that a close, connected and trusting relationship between a young mother and her doula provides the best context for doula support but see value in doula support in a range of relationships and contexts. This claim reflects findings on the positive obstetric outcomes that are associated with continuous labour support, as most of the randomized and controlled trials that have been conducted on doula care have been limited to support during labour and delivery only (e.g., Hodnett et al., 2003; Scott, Berkowitz & Klaus, 1999; Zhang et al., 1996).

*Ensuring women’s choice in matching.* Participants also expressed the view that it is important for a birthing woman to have control over who her doula is as there was concern that a woman’s ability to choose her doula may become compromised if doula care were to become regulated and publicly funded. It is not only private doula clients who are able to choose their doulas. The Birth Companion Program recognizes the importance of a client feeling connected to her doula and, although it is limited by volunteer availability, does try to offer women some degree of control over their choice of a doula. If a client does not feel a connection with her doula then the program will try to match her with another doula. One of the young mothers who participated in this study, Jennifer, mentioned that she had felt like this was an option.

Sonya and Marisa both suggest that women should retain a choice over their doula. Marisa states:

I think there would still need to be some choice for a [pregnant] woman, in terms of who she chooses to be a part of the birth. Although we all pretty much offer the
same services, we’re all individuals and we all bring something a little different and a little bit unique to it. To say “Okay, you’ve chosen to have a doula and we’re just going to randomly send someone to your house”—I don’t think that’s the way to go because it is an intimate and private moment in a person’s life. I know there have been studies that show that a woman in the room, regardless of who they are will make a difference, but the woman in labour still needs to feel safe and secure and all of those things and if there is a person there that is not of her choosing then it could be really hard to help her feel that way, not to say it can’t be done. There still needs to be the choice of women to be able to say, no, I’m going to interview a bunch of doulas from this list and chose the one that best suits me.

In this excerpt from Marisa and another that follows, from Sonya, both women seem to point to the subjectivity and particularity of women’s connections with their doulas as well as the uniqueness of women’s needs (e.g., “find the right person”; “we’re all individuals and we all bring something a little different”). Retaining a woman’s sense of choice over who her doula is can be understood as a means of women retaining control over this matter of their birth experience. Oakley (1993) states that “issues of control and responsibility come up again and again in looking at women’s health” and claims that “it is not often women who are in control of matters affecting their own health” (p.13).

Sonya, a doula, also describes how important it is for a woman in labour to have the “right” doula with her:

[When] you go into labor you are given a nurse, you can’t choose your nurse. If it’s [doula care] regulated by health care it would be sad if you were appointed a doula and you’re stuck with her. I encourage my clients to meet with two or three or five and find the person you are most comfortable with, it’s not about just having a person there, yes that will definitely help, but to find the right person for the woman is I think very important... Even with a midwife because there is a shortage right now you are appointed a midwife.... It’s different when you are paying for it, you think of it like you are going to buy a TV you [shop around] and say this is the one I like the most... doulas are kind-of the same thing you want to make sure you get the right match.... There should definitely be a choice.

There are multiple issues that surface in Sonya’s comments. For one, Sonya points to the importance of a woman’s birth experience and her sense of control during labour (e.g.,
not wanting women to be “stuck” with a particular doula). At the same time, Sonya draws an analogy between a woman’s choice regarding her childbirth experience and purchasing a television. I would suggest that this analogy can construct the birthing woman as a consumer of doula care which, again, embodies neo-liberal assumptions that are more reflective of privatized models of healthcare (Oakley, 1993). In my view, thinking of birthing women as consumers offers both possibilities and drawbacks. The term can imbue more of a sense of agency than “patient” and I suspect it is for this reason that it is often used in midwifery literature. At the same time, if this sense of agency is conceptualized in consumeristic ways (as Sonya seems to have here) then it may actually hinder connections from forming between women and their doulas. For example, it may foster a dynamic of the doula doing for the birthing woman rather than being with in a supportive and egalitarian way.

I think these considerations are important because the ways in which a woman’s choice of her doula becomes constructed and articulated will likely affect how women’s choices play out in the event of regulation and public funding. To elaborate, if choice is constructed as a means to provide a woman with individual support that is tailored to meet her needs then it places her needs at the centre and potential matches might be selected according to language or ethnic/racial background (as is often done in community-based doula programs). Whereas, if choice is constructed as a means for a birthing woman to select “the best” doula then attributes such as number of births or additional educational training may be considered prized. The first route places the emphasis on the particularities of fit whereas the second route places the emphasis on comparison. As has been noted, matching of women is an area that warrants further
investigation. The challenge that participants seem to be putting forth is to regulate and fund doula care in a way that retains the element of choice that fee-for-service models make available, while also ensuring that payment is structured in a way that encourages the provision of relationship-based care. In the event of regulated and publicly funded doula care, I would suggest that women be matched with a doula initially and then be provided with an alternate option if the match is not positive. This approach is in line with the Birth Companion Program’s practice on this issue. By managing matching in this way I think it may be possible to emphasize the particularities of fit and minimize associated financial costs while also partially retaining a woman’s sense of choice over her doula.

In this chapter I have explored participant views on increasing the accessibility and availability of doula care and the potential for the regulation and public funding of doula services. In the previous chapter participants described the nature of the close and connected relationships that often form between young mothers and their doulas. Here, they have responded to a key research question by describing the challenges that regulation and public funding of doula care might present; in particular, the ways that the importance of the relationship between mothers and their doulas may become compromised. As has been discussed, participant concerns regarding the challenges that regulation and public funding would present may be warranted. According to Daviss (2001) many post-regulation midwives find their biggest challenge to be maintaining their ideals and their holistic approach to practice as they attend more and more hospital births.
However, participants' apprehensions were presented *hopefully*, in tandem with recommendations that respond to a second central research question on how the nature of doula care might best be maintained. Participant recommendations (to safeguard the doula's position as independent from and external to the hospital system, match women during pregnancy, and ensure that women retain control over the choice of their doula) are all measures that could help to ensure reciprocity and a sharing of power which could help to protect the relationship-based nature of doula care. It appears that participants' concerns about the constraints that regulation and public funding might place on doula care were mediated by their hope for the possibilities that public funding would bring about; a belief in increasing women's accessibility to doula care was their foremost motivating factor.

In the final chapter, which follows, I will draw the discussion to a close by acknowledging the limitations of this research and offering summative conclusions, as well as my thoughts on future research and next steps on this issue.
Chapter Six: Conclusion

In this work I have explored the experiences of a small group of young mothers who access doula care, as well as the views of a small group of young mothers and doulas on increasing the accessibility of doula care. I have explained that doula care is only available on a private fee-for-service basis or, in a limited number of communities, through community-based doula programs. Participants in this study have spoken to the ways in which doula care can enrich maternal healthcare services for young mothers and have clearly called for increased availability and accessibility of doula care. Bringing about greater access to doula care could serve to enhance maternal healthcare services for women who are at risk by minimizing current inequities and expanding the availability of woman-centered care options.

The importance of women’s choices and sense of control in their birth experiences underpins feminist critiques of the maternal healthcare system (Beckett, 2005; Fox and Worts, 1999). The obstetrician-led medicalization of childbirth constructed birth as “unnatural” and dependent on “management” in a high-tech and hierarchical setting. The natural childbirth movement, of which midwifery’s professional project can be seen as a part, positioned itself in opposition to the medical system and advocated home birth and woman-centered care as childbirth alternatives (Bourgeault, 2006). The ideal of natural birth became a successful rhetorical strategy (Macdonald, 2006) and provided footing from which to critique the medical system’s appropriation of women’s choice and control. Yet, with the integration of midwifery into the maternal healthcare setting, women’s choices and options within the system have now expanded. I would suggest that the emphasis now, among birth activists and authors, is shifting from
a critique of the medicalization of childbirth and the medical system per se, to a more nuanced critique of the ways in which women's choices and experiences of control can be both constrained and supported in varied ways within the system. The critique has moved from exploring the medicalization of a "universal, objectified [woman's] body" to deconstructing "the social and cultural constructedness of all bodies" (Macdonald, 2006, p.239).

An important part of this shift involves recognizing and challenging the ways that women's sense of choice and control in the maternal healthcare system can be intensified or buffered by experiences of oppression and privilege. Many women who are at risk deviate from social constructions of "good" motherhood (Coll et al., 1998; Ladd-Taylor & Umansky, 1998) which can compromise their authority and credibility in healthcare contexts (Sherwin, 1998). For these women, the effects of "masculinist medical authority" (Simonds, 2002) can be particularly hard-hitting when not buffered by factors such as age, whiteness, middle-class status, and marital status.

Based on a review of the literature and the experiences of participants in this study, I have argued that young mothers' experiences can be shaped and influenced by societal beliefs about young motherhood and notions of immaturity, incapability and irresponsibility and that as a result, the impact of stigma and stereotypes that surround young motherhood can carry into experiences of felt discrimination in the maternal healthcare system. For the young mothers who participated in this study, the relationship they formed with their doulas seems to have been central to the effectiveness of the care their doulas provided. Building on Fahy and Parratt's (2006) theory of birth territory, as well as Bergum and Dossetor's (2005) work on the ethicality of relationships in
healthcare settings, I have argued that the relationship between a young mother and her doula provides a relational space within the maternal healthcare setting where it may be more possible for the birthing woman to access strong social support, articulate her needs, and feel in greater control of creating her own birth experience.

With acuity to the importance of such social support, participants in this study indicated that integrating doula care could serve to further enrich maternal healthcare and further expand women's choices and options within the healthcare system. Research on obstetric outcomes, as was reviewed and discussed in depth in Chapter Two, demonstrates that positive obstetric outcomes are associated with doula care. However, few studies have explored what precisely it is about doula care that translates into positive obstetric outcomes; or in other words, how and why doula care is effective. This study suggests that the social support provided through the relationship between a mother and her doula can be central; participants have recommended that, if doula care were to become regulated and publicly funded, the relationship-based nature of doula support could be protected by locating doula care in the community, matching women during pregnancy, and, ensuring that women retain some control over the choice of their doula.

**Researcher Recommendations and Critical Self-Reflection**

In this section, I will reflect on the influence I had on the study as a researcher, will discuss how participants views emerged in ways that I did not expect, and will then outline my own recommendations on proceeding with increasing the accessibility of doula care.
As was discussed in Chapter One, my own interest in "natural" childbirth and in doula care served in some ways as a starting point for the study. My key research questions were built on the assumptions that doula care is of value and that the obstetric outcomes that are associated with doula care are positive. My "insider" status as a volunteer with the Birth Companion Program and the questions that I posed to interviewees likely created a certain context which encouraged some participant responses more than others. In all phases of the study I made attempts to negotiate the influence of my own views, biases, expectations, and social location. For example, I kept an interview journal during the process of data collection as a tool for critical reflection and to better examine the influence of my assumptions and biases. During the analysis and writing phases, I also tried to reflect on and manage the influence of my expectations about what would surface in the data; for instance, I looked for sentiments that conflicted with those of other participants, or ways in which participants contradicted themselves within interviews. I think that these efforts to manage my biases were effective, in so far as is possible.

I came into this study with the view that regulation and public funding of doula care would increase woman-centered labour support within the maternal healthcare system and could therefore improve the system for all women. Secondly, I believed that increasing access to woman-centered support could help to mediate structural barriers to adequate healthcare and could be particularly beneficial for many women who are at risk. My views coming into this study were rather linear: namely, that doula care improved obstetric outcomes and should be made available on an equitable basis by pursuing regulation and public funding. I posed a key research question on the challenges of
integrating a woman-centered model of care into the maternal healthcare system because I knew that midwives had made efforts to protect their model of care. This research question, however, was asked in a way that pre-supposed that regulation and public funding for doula care was the route ahead (e.g., I referred to "this movement" in interview questions). In retrospect, I presumed that the challenges of integrating a woman-centered model of care would be surmountable and may not have provided adequate room in my interview guide for participants to disagree.

As was noted in Chapter One, participants’ views on regulation and public funding emerged in ways that I did not expect and this challenged me to reflect on, and adapt, the beliefs that I brought into this study. I undertook this study with an expectation that participant views on the regulation and public funding of doula care would be action-oriented in nature. Yet while participants believed that doula care should be made more accessible, apprehensions about regulation and public funding were at times at the forefront of our conversations. Many participants expressed caution, and seemed to be telling me to slow down and begin by building a better understanding of what makes community-based doula care with young mothers work. The importance of the relationship between young mothers and their doulas was more prominent in the data than I had expected and this invited a process of analysis that revealed the relationship as foundational to the nature of care during labour, rather than an added "bonus" of community-based doula support during pregnancy and the postpartum period. While I had previously seen community-based doula care primarily as a means of providing doula care to women who would not otherwise be able to access doula care, I would now suggest that it may be quite distinctly different from fee-for-service doula care. I believe
that the innovation of the community-based doula care model (which the Birth Companion Program espouses) may lie in combining social support for young mothers with labour support during childbirth. The community-based doula model provides young mothers with support in the community during pregnancy, in the maternal healthcare setting during labour and delivery, and again in the community in the postpartum period; this serves to bridge these two sites and brings continuity of support to new heights.

As such, and to offer my own recommendations, I would like to see further development of the community-based doula care model in Canada. I still envision a professional project but now believe that doula care could be advanced by first building up community-based services across the province and the country. In doing so, community-based doula care could strengthen its network of supporters and trained volunteers, increase awareness of doula care amongst medical personnel, educate community members on doula care, and conduct additional research on the community-based doula care model. At the same time, I would like to see a push for the regulation and public funding of doula care in Ontario get underway and build as the development of community-based doula programs also builds; this two-pronged effort may afford an opportunity for women and communities to clearly envision their own terms for regulation and public funding. While the recent recommendation to publicly fund doulas by British Columbia’s Caesarean Birth Task Force (British Columbia Perinatal Health Program, 2008) is encouraging, if a provincial Ministry of Health makes the first move toward regulating and publicly funding doula care then their initial terms may not reflect the values and principles of woman-centered care; whereas, if women and communities
build a strong network of community-based programs and a clear vision of public funding for doula care then they may be better able to represent their own interests.

Reflecting on the midwifery movement and taking participant suggestions into account, I would make several recommendations regarding a possible model of universal publicly funded doula care. First, in line with the approach of Ontario’s midwives, self-regulation would provide doulas with a means of setting standards of practice, yet would ensure a degree of autonomy. Second, I would recommend that public funding be channeled through the Community Health Centres (CHCS) which are funded through the Community Health Branch (CHB) of the Ministry of Health. The CHCS would likely provide more means for community input than hospitals. Channeling funding through CHCS could also help to foster collaborative working relationships with other CHCS staff who may be servicing the same clients. In those Ontario communities that do not have a CHC, doulas could be housed within a midwifery collective, a family services centre, or within their own space. Third, I would recommend that doulas establish their own training programs; as non-clinical care providers they may have greater capacity than midwives to negotiate such autonomy. Fourth, I would suggest that women be matched with doulas in advance and that broader social support during pregnancy and in the postpartum period be provided in accordance with a needs assessment and at the request of the birthing woman. Lastly, also in line with the funding of midwifery services, I would propose that doulas be remunerated on salary so as to avoid the “pressure ‘to do more’ which is inherent in the physicians’ fee-for-service system” (Bourgeault, 2006, p.191).
Implications for Social Work

The findings of this study suggest several implications for social work. First, there are possibilities for linkages between doula care and social work institutions and community services that work with pregnant and/or parenting women who are at risk (e.g., hospitals, CAS, sexual health clinics). Participants in this study discussed broader social support (such as assistance with housing, relationships, schooling, child support or social assistance) as an important part of community-based doula care. Community-based doula programs can complement and bridge the existing social supports available during pregnancy and in the postpartum period for women who are at risk; as was noted in Chapter Two, there are a range of social support services that young mothers can access while pregnant and as young parents, yet in most Canadian communities there are no social services that young mothers can access for support during childbirth. The Birth Companion Program is well networked and each year the program receives hundreds of referrals from public health nurses, hospital social workers, CAS, and St. Mary's Home and Outreach Centre, amongst other Ottawa area social service agencies. The Birth Companion Program also trains its volunteers to assist their matches with accessing existing community supports and resources on breastfeeding, infant care, nutrition and parenting (including affiliated programs such as the Parent Companion Program).

Two issues that were discussed in this work are of particular relevance to social work and warrant highlighting: 1) the structural barriers to adequate care that are encountered by many women who are at risk within maternal healthcare; 2) the effect of societal stigma and stereotyping surrounding young motherhood within child protection agencies. Social workers, both within and external to these institutions (hospitals and
CAS), can advocate for the advancement of anti-oppressive practices and policies within these institutions in an effort to create change on these issues. For example, in response to research on the effectiveness of teen-specific care (e.g., Bensussen-Walls & Saewyc, 2001; Quinlivan and Evans, 2004) social workers could work towards, and take a key staffing role within, additional teen-specific healthcare programs and settings (e.g., prenatal education classes, clinics). In child protection agencies, attention can be called to deconstructing the influence of middle class values and reforming prevailing notions about “good” and “bad” parenting, including the belief that adolescent pregnancy is, in and of itself, “bad” (Rutman et al., 2002). Strega (2007) discusses anti-oppressive approaches to child welfare; she critiques the presence of “isms” in child welfare practices (e.g., classism, racism, sexism) and points to how everyday practices of injustice can serve to reinforce dominance and marginalization. Strega (2007) offers several suggestions on how anti-oppressive theory can be applied to child welfare practice; for example, she includes an emphasis on the relationship between worker and client and suggests that increasing workers’ understanding of “the traumatic, stigmatizing and threatening nature of child welfare involvement” can create possibilities for fostering greater respect (p.75).

Lastly, I would suggest that social workers can encourage the expansion of community based doula care programs across the country by providing regional support for such initiatives and helping to facilitate the housing of new programs within appropriate community agencies. If doula care is to become regulated and publicly funded then I could see many social workers with interest or experience in doula care, childbirth education, or women’s health taking the lead in coordinating local programs.
Limitations

As was noted in Chapter One, the participant sample size for this study was small (eight participants) which means that the findings of this study can only be said to reflect the experiences of the study's participants and cannot be generalized to all doulas and/or clients of community-based doula programs. Furthermore, because all of the participants were associated with the Birth Companion Program they represent a particular sub-set of doulas and doula care clientele (they are all from the Ottawa area, and suited the volunteer or client eligibility requirements of the program). They are also a subset in the sense that they were willing to participate in the study. Those doulas that came forward to be interviewed were likely to have had positive experiences with clients and with the Birth Companion Program and have demonstrated a commitment to the aims of the program insofar as providing doula services for women who are at risk.

Similarly, the young mothers who came forward to be interviewed had likely had positive experiences with their birth companion and early parenting. As was noted earlier, I suspect that young mothers whose babies had been apprehended by CAS would be less likely to respond to my call for participants because it would be emotionally challenging to discuss their pregnancy and birth. In addition, the young mothers who participated in the study may have been more stably housed and better networked and supported than some of their peers (i.e., other young mothers who were clients of the Birth Companion Program) because they had the time and emotional energy to arrange and participate in an interview; therefore the results may underestimate the support needs of these clients generally. Lastly, my own views, particularly my involvement with the Birth Companion
Program, may have also acted as a limitation by encouraging participants to share positive experiences and to withhold negative feedback.

As has been discussed, efforts were taken to mediate the influence of these limitations and I consider these efforts to have been effective. For example, questions designed to solicit negative feedback on doula care and/or the Birth Companion Program were incorporated into the interview guides. Similarly, during interviews I stated to participants that I recognize that there are both pros and cons to the potential regulation and public funding of doula care, and that I wanted to hear all thoughts that they had on the subject, including any fears or concerns. In addition, during the analysis and writing phases I aimed to critically reflect on my role in constructing research findings and to question my own assumptions and processes of inquiry (Trinder, 2000). While the findings of this study are not generalizable, they do provide some insight into participants' experiences with community-based doula care, a model that arguably warrants further investigation and future research.

Future Research

The existing body of studies on doula is almost entirely epidemiological (e.g., randomized controlled trials) and quantitative in nature. As noted in Chapter One, the current study is one of only a few to have conducted qualitative research on doula care, and particularly on community-based doula care. In order to discuss the kinds of relationships and connections that form between young mothers and their doulas in the community-based doula care context I have drawn from literature on social support during pregnancy and the postpartum period. Existing research on doula care and social
support for young mothers seems to be roughly divided along these lines, with one body of literature on doula care, and another on social support for young mothers. More qualitative research with clientele of community-based doula care could help to better determine the role of broader social support during pregnancy and the postpartum period in clientele's experiences of support during childbirth.

Furthermore, while the epidemiological studies that have been conducted on doula care to date are compelling, Rosen (2004) suggests that existing studies vary a great deal in terms of definitions of training and support and that many have limited statistical power. I would suggest that it is still a relatively small body of research and could benefit from further investigation. In addition, I agree with Sauls (2002) who suggests that further epidemiological studies should be focused on discerning which aspects of professional labour support work best with different groups of women (e.g., young mothers). In particular, a randomized controlled trial with young mothers of a community-based doula program and young mothers who receive doula care only during labour and delivery could help to increase understanding of the importance of broader social support during pregnancy in young mothers' birthing experiences.

Lastly, I hope that future research can better address questions related to mobilizing women and communities on increasing the accessibility of doula care. I think it would be interesting to explore this issue from the varied perspectives of other stakeholders in the process: additional consumers (of both community-based and fee-for-service care); health professionals (e.g., midwives, nurses, obstetricians, lactation consultants); women involved in the alternative birthing and women’s health movements; professionals engaged in social work with pregnant and parenting women who are at risk;
and, doulas who are not volunteers for a community-based doula program (particularly as they may provide a different perspective on issues of professionalization).

**Dissemination**

A copy of my thesis will be publicly available in the MacOdrum Library at Carleton University. I also hope to make the findings more widely available through community and conference presentations, as well as published articles. In addition, a summary report of my thesis findings will be prepared in March/April 2009 and will be shared with relevant organizations (e.g., national doula care organizations, women’s health organizations) and study participants. I will encourage study participants to also assist with disseminating the results. I hope that this thesis will be of some assistance in effecting change in maternal healthcare services and in increasing the accessibility and availability of doula care, particularly for women who are at risk.
References


Scott, K.D., Klaus, P., & Klaus, M. (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Women’s Health and Gender-Based Medicine, 8*(10), 1257-1264.


Appendix A:

Interview Guide for Clients of Doula Care
Interview Guide for Clients of Doula Care

Gathering Information
1. How many months were you matched with a Birth Companion?
2. Are you currently connected to the Parent Companion Program?
3. Aside from the Birth Companion Program, what other programs and community services did you make use of during your pregnancy and the postpartum period?
4. Did you take a pre-natal education class? If so, did your Birth Companion attend class with you?

Demographics
5. What is your baby’s birthday?
6. How old were you on your baby’s birthday?
7. Would you describe your family’s income level: as below average, average, or above average?
8. Who is a part of your family? Who do you live with?
9. How would you describe your ethnic or cultural background?

Her Birth Story
10. What was your baby’s birth like?
11. What was the most memorable moment of your labour and delivery?
12. Was your labour and the birth what you expected it to be? How was it similar? How was it different?
13. Was there anything you wish you had known about labour and birth beforehand? If so, what?
14. Who provided you with information and support in pregnancy, labour and the postpartum period?
15. How did those people/services provide information and support?
16. All mothers experience birth differently and it often takes a little while before a mother feels really bonded to her infant. On a scale of 1-10 with 10 being ‘I am just bursting with love’ and 1 being ‘I have no positive feelings towards my baby at all', where do you think you are?

Her Birth Companion
17. How did you find out about the Birth Companion Program?
18. What did you know about doula care before you met with your Birth Companion?
19. Can you tell me what your first meeting with your Birth Companion was like?
20. Did you have any fears or concerns about having a Birth Companion? If so, can you tell me what those were?
21. What was the role of your Birth Companion in your pregnancy? How did she provide you with information and support?
22. What was the role of your Birth Companion during your labour and delivery? How did she provide you with information and support?
23. What was the role of your Birth Companion during the postpartum period? How did she provide you with information and support?
24. How do you think your pregnancy, labour and postpartum period would have been different without your Birth Companion?
25. What, if anything, do you wish your Birth Companion had done differently?
26. Would you recommend having a Birth Companion to other women? If you have more children would you want to have a Birth Companion again?

On Mobilizing Women and Communities
27. Do you think that every woman should be able to have a Birth Companion if she wants one? If so, why? If not, why not?
28. Could you see yourself working with other women to try to convince the government to make doulas an option for every woman? If not, what would hold you back from working on that issue? If so, what would motivate you to work on that issue? Who would you ideally want to work with (other young mothers?, doulas?)? What kinds of activities would appeal to you?
29. If you could choose between a Birth Companion who works for the hospital and a Birth Companion who works for a community health centre, who would you prefer to have as your Birth Companion, and why?
30. If doula care were to become covered under Ontario’s healthcare system then how much do you think doulas should be paid?
31. If doula care were to become covered under Ontario’s healthcare system then how do you think doulas should be ‘matched’ with pregnant women? (i.e., in advance or at the hospital (‘on call’)) How important do you think it is for a pregnant woman to establish a relationship with her Birth Companion in advance of her labour and delivery? In your view, how much of the Birth Companion’s role is about providing information and support in pregnancy and the postpartum period vs. during labour and delivery?

Closing
32. Is there anything else you would like to share?
33. How did you find the interview?
34. Any questions for me?
Appendix B:

Interview Guide for Doulas
Interview Guide for Doulas

Gathering Information
1. How long have you been a doula?
2. How long have you volunteered for the Birth Companion Program?
3. How many births have you provided labour support for?
4. What first sparked your interest in doula care?
5. How does being a doula fit into your career plans and your life in general?

On Doula Care for Women who are at Risk
6. What motivates you to volunteer for the Birth Companion Program?
7. How do you think that doula care can be of benefit to women who are at risk? What experiences (both with the program and external to the program) have you had with providing doula care to women who are at risk? How do you think that doula care can be of benefit to young moms in particular?

On Mobilizing Women and Communities
8. Do you think that every woman should be able to have a doula if she wants one? If so, why? If not, why not?
9. Could you see yourself working with other women to try to convince the government to make doulas an option for every woman? If not, what would hold you back from working on this issue? If so, what would motivate you to work on this issue? Who would you ideally want to work with (other young mothers?, doulas?)? What kinds of activities would appeal to you?
10. Do you have any concerns/fears regarding the regulation and public funding of doula care?
11. How do you think doulas across Canada, in general, would respond to this movement?
12. What resources do you think this movement has?
13. What challenges do you think this movement is facing? Or would face?
14. What barriers to involvement in the movement do you think doulas face?
15. What do you see as the principles and values of doula care? How do you think those principles and values could best be preserved if doula care were to become regulated and publicly funded?
16. How would you envision doula care being incorporated into the medical system? Fee for service vs. salary? Matched on call vs. in advance? Hospital vs. community-based?
17. If doula care were to become covered under Ontario’s healthcare system then how much do you think doulas should be paid?

Demographics
18. Who is a part of your family?
19. How would you describe your ethnic or cultural background?
20. Would you describe your family’s income level: as below average, average, or above average?
21. Is there anything else you would like to share?
22. How did you find the interview?
23. Any questions for me?
Appendix C:

Recruitment Email for Clients of Doula Care
Recruitment Email for Clients of Doula Care

Are you a young mom who had a ‘birth companion’ when your baby was born?

If so, then would you be interested in telling me about your baby’s birth? And about what it was like to have a birth companion? I have been a birth companion for 2 years. Right now, I’m a student and I’m researching how birth companions can be a support to young moms. I would like to talk to you for about an hour and your participation in the study would be anonymous.

I can meet you wherever would work well for you: at your place, at Carleton University or at Mothercraft.

If you want to participate or if you have any questions at all about the project then you can reach me at:

Heather Holland

hholland@connect.carleton.ca

613.301.4576

Unfortunately, if you had me as your Birth Companion then you aren’t able to participate in the study. The findings will be compiled in a research report for a Masters of Social Work Thesis. This research project has been approved by the Carleton University Research Ethics Committee.
Appendix D:

Recruitment Email for Doulas
Recruitment Email for Doulas

Dear Birth Companions,

I hope this finds all of you well:) 

I am writing because I am looking for participants for a study on doula care. I have been a BC for about two years and I am focusing my Masters of Social Work thesis on mobilizing communities for the regulation and public funding of doula care. I’ll be interviewing some of you as well as matches who have been through the program.

I would appreciate an opportunity to interview you about your experiences and views on providing labour support. I am most interested in talking to BCs who also provide private doula care outside of the Birth Companion Program. Interviews will be approximately one hour in length and your participation will be anonymous.

Please let me know if you would be willing to offer an hour of your time for an interview. I can meet you at your home, at Carleton University, or at Mothercraft.

If you are interested in participating or if you have any questions at all about the research project then please contact me at:

Heather Holland

hholland@connect.carleton.ca

613.301.4576

The findings will be compiled in a research report for a Masters of Social Work Thesis. This research project has been approved by the Carleton University Research Ethics Committee.

Thank you!

Heather