

"THERE'S MORE TO BIRTH THAN A BABY COMING OUT":
A FEMINIST PHENOMENOLOGICAL EXAMINATION
OF DOULA WORK IN ST. JOHN'S, NEWFOUNDLAND
AND LABRADOR

CHRISTINA YOUNG

**“THERE’S MORE TO BIRTH THAN A BABY COMING OUT”:
A FEMINIST PHENOMENOLOGICAL EXAMINATION OF DOULA WORK IN
ST. JOHN’S, NEWFOUNDLAND AND LABRADOR**

by

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ABSTRACT

In this thesis I present a feminist interpretive phenomenological examination of the lived experiences of doulas in St. John's, Newfoundland and Labrador, Canada, in relationship to three research objectives: (1) to investigate if membership in a collective provides doulas with particular forms of support, (2) to examine how doulas construct the significance of their relationships to their clients, and (3) to explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth. Data were collected via focus groups and interviews with eight doulas in St. John's, including seven members of the Doula Collective of Newfoundland and Labrador (DCNL), and one doula who practices independently.

Analysis and interpretation of these data resulted in four key findings: (1) the DCNL acts as a system of support for its members, but also poses particular challenges for insiders and outsiders, (2) doulas create meaningful relationships with their clients, but sometimes encounter difficulties with setting and maintaining boundaries with them, (3) doula work in St. John's is associated with overt activism for women's birthing rights, but doulas are careful to separate this activism from their care for their clients, and (4) it is possible to conceptualize the typical activities associated with doula care as forms of subtle resistance, falling along a continuum of subtle to overt acts. These findings are interpreted in relationship to the medicalization of childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour – in addition to my analytical frameworks of community and resistance. I discuss the practical and theoretical implications of my findings, and provide directions for future research.

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Table of Contents

Abstract	ii
Acknowledgements	iii
Table of Contents	v
List of Appendices	viii

Part 1: Background

Introduction	1
Research Objectives	1
Locating Myself as the Researcher	1
Rationale for the Study	4
Assumptions and Scope of the Study	5
Significance of the Study	6
Summary and Outline of the Thesis	6
Chapter 1 Literature Review: Contextualizing “Doula” in Newfoundland and Labrador	8
Defining “Doula”	8
The Doula Collective of Newfoundland and Labrador	15
Lived Experience of Doulas	16
Differences between Doulas and Midwives	19
Historical Context of Birth in Newfoundland and Labrador	21
Present Context of Birth in Newfoundland and Labrador	25
Chapter 2 Methods and Methodology: Feminist Interpretive Phenomenology	29
Epistemological Perspective	29
Feminist Approaches to Research	29
Feminist Standpoint and Feminist Poststructuralism	31
Methodological Approach	34
Interpretive Phenomenology	35
Feminist Phenomenology	37
Critiques of Experience as a Source of Knowledge	39
Research Design	40
Participant Selection	40
Participant Recruitment	42
Data Collection Tools	42
Implementation of Research Design	45
Engagement with Participants	45
Coding and Interpretation	49
Ethical Considerations	50
Reflexivity	51

Chapter 3 Theory: Medicalized Childbirth and the Gendering of Care	56
Medicalization of Childbirth	56
Feminist Theories of Maternal Embodiment	60
Gendered Nature of Caring Labour	70
Part 2: Analysis	
Introduction	76
Description of Participants	77
Feminist Interpretive Phenomenology	79
Chapter 4 Doula Work and Relationships	82
Doulas and Relationships in the Literature	82
A Framework of Community	84
Relationships to the Doula Collective of Newfoundland and Labrador	88
Receiving Support	88
Negotiating Conflict	98
Insider/Outsider Discourse	102
DONA International and Doula Certification	105
Relationships to Clients	116
Special Bonds and Unique Relationships	117
Setting and Maintaining Boundaries	124
Chapter 5 Doula Work as a Continuum of Resistance	129
Conceptualizing a Continuum	129
Doulas Performing Resistance in the Literature	133
A Framework of Resistance	135
Doulas and Overt Forms of Activism	138
Activism Versus Client Care	142
Doulas and Subtle Forms of Resistance	146
Empowering Women and the Discourse of "Choice"	150
Highlighting Gaps in the Hospital System	154
Disputing the Biomedical Model of Childbirth	161
Necessity for Doulas to be Activists in Newfoundland and Labrador	165
Troubling Doulas Work as a Form of Resistance	166
Conclusions	170
Overview of Findings	170
Directions for Future Research	172

References	174
Appendices	185

List of Appendices

Appendix A: Advertisement	185
Appendix B: Interview Protocol	186
Appendix C: Focus Group #1 Protocol	188
Appendix D: Preliminary Interview Questions	189
Appendix E: Preliminary Research Findings/Focus Group #2 Protocol	190
Appendix F: Consent Form	192

PART 1: BACKGROUND

Introduction

There's more to birth than a baby coming out, you know. And we get that, because that's what we're all about. But I think that doctors and nurses could give so much more...well rounded support and women wouldn't be crying after their births when they're recounting what happened.

Devi

Research Objectives

In this thesis I present a feminist interpretive phenomenological examination of the lived experiences of doulas in St. John's, Newfoundland and Labrador, Canada. More specifically, I examine the phenomenon of performing doula care, and identifying as a doula, in relationship to three research objectives: (1) to investigate if membership in a collective provides doulas with particular forms of support, (2) to examine how doulas construct the significance of their relationships to their clients, and (3) to explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth.

Locating Myself as the Researcher

Locating my own perspective as a researcher is an important element of my feminist interpretive phenomenological approach to knowledge production. I became interested in childbirth for the first time as an undergraduate student taking a Women's Studies course about women's health in Canada, which was taught by my current co-supervisor, Dr. Diana Gustafson. While the content of this course would come to shape many of my academic interests related to women's reproductive health, the class I remember most vividly was that on midwifery. Having lived in Newfoundland and

Labrador for all of my life, I had some familiarity with the concept of “granny midwives” attending births “around the bay.”¹ However, this class was my first introduction to midwifery as a modern phenomenon. Cecilia Benoit, whose work on childbirth practices in Newfoundland and Labrador would come to provide much of the historical context for this thesis, co-authored one of the course’s required readings about women’s access to maternity services in Canada (Benoit, Carroll, & Westfall, 2008). Although, at the time, I overlooked the article’s reference to “doulas” as childbirth attendants, I became captivated by midwifery and women’s experiences of childbirth within the broader context of feminist women’s health movements.

I began to learn more about women’s childbirth experiences, and came to the realization that much of the emotional and physical harm that women suffer during pregnancy and childbirth can be understood as a result of the care that they receive via the medical system, rather than of the childbirth process itself. Having identified myself as a feminist since at least the age of 14 (when I recited a speech on the topic to my ninth grade English class), this horrified me. Childbirth, and women’s reproductive health more generally, were rarely issues that I encountered as a burgeoning feminist. Prior to taking the course in women’s health in Canada, I had no conceptual schema for childbirth outside of the frantic, screaming, and out-of-control women whose births were showcased on television on weekday afternoons.

I entered my Master’s program in Women’s Studies with a desire to examine childbirth practices in Newfoundland and Labrador, both because of my concerns about

¹ Provincial dialect that refers to rural Newfoundland, or in some cases, any part of Newfoundland outside of the St. John’s metro region.

the lack of midwifery regulation in the province, and due to my interest in this province's unique history of childbirth practices in rural and urban areas. I became aware of the existence of the Doula Collective of Newfoundland and Labrador (hereafter referred to as the "DCNL" or the "Collective"), and decided to approach the issue of childbirth practices in this province from the perspective of doulas. More specifically, I was interested in understanding their experiences of providing care to women seeking alternative care during childbirth. I imagined this could provide important insights into the ways that doulas fit into the medical system in the St. John's area where, like the rest of the province, childbirth is highly medicalized and there are minimal if any choices available for women to make about their care in childbirth. This study has provided me with these insights and many more, including the dynamics associated with membership in, or independence from, the DCNL; the unique ways that doulas understand the significance of their relationships with their clients; and the potential to conceptualize the work performed by doulas as forms of resistance and activism.

I would describe my current social positioning as a white, cisgendered,² and middle-class graduate student. I have never performed doula care; nor have I ever been pregnant, given birth, or parented a child. I believe that my day-to-day embodied experiences differ significantly from those of the majority of my participants: I am not a provider of care, I am not a mother, and I have minimal obligations outside of my role as a graduate student. I highlight these differences because my feminist interpretive phenomenological approach is not guided by my own lived and embodied experiences, but rather by my desire to critique the medicalization of childbirth. I am conscious of my

² Individuals whose gender identity matches their gender assigned at birth.

belief that the medicalization of childbirth leads to problematic treatment of women's bodies and experiences throughout pregnancy and childbirth. However, I make no claims of objectivity or removal of this belief from my interpretation. I highlight my rejection of objectivity because this perspective is consistent with my feminist interpretive phenomenological methodology (described in detail in Chapter 2).

Rationale for the Study

This study contributes to a gap in the literature related to the lived experiences of doulas, as well as literature about contemporary birth practices in Newfoundland and Labrador. The literature that currently exists about doulas has adequately demonstrated the emotional and physiological benefits of doula care for mothers and infants (Klaus, Kennell, & Klaus, 2002; Hodnett, Gates, Hofmeyr, & Sakala, 2012). However, only a small portion of literature related to doula care focuses on the perspectives of doulas themselves (Deitrick & Draves, 2008; Humphries & Korfmacher, 2012; Kane Low, Moffat, & Brennan, 2006; Lantz, Kane Low, Varkey, & Watson, 2005; Stevens, Dahlen, Peters, & Jackson, 2011; Torres, 2013). As well, whereas the literature related to birth practices, such as midwifery and nursing in Newfoundland and Labrador, is quite extensive, there is currently no literature related to the emergence of doulas in this province. Since Newfoundland and Labrador is often cited (Benoit, Carroll, & Westfall, 2008) as having a unique history of childbirth practices in comparison to much of Canada, it is important to document how the appearance of doulas fits within both historical and contemporary contexts of childbirth practices in this province.

Assumptions and Scope of the Study

My own perspective as a researcher influences my conceptualization of the research objectives, the data collection and analysis, and the writing of this thesis. This perspective includes my epistemological, methodological, and theoretical perspectives and assumptions, as they relate to the lived experiences of doulas in St. John's. First and foremost, I describe my epistemological stance as a feminist researcher. My approach to conducting feminist research involves elements of feminist standpoint and feminist poststructuralism. This means that I place value in the knowledge produced via particular standpoints (including particular social, political, and geographic contexts that may or may not be disadvantaged) in order to gain insight into a particular experience, while also remaining attentive to differences within and between experiences produced from these standpoints. I describe my methodological approach as feminist interpretive phenomenology, which involves the intersection of feminist phenomenology as a philosophical tradition aimed at theorizing women's experiences that have been neglected in the male dominated philosophical tradition, with applied approaches to interpretive phenomenology as a tool for examining lived experiences through qualitative inquiry. Finally, my theoretical grounding involves studying the lived experiences of doulas in relationship to the medicalization of childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour – in addition to my analytical frameworks of community and resistance. The scope of this project is limited to representing the experiences of doulas practicing in the St. John's area. Although this project is grounded in the historical context of birth practices in Newfoundland and Labrador more generally,

the absence of individuals professionally identifying as doulas in other parts of the province restricted my project to doulas in St. John's.

Significance of the Study

This study is important because it contributes to filling gaps in the literature related to the lived experiences of doulas, as well as contemporary childbirth practices in Newfoundland and Labrador. Furthermore, this study presents unique theorizing of the lived experiences of doulas in relationship to the medicalization of childbirth and maternal embodiment, the gendered nature of caring labour, community, and resistance. At a practical level, this study has the potential to bring awareness to the work currently being performed by doulas in St. John's. Moreover, it highlights the current lack of childbirth options currently available in the province in general, including both doula and midwifery care.

Outline of the Thesis

In Part 1 of the thesis, I provide the background context, including the literature review, methods and methodology, and theoretical foundation that have shaped this study. In Chapter 1 – Literature Review, I explore the concept of “doula,” and situate the current presence of doulas in St. John's within the historical and present day contexts of childbirth in Newfoundland and Labrador. In Chapter 2 – Methods and Methodology, I describe my perspective as a feminist researcher employing a feminist interpretive phenomenological framework, and describe the interviews and focus groups I conducted with eight participants (seven of whom are members of the DCNL and one who practices doula work independently). In Chapter 3 – Theory, I explore the theoretical foundation that shaped my perspective on this study, including theories of the medicalization of

childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour.

In Part 2 of this thesis I present my analysis of my research data, as it relates to the background context explored in Part 1. In Chapter 4 – Doulas and Relationships, I discuss doulas' relationships to the DCNL, and to their clients, in relationship to theories exploring the nature of community. In Chapter 5 – Doula Work as a Continuum of Resistance, I discuss my understanding of doula work as a continuum of resistance and activist behaviours, in relationship to birth activism and a framework of resistance. Finally, in the Conclusion I outline my major findings, including: (1) the DCNL acts as a system of support for its members, but also poses particular challenges for both insiders and outsiders, (2) doulas create meaningful relationships with their clients, but sometimes encounter difficulties with setting and maintaining boundaries with them, (3) doula work is associated with overt activism for women's birthing rights, but doulas are careful to separate this activism from their care for their clients, and (4) it is possible to conceptualize the typical activities associated with doula care as forms of subtle resistance along a continuum of subtle to overt acts. I also discuss future directions for research in this area.

Chapter 1

Contextualizing “Doula” in Newfoundland and Labrador

And we had midwives like 50 years ago! You know, like my mom’s siblings were born at home by midwives, and then within 50 years...it vanished. And people don’t know what a midwife is and people think you’re going out in a shed catching [someone’s] baby with no medical equipment and no professional training...you know what I mean? They’re thinking like granny midwives back 60, 70 years ago around the bay in Newfoundland. I’m like no...that was midwifery then....But that’s not even a thing here so people just don’t get it.

Katie

This study is located within the currently existing literature about the lived experiences of doulas, and within the geographical context of St. John’s, Newfoundland and Labrador. In this chapter, I discuss how doulas are defined, provide an introduction to the DCNL, present the existing literature examining the lived experiences of doulas, describe the differences between doulas and midwives, and trouble the normative assumptions of doula care. As well, I consider the historical and present day context of childbirth practices in St. John’s, and Newfoundland and Labrador more generally, and how the current presence of doulas fits into this complex history.

Defining “Doula”

Doulas are generally described as non-medical support persons to women during pregnancy, childbirth, and the postpartum period. The Oxford Dictionary of English (Stevenson, 2010) defines “doula” as “a woman who gives support, help, and advice to another woman during pregnancy and during and after the birth” and describes the etymology of the word as deriving from the modern Greek word “doulē,” meaning “female slave” (para. 1). The term “doula” first appeared in an anthropological study by Dana Raphael (1973), and was used to describe the history of women providing

postpartum support to other women, particularly contributing to long-term breastfeeding success. The recent emergence of doulas as health care providers in North America has been described as follows:

The notion of women providing support to other women during childbirth is certainly not new. What is newly emerging, however, is the role of specific training and credentials for women who provide this type of service for a fee. No longer is a doula simply a female friend or community member who volunteers her knowledge and experience regarding childbirth to others with whom she already has a relationship. Rather, doulas have become a new type of “paraprofessional”³...with a specialized role and an interest in finding clients who will hire them for their services (Lantz, Kane Low, Varkey, & Watson, 2005, p. 110).

Contemporary usage of the word “doula” in North America generally implies that an individual is a provider of care during pregnancy and childbirth, but also that that individual has obtained training or certification through a doula organization such as DONA (Doulas of North America) International.

DONA International (2005e), the largest doula association in the world, defines “doula” as “a trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth” (para.1), and states that the word “doula” comes from ancient Greek and means “a woman who serves” (para. 1). DONA’s etymology of the term is less severe than that suggested

³ Defined as “a person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional” (Stevenson, 2010, para.1).

by the Oxford Dictionary of English, which may be related to DONA's role in "branding" the doula profession in a particular (and arguably, professional) way. The DONA definition of "doula" is unquestionably the most frequently cited in both academic and lay literature, and their doula certification (denoted as CD(DONA)) is the most popular and easily recognized of any doula association. Because of DONA's significant influence in defining the term "doula," and in determining the parameters of their role via their certification guidelines, it is important to interrogate the potential implications of a single organization maintaining substantial influence over a role that some view as part of a grassroots birthing movement, rather than the emergence of a new profession. However, it is equally important to note that the recent appearance of the role "doula" in North America can be largely attributed to DONA and their founding members, who are responsible for the construction of "doula" as a particular type of childbirth attendant.

The founding members of DONA International (2005a), including Marshall Klaus, John Kennell, Phyllis Klaus, and Penny Simkin, adopted the term "doula," (from the work of Dana Raphael) and determined the roles and responsibilities that doulas should fulfill. The term "doula," and the organization, DONA International, were created as a means of "promot[ing] the importance of emotional support for mothers and their partners during birth and the postpartum period" (DONA International, 2005c), based on clinical studies conducted by the founding members, which demonstrated the physical and psychological benefits of continuous support during childbirth. DONA's influence over how doulas are defined and what their responsibilities are is undeniable. However, some doulas (including some of my participants) have been critical of DONA's certification guidelines for being inattentive to differences of race, class, gender,

sexuality, and ability of doulas and their clients; for imposing limits on how a doula can be defined and how they should practice; and for placing an emphasis on doula work as a profession rather than a form of birth activism (Pérez 2012, 2013).

Doulas are generally trained as birth doulas, postpartum doulas, or both. My research focuses on birth doulas, who assist women with preparing and carrying out birth plans, stay with women throughout their labour, provide various forms of emotional and physical support (such as massage), and facilitate communication between the labouring woman, her partner, and medical professionals. DONA International states that birth doulas perceive their role as nurturing and protecting the woman's memory of her birth experience, and allowing the woman's partner, or other birth companion(s), to participate at their own comfort level (DONA International, 2005e).

A Cochrane Review of the benefits of having a continuous support person (such as a doula) during labour states that, due to North American women giving birth in hospital rather than at home with the support of other women, continuous support for women during childbirth has become exceedingly rare. The review describes this process as a "dehumanization" of the childbirth process and states that:

Modern obstetric care frequently subjects women to institutional routines, which may have adverse effects on the progress of labour. Supportive care during labour...may enhance physiologic labour processes as well as women's feelings of control and competence, and thus reduce the need for obstetric intervention.

(Hodnett, Gates, Hofmeyr, & Sakala, 2012, p. 2)

This review highlights the relationship between supportive care involving emotional, physical, and informational support, and tangible benefits such as increasing women's

feelings of control during birth and decreasing the necessity for various obstetrical interventions.

The current presence of doulas in North America can be understood as a continuation of the feminist women's health movement in Canada and the United States, which began in the late 1960s and early 1970s. Individuals involved in this movement have "criticized the health care provided to women; voiced frustration with the traditional paternalistic doctor-patient relationship; challenged professional authority and expertise; [and] objected to the medicalization of childbirth, menopause, and other natural processes in women's lives" (Ratcliff, 2002, p. 284).

The beginning of this movement is often marked by the publication of *Our Bodies, Ourselves* in 1971 by The Boston Women's Health Collective, which aimed to educate women about their own bodies, health, and sexuality. The most recent edition of the text (2011) describes some doulas as "specializ[ing] in certain situations, such as teen mothers, women whose native language is not English, women who have experienced a prior loss, VBAC⁴ mothers, women whose partners are deployed overseas, or women who cannot afford...doula services" (The Boston Women's Health Book Collective, 2011, p. 394). In addition to suggesting that doulas disrupt the normative model of childbirth in North America, in which women receive solely medical-based care during pregnancy and childbirth, this quote emphasizes the ways that doulas may pursue work that is particularly oriented around social justice. Therefore, as they provide care that may disrupt the medicalization of childbirth – in some instances providing care specifically to

⁴ Vaginal birth after caesarean section.

women who are most severely impacted by the biomedical model of birth – doulas can be understood as an extension of the women's health movement.

Despite a tendency for doula care to be associated with the women's health movement, or a feminist approach to supporting women during childbirth, I have found that discourses surrounding doula care are often uncritical of classist, heteronormative, and cisgender assumptions associated with reproduction. Biggs (2004) has highlighted the ways that advocacy discourses surrounding midwifery in Canada are often uncritically presented as part of a broad "feminist health agenda" without consideration for the ways that midwifery primarily addresses the concerns of white, middle-class, and heterosexual women. Biggs argues that midwifery advocates can therefore be guilty of perpetuating systemic discrimination, and additionally states:

By virtue of the fact that midwifery, maternity care, and childbirth centre on women's reproductive and biological status, it is all too easy to fall into the essentialist trap of assuming commonalities among women rather than examining their experiences in socio-cultural and historical contexts. (p. 19)

The literature about doula care and childbirth that I have drawn on generally demonstrates an assumption that both doulas and their clients fall within a normative framework of white and middle-class heterosexuality. For example, DONA International (2005b) emphasizes that doulas do not make the "father" obsolete during labour, and have a section on their website called "Dads and Doulas" that does not acknowledge the potential for non-male partners. Conversely, however, the DCNL's website does highlight the potential for differentially located clients as they state that doulas "respect the sexual

orientations and identifications of all clients” including reference to the role of the “father or partner” (Doula Collective of Newfoundland and Labrador, n.d.).

The failure to examine the experiences of doulas and doula clients from various social locations, or to take into consideration the impacts of gender, sexuality, race, class, ability or size on doula care, is certainly a limitation of research in this area.

Unfortunately, this study does not explicitly address this gap. Based on my interviews, there seemed to be an implicit assumption that doulas and doula clients in St. John’s were heterosexual, cisgendered, and middle-class, and my interview questions did not serve to interrogate or challenge these embedded assumptions.⁵ However, I aim to be attentive to the ways in which femaleness, whiteness, and particular social locations shape the narratives around doula care and childbirth more generally. In particular, in this study, I attempt to be conscious of the ways that doula care primarily improves the childbirth outcomes and experiences of white, middle-class, and educated women, who presumably do not face additional discrimination during childbirth, beyond the sexism inherent in the biomedical model of childbirth.

One of the only resources that I have encountered that highlights counter-normative doula care is *The Radical Doula Guide* by Miriam Pérez (2012), which highlights the importance of providing doula care that is attentive to the various social locations of doula clients. Pérez states “To me, being a Radical Doula is committing to

⁵ An explicit interrogation of the homogeneity of doulas and doula clients in St. John’s was beyond the parameters of this research project. However, as discussed in Chapter 4, one participant, Katie, did acknowledge the failure of her doula training to address the different needs of clients from varying social locations. This suggests that questions of social location are an important direction for future research.

the hard work of facing issues of racism, classism, ableism, homophobia, and transphobia head-on in our work with pregnant and parenting people” (para. 11). This project, and the doula work performed by my participants, does not explicitly address these issues.

Therefore, I aim to highlight the ways that doula care can be understood as improving the birth experiences of *already* privileged women, and may in fact perpetuate the normative values of the dominant society.

The Doula Collective of Newfoundland and Labrador

Seven of the eight participants in this study identified themselves as members of the DCNL at their time of participation.⁶ The DCNL was founded in 2008, and currently has 19 members, including a doula coordinator, 15 birth doulas, and seven postpartum doulas (four of whom are also birth doulas). Although the name of the Collective indicates that it encompasses doulas practicing in all areas of the province, the Collective is based in St. John’s, and none of the doulas currently listed on their website indicate that they practice outside of the St. John’s area. There have previously been doulas practicing in other parts of the province, such as in Central Newfoundland, but no doulas in Labrador have ever been affiliated with the Collective (Doula Collective of Newfoundland and Labrador, n.d.). The Collective’s website demonstrates an affiliation with DONA International, in that its “Ten Frequently Asked Questions” are derived from the DONA website, and an included hyperlink stating “how to become a doula” directs to DONA’s “Birth Doula Certification” page (DONA International, 2005a).

⁶ One participant, Olivia, decided not to renew her membership in the DCNL while I was completing my data collection.

Throughout the course of this research project, the Collective underwent several changes. When I began conceptualizing this thesis in February 2012, the Collective's website listed 27 doulas in three categories: DONA certified birth doulas (\$600 fee); doulas in training who have attended the births required for certification (\$300 fee); and doulas in training who have not attended any, or all, of the births required for certification (no fee). The website currently lists the Collective's 15 birth doulas in three categories: birth doulas with experience and certification; birth doulas with experience; and birth doulas in training, along with the statement that "Doula fees range from \$0 - \$800 and reflect experience, level of training and different services offered. Please contact doulas for pricing" (Doula Collective of Newfoundland and Labrador, n.d.). The website also describes a new development in the position of doulas in the hospital in St. John's: in addition to the two people that were previously allowed to attend hospital births, labouring women are now able to have a doula in attendance at their birth. Previously, if a labouring woman wanted a doula in attendance, that doula took one of the two allowed positions.

Lived Experiences of Doulas

Although only a small portion of literature related to doula care focuses on the personal experiences of doulas (rather than on the physical and emotional benefits of doula care), several studies have, nonetheless, examined the experiences of doulas from their own perspectives. Generally, doulas describe their work as personally fulfilling (Deitrick and Draves, 2008; Humphries and Korfmacher 2012; Lantz et al., 2005), portray their emotional support techniques as filling important gaps in maternity care (Gilliland 2011; Stevens, Dahlen, Peters & Jackson, 2011; Torres, 2013), and highlight challenges

associated with balancing their responsibilities as a doula with other paid employment and their personal lives (Kane Low, Moffat, & Brennan, 2006; Lantz et al., 2005). Deitrick and Draves (2008) found that doulas described personal benefits from their work, including increases in their own self-esteem and confidence as a parent, and improvements in their interpersonal and communication skills. As well, Lantz and colleagues (2005) found that one third of the participants aspired to be midwives or nurses in the future.

Additionally, I have encountered three studies that address my three research objectives, respectively. Firstly, a study by Kane Low, Moffat, and Brennan (2006) examined the experiences of doulas in a volunteer doula program in the United States. While doulas found that the program provided them with useful support, they nevertheless identified several areas where this support could be improved, including support groups for members; increased education (improved labour support training and care for clients facing particular social problems or barriers); greater material resources; scholarships for women who cannot afford to pay for training; and increased infrastructure support (such as ways to assess the quality of doulas' care and reimbursement of travel costs to visit clients).

Secondly, a study by Humphries and Korfmacher (2012) examined the relationship between doulas and mothers in a volunteer doula program that provided care to teenage, African American mothers. Doulas particularly emphasized that their relationships to their clients reached beyond professional boundaries, and spoke explicitly about their feelings of love for their clients. The authors describe this emotional connection as a necessary element of a positive working relationship. Additionally,

doulas emphasized trust and honesty with their clients were essential for building strong relationships with their clients.

Finally, a study by Torres (2013) compared the experiences of International Board Certified Lactation Consultants to those of DONA International certified doulas, and found that lactation consultants are able to use a “front-door” approach to accessing the maternity system, and gaining legitimacy within in it, whereas doulas must employ a “back-door” approach, by emphasizing their caring role, and diminishing their active advocacy for natural birth, in order to gain entry. The study explores the ways that this “back-door” approach can be read as a subtle form of resistance against medicalization. Doulas make space for natural childbirth in the hospital system, help their clients understand medical procedures and interventions, and expose medical professionals to natural birth.

Doulas generally reflect on their work as positive; nevertheless, as the previously cited studies demonstrate, they also identify numerous challenges in relationship to fulfilling their role, including experiencing a lack of support from the medical community; balancing doula work with other paid labour and personal responsibilities, particularly family and childcare; and the emotional stress that occurs as a result of being on call and working unpredictable hours (Lantz et al., 2005). Kane Low, Moffat, and Brennan (2006) outline further challenges that doulas have cited, including the fear of failure or of doing something wrong while providing care to a client; the necessity to support women’s birth choices that they understood to be harmful; the tensions associated with their presence in the hospital system; and other people misunderstanding or undervaluing the roles of doulas. As well, doulas have cited additional challenges

associated with their tenuous position that falls between certified professionals, and being part of a grassroots birthing movement, as their unclear professional distinctions can sometimes make it difficult to determine appropriate boundaries with clients around how much care they should provide (and the client should expect), particularly in volunteer settings.

Although the currently available literature related to the lived experiences of doulas provides some insight into the benefits and challenges associated with providing doula care, further research is required to gain a greater understanding of how doulas' experiences can be understood in relationship not only to membership within (or independence from) a doula collective, but also to the relationships they develop with their clients, and finally, their understandings of doula work as a form of activism or resistance against the medicalization of childbirth. My research will contribute to this small body of literature through my examination of the lived experiences of doulas in St. John's.

Differences between Doulas and Midwives

This study examines the position of doula care within the broader context of childbirth histories in Newfoundland and Labrador, particularly related to the changing role of lay and trained midwives. Therefore, it is important to examine the similarities and differences that exist between doulas and midwives in order to critically examine the current presence of doulas in this province. Both doulas and midwives have been associated with improved emotional and health outcomes for women and infants (Hodnett, Gates, Hofmeyr, & Sakala, 2005; Janssen, Saxell, Page, Klein, Liston, & Lee, 2009), and both doulas and midwives are, at least in North America, generally understood

to fall outside of mainstream, medicalized, birth practices. While doulas and midwives can both be understood in relationship to non-medicalized and woman-centred models of childbirth, it is important to acknowledge that their roles and responsibilities are distinct.

Registered midwives in Canada are health professionals who provide primary care to women during pregnancy, labour, birth, and the postpartum period, and are fully responsible for clinical decisions. Generally, midwives provide care to women with pregnancies that are deemed to be “low-risk,” though midwives may share primary care responsibilities with an obstetrician for women with “high-risk” pregnancies. The midwifery model of care supports informed choice, continuity of care, and natural birth (Canadian Association of Midwives, 2012). Currently, midwives are regulated in most parts of Canada, excluding Newfoundland and Labrador, Prince Edward Island, and Yukon (Canadian Midwifery Regulators Consortium, 2012). In Canada, midwives are trained through four-year bachelor degree programs, and must qualify for registration through the College of Midwives in the province in which they choose to practice. This is similar to the training and registration of a registered nurse.

Doulas are similar to midwives in their commitment to providing continuity of care to labouring women, but differ in that their primary role is providing women with emotional, rather than clinical, support during labour. Furthermore, while doulas are often knowledgeable about the physiology of birth, their main focus is on supporting the emotional needs of a woman in labour, including providing advice about pain reduction strategies, assisting women in carrying out a birth plan, and facilitating communication between women and their family, friends, and health-care providers (DONA International, 2005e). While there is no entity capable of dictating that doulas obtain a

certain level of training or certification, many doulas complete training programs through associations such as DONA International, Childbirth and Postpartum Professional Association (CAPP), and Childbirth International. Certification through DONA International, for example, requires the completion of a DONA approved birth doula workshop; the completion of various required readings related to pregnancy, childbirth, and postpartum; the evaluation of one's doula services at three separate births, from the birthing woman, nurse, and physician or midwife; signing DONA International's "Code of Ethics" and "Standards of Practice;" as well as other additional requirements (DONA International, 2005a). Doulas are not currently regulated in any part of Canada, but doulas are present in many parts of the country.

Historical Context of Birth in Newfoundland and Labrador

To understand the significance of the current presence of doulas in Newfoundland and Labrador, it is important to examine the history of non-physician birth support in this province, including a range of midwifery and nursing practice. This province experienced a gradual shift from home birth, to small cottage hospital, to the current regionalized hospital system. This slow transformation of midwifery care in the province sharply contrasts the rapid and systematic elimination of midwifery that occurred in much of Canada (Benoit, 1991). Also, unlike the majority of Canadian provinces, Newfoundland and Labrador does not currently have midwifery regulation (Canadian Midwifery Regulators Consortium, 2012). Examining the integration of doulas into a population that experienced a slow decline in midwifery practice, but currently does not have midwifery regulation, provides a unique opportunity to examine the merger of medicalized birth with the traditional model of woman-to-woman support.

Cecilia Benoit has written extensively on the history of childbirth in Newfoundland and Labrador, particularly related to midwifery practice in the province. Benoit (1991) distinguishes between four different types of midwives in the province. These include traditional homebirth attendants, solo practitioners in rural clinics, cottage hospital midwives, and workers in large, regional hospitals. More broadly, Benoit emphasizes the distinction between traditional lay midwives and trained midwives. Traditional lay midwives, often referred to as “auntie” or “granny,” were homebirth midwives with no formal training who obtained knowledge through informal apprenticeship from other midwives, including female family members. These midwives provided care related to childbirth and sexuality, but were also responsible for more general treatment of illness within their community. “Granny” midwives were generally married, working class women with large families. These women provided essential services to their communities, but often faced many challenges, such as attending difficult births without support or obstetrical technologies and travelling long distances to reach labouring women. Conversely, Benoit describes trained midwives as women who received some level of formal vocational training, and generally practiced within cottage hospitals, rural clinics, or regional hospitals.

In the 1920s, the government of Newfoundland and Labrador aimed to improve maternal and fetal health outcomes, and introduced formally trained nurse-midwives into isolated rural areas through the Newfoundland Outport Nursing and Industrial Association (NONIA). Many of these nurse-midwives had received vocational training in the United Kingdom, or had attended a midwifery-training course in St. John’s. This initiative faced many difficulties, as these nurse-midwives experienced heavy workloads,

limited supplies, isolation from other health professionals, lack of emergency medical technologies, and high expectations from communities anticipating a greater level of care than they had previously received from a traditional lay midwife, or “granny” (Benoit, 1991).

There were many legal and political changes associated with the shift from traditional home birth midwife to physician attended hospital birth in Newfoundland and Labrador (Association of Midwives of Newfoundland and Labrador, 2013). In 1920, The Government of Newfoundland implemented *Chapter 235: An Act Respecting the Practice of Midwifery*, which involved the creation of a Midwives Board to examine and provide midwives with a license to practice. Then, in 1935, the government of Newfoundland and Labrador launched the “Cottage Hospital Plan,” as a response to the inadequate medical services available in most rural areas of the province (Association of Midwives of Newfoundland and Labrador 2013). Benoit (2004) describes cottage hospitals as 30-50 bed institutions, with a small staff consisting of physicians, nurses, midwives, and other support staff. This new system of cottage hospitals alleviated some of the problems associated with traditional lay midwifery and NONIA initiatives, such as lack of medical equipment and increased support for caregivers. Cottage hospitals employed some traditional lay midwives with apprenticeship experience, but primarily employed women from around the province who had received midwifery training in St. John’s, or midwives from the United Kingdom who had previously been employed by NONIA (Benoit, 1991).

In 1949 when the province joined confederation, Canada did not formally recognize midwifery. The Hospital Insurance Plan, implemented in 1958, only funded hospital births attended by physicians. These historical milestones meant that there was

no legislative support for midwives in the province. That lack of formal support may have translated into a lack of public support for midwives. This hypothesis appears to be supported by two further events. First, the last license to practice midwifery was issued by the Government of Newfoundland and Labrador in 1963, after which the government ceased to appoint a Board to issue midwifery licenses, as this had been the only license requested in that year. Second, in 1979 the first cohort of nurses was admitted to a midwifery program at the School of Nursing at Memorial University, but this program was discontinued in 1986 due to dwindling enrollment and decreased funding (Association of Midwives of Newfoundland and Labrador, 2013).

During the 1980s, a provincial shift towards the regionalization of health care services resulted in the closure of most cottage hospitals. Within the new regional hospitals, non-formally trained maternity personnel were able only to apply for the position of “obstetrical nurse,” and were not able to act as autonomous or primary caregivers to labouring women (Benoit, 2004). In 2000, when the Grace General Hospital in St. John’s closed, all maternity services were moved to the Health Sciences Centre. The Health Sciences Centre remains the only hospital in the St. John’s area in which women can give birth (Association of Midwives of Newfoundland and Labrador, 2013).

Women living on the island of Newfoundland and those living on mainland Labrador have historically faced many of the same issues in gaining access to quality maternity care because the population was distributed in isolated fishing villages or rural farming communities until the mid-twentieth century (Benoit, Carroll, & Westfall, 2008). However, Aboriginal women’s traditional birthing practices have been systematically removed in ways that white settler populations of the province have not. In the late

nineteenth century, colonial governments across Canada began to implement policies aimed at assimilating Aboriginal peoples into settler colonies, including settler birth practices and a biomedical approach to pregnancy and childbirth. These policies lead to the dissolution of many Aboriginal family structures, in which childbirth was historically based, and included particular governmental influence over the health of Aboriginal populations (Benoit, Carroll, & Westfall, 2008). The National Aboriginal Health Organization (2004) states that Indigenous knowledge of birthing practices among Aboriginal women was lost through the process of colonization and the broader loss of cultural identity as a result of the residential school system, the imposition of Western medicine, government legislation, and epidemics leading to high mortality of Aboriginal people. There is currently a dearth of detailed literature on the history of traditional Aboriginal birthing practices across Canada (Biggs, 2004), and particularly in Newfoundland Labrador, which can be understood as a consequence of the colonization of Aboriginal peoples. However, Biggs has observed that the limited information that does exist about traditional Aboriginal birth practices in Canada indicates that the meaning of the term “midwife” differed substantially from that of Anglo-European communities; childbirth, and childbirth attendance were so fully integrated in some communities that “midwife” was not a distinct role (Biggs, 2004, p. 25).

Present Context of Birth in Newfoundland and Labrador

Midwifery is currently one of the professions identified in the Health Professions Act, which passed legislation in Newfoundland and Labrador in 2010. This Act is responsible for implementing the regulation of seven health professions in the Newfoundland and Labrador Council of Health Professionals, including acupuncturists,

audiologists, dental hygienists, medical laboratory technologists, respiratory therapists, speech-language pathologists, and midwives. Each profession is responsible for authoring its own standards of practice. As of July 9, 2013 all of these professions, except midwives, had met the requirements for regulation (Newfoundland and Labrador Council of Health Professionals, 2012). However, there are currently no midwives practicing in the province, and therefore no midwives to establish the professional guidelines necessary to establish regulation. Consequently, the future of the regulation of midwifery in this province remains unclear.

Anecdotal evidence from my participants suggests that some women in the St. John's area do give birth at home under the care of a midwife. But, because of a lack of regulation, along with a fear of stigmatization from medical professionals (for both birthing women and doulas), this practice remains relatively underground. As well, despite the fact that midwives are not currently regulated in this province, nurses with midwifery qualifications are employed by the Labrador-Grenfell Regional Health Authority to practice a limited scope of midwifery through a special agreement between the Newfoundland Medical Board and the Association of Registered Nurses. These midwifery services are offered in areas with substantial Aboriginal populations (Mi'kmaq, Innu, Inuit, and Labrador Métis) and are funded through the provincial Medical Care Plan (MCP). However, because midwifery services are offered only in regional or urban hospitals, many pregnant Aboriginal women must be evacuated from their homes in order to give birth (National Aboriginal Health Organization, 2004). Due to the presence of midwives within the Labrador-Grenfell Regional Health Authority, it may appear that childbirth options are somewhat broader for women in Labrador than on

the island of Newfoundland. However, these services are not available in all areas. The geographical isolation of many towns, such as Labrador West and the refusal of general practitioners to attend births (citing the absence of local obstetricians), has resulted in the routine evacuation of pregnant women to Newfoundland to deliver their babies (CBC, 2011a, 2011b).

Although some doulas that I interviewed performed doula care in some form as early as 2004, doulas meaningfully entered the history of childbirth in this province in 2008, with the formation of the DCNL. The concerns that doulas bring to the table – and the needs they address for pregnant and labouring women – have their antecedents in Newfoundland and Labrador’s complex childbirth history. As a “granny” midwife (born in 1889) from the west coast of Newfoundland stated, “I first learned to doctor the women and others in the village from my dear mother....I was always present during birth, consoling and guiding my expectant mother” (Benoit, 1990). This midwife’s commitment to being a constant, reassuring presence during the birth foreshadows the way that doulas in this province would come to describe the importance of their presence in the hospital system. Correspondingly, the need for midwifery regulation in Newfoundland and Labrador was a recurring theme throughout all of my interviews. It is essential to understand the childbirth options currently available in the province, and particularly in the St. John’s area, in order to gain a greater understanding of how doulas fit into the current medical model of birth, and how their presence points to the need for improved childbirth options in this province.

The type of continuous care typically provided by a midwife is not available in St. John’s, and the women who yearn for this type of care may turn to the services of a doula

as an alternative. Due to a limited number of general practitioners currently attending births in St. John's, the majority of women in this area receive the clinical care of an obstetrician or an obstetrical resident at the Health Sciences Centre at the time of their delivery. Therefore, most women will be unfamiliar with the physician who will be delivering their baby. As a result, within the current environment, paying for the services of a doula is one of the only active choices that women in the St. John's area can make about their care in childbirth, and one of the only ways that a woman is guaranteed a familiar and continuous care provider during labour. However, despite the presence of doulas in this province being significant in terms of their ability to provide an alternative form of care during childbirth in a province with minimal birth options, the "choice" to access doula services is limited to women residing in the St. John's area, and further, to those who possess the privilege required to be both aware of the existence of these services, and to have the financial means to obtain them. I examine the implications of this in Chapter 5.

In this chapter I have contextualized the presence of doulas in Newfoundland and Labrador within literature exploring the definitions and roles of doulas, and the historical and present day context of childbirth practices in this province. I have also outlined how "doula" is defined, demonstrated the influence of DONA International in determining the roles and responsibilities that doulas should fulfill, provided an overview of the current literature examining the lived experiences of doulas, outlined the differences between doulas and midwives, and troubled the normative assumptions of doula care. In the next chapter, I outline my methodological approach and research design.

Chapter 2

Methods and Methodology: Feminist Interpretive Phenomenology

I do consider myself a feminist and I think there are definite aspects of my doula work that are feminist in nature. Particularly what comes to mind is the advocacy that many of us doulas do to promote a woman's right to choose how and where she gives birth. Over the years, birth has been moved from the comforts of one's own home, attended to by midwives and other supportive women – to the hospital...where [it] has been medically managed by physicians.

Melissa

This chapter describes my epistemological perspective, my methodological approach, and the various aspects of my research design and implementation. I conceptualize my methodology, or the theoretical perspective from which I approach all aspects of this research project, as feminist interpretive phenomenology. This encompasses feminist approaches to phenomenology, and applied approaches to interpretive phenomenology, as they relate to the study of lived experiences. I discuss my use of focus groups and in-depth interviews in order to gain insight into the experiences of doulas in the St. John's area, my approach to coding and analyzing the data, and delineate some of the ethical and reflexive considerations of this research project. As well, this chapter demonstrates the congruence between my epistemological perspective, my methodology, and my research design and implementation.

Epistemological Perspective

Feminist Approaches to Research

Feminist approaches to research have been described as “political in standpoint, gendered in focus, reflexive in process, and transformative in outcome” (Gustafson, 2000, p. 724), and typically involve some combination of knowledge derived through feminist

theory, an attentiveness to research ethics and power dynamics in the research process, and a motivation to produce some form of social change (Ramazanoglu & Holland, 2002, p. 147). Ackerly and True (2010) depict a feminist research ethic as “a methodological commitment to any set of research practices that reflect on the power of epistemology, boundaries, relationships, and the multiple dimensions of the researcher’s location...[and] to transforming the social order in order to promote gender justice” (p. 2). Similarly, Hesse-Biber and Yaiser (2004) portray research conducted within a feminist framework as “attentive to issues of difference, the questioning of social power, resistance to scientific oppression, and a commitment to political activism and social justice” (p. 3). The authors also argue that feminist epistemologies critique positivist approaches to knowledge production, and feminist researchers generally avoid placing greater value on one research method over another (Hesse-Biber & Yaiser, 2004). As well, feminist researchers attempt to question the ways in which andocentric knowledge production determines who can possess knowledge, how knowledge can be produced, and how knowledge can be defined (Gustafson, 2000).

My research interests are tied to my desire to highlight the systemic discrimination against women’s reproductive health concerns in the Canadian context, and are motivated by my intention to conduct research that is both critical of these inequities, and oriented towards the production of social change. Prior to and throughout this research project, I have held a deep skepticism and distrust towards the medicalization of childbirth.⁷ This heavily influenced my conceptualization of this research project, my research questions,

⁷ See Davis-Floyd (2003). Also, see Chapter 3 for an examination of the medicalization of childbirth.

and my specific interview questions. I approached this research with the expectation that my participants would also express some degree of dissatisfaction with the medicalization of childbirth, and in general, I think that this was true. However, I feel that it is important to acknowledge that I approached the conception and analysis of this research project through this lens, and therefore the outcomes of this research are inherently tied to my own personal perspective of doula care within the context of medicalized birth.

Feminist Standpoint and Feminist Poststructuralism

My perspective as a feminist researcher incorporates elements of feminist standpoint theory (Harding, 2004b), feminist poststructuralism (Gavey, 1989), and feminist approaches to embodied knowledge production (Young, 2005). This epistemological approach can be described as placing value in knowledge that is produced through embodied ways of knowing (such as knowledge produced through caring activities performed by doulas) that are produced within a specific social location, while also being attentive to both deconstructing the category of “woman,” and essentialized understandings of women as naturalized caregivers.

Feminist standpoint theory originated in the 1970s and 1980s as a response to discourses of power within the production of knowledge; namely the absence of female-centred experience from academic knowledge production and the “surprising success” of politically motivated feminist research (Harding, 2004a, p. 1). Sandra Harding, who has been credited with bringing feminist standpoint into existence, explains that this theoretical perspective acknowledges how certain forms of social and political disadvantage can be transformed into “epistemological, scientific, and political advantage” (2004a, p. 8). Speaking particularly about feminist standpoint theory in

relationship to maternal thinking and caring labour, Sara Ruddick (2004) states “caretakers work with subjects; they give birth to and tend to self-generating, autonomously willing lives. A defining task of their work is to maintain mutually helpful connections with another person...whose separateness they create and respect” (p. 163). She also emphasizes “careworkers depend on a practical knowledge of the qualities of the material world, including the human bodily world, in which they deal” (p. 163). Sara Ruddick (2004) points to the importance of critiquing knowledge produced from a particular standpoint as constituting a “Truth” but instead imagines a world organized around the tenets of caring labour (p. 164-165). The care provided by doulas can be understood in relationship to their engagement with materially constituted caring labour. Additionally, doulas’ work can be interpreted as placing inherent value in the provision of care, and in the knowledge produced from a woman-centred, care providing perspective.

Feminist standpoint theory has been critiqued on the basis that it “appears to be opposed to two of the most significant influences in recent feminist theory: postmodernism and poststructuralism” (Hekman, 2004, p. 225). Therefore, critiques of feminist standpoint theory suggest that this perspective relies too heavily on the details of an individual’s experience, rather than on the discourses that have shaped these experiences. Conversely, a poststructural feminist approach to research is characterized by an emphasis on experience as possessing no essential meaning, and on experience as inherently linked to language (Gavey, 1989). Gavey (1989) argues that feminist theories that privilege women’s experiences as holding particular epistemic value represent a “less radical challenge to patriarchal discourse” than perspectives that attempt to disrupt the boundaries of “male” and “female” experience entirely (p. 461). Ramazanoglu & Holland

(2002) interrogate the tension that exists within feminist research between a reliance on women's subjugated experiences as a source of knowledge, and a rejection of experience in favor of the examination of how subjugated positions are discursively created and performed. The authors argue that "there is a strong case for taking people's accounts of their experiences as a necessary element of knowledge of gendered lives and actual power relations" (p. 127), and that "questions about what an experience is like, and why it happens as it does, are not independent of how this experience is constituted in theory, politics, conceptions of injustice" (p. 128). In other words, they suggest that experience must be studied and evaluated within the context of the particular social circumstances that constrain them. I aim to incorporate feminist poststructural critiques into my approach to feminist standpoint by acknowledging the potential essentialism inherent in my examination of the experiences of doulas as women who provide care in highly gendered ways. Furthermore, although I approach this research topic with the expectation that my participants' experiences demonstrate many commonalities, I am also careful to emphasize the unique contributions of each participant, and my inability to abstract my findings to other doulas outside the scope of this study.

I acknowledge that reconciling feminist standpoint theory with its feminist poststructural critiques, and with feminist poststructuralism in general, is far beyond the scope of this study. However, I feel that these theoretical debates are central to my epistemological negotiation between feminism (and in turn, feminist research) as a political movement that aims for the emancipation of individuals inhabiting the category of "woman," and the dismantling of identity categories in order to avoid the hierarchical privileging of some identities over others. In addition to this, my approach to feminist

research involves a constant negotiation between the strengths and weaknesses of experience as a source of knowledge (which I discuss further in relationship to interpretive phenomenology as a methodological technique). This negotiation is inherently linked not only to the value that I place in embodied ways of knowing, but also to my feminist interpretive phenomenological approach to the design and analysis of this research project.

Methodological Approach

My conceptualization of a feminist interpretive phenomenology incorporates interpretive phenomenology as a methodological technique, and feminist approaches to phenomenology as a theoretical perspective on woman-centred knowledge production. While I conceptualize feminist interpretive phenomenology as my overall methodological approach, it is necessary to discuss this approach in relationship to interpretive phenomenology and feminist phenomenology separately, as my approach represents the intersection of two distinct, yet overlapping, methodological and theoretical literatures. Although feminist interpretive phenomenology is not an approach that I have found explicitly described in the literature, I conceptualize this approach as incorporating elements of interpretive phenomenology as an applied methodological approach to qualitative research, and feminist approaches to phenomenological philosophy more generally. This allows me to approach this research project from a specific and rigorous technique for research design, data collection, and data analysis, and with attentiveness to the examination and interpretation of woman-centred embodied experiences.

Interpretive Phenomenology

At a methodological level, my work is deeply indebted to the insights of Smith, Flowers, and Larkin (2009) and their text *Interpretive Phenomenological Analysis: Theory, Method and Research*. The authors provide a thorough overview of the theoretical foundations of interpretive phenomenological analysis (IPA), in addition to suggestions for planning an IPA research study, collecting data, conducting the analysis, and writing about the findings. Whereas much of the literature describing phenomenology as a research methodology does not address the particular approaches to data collection, analysis, and writing that its proponents should follow, Smith, Flowers, and Larkin (2009) suggest practical and applied approaches to conducting research that are congruent with the philosophical underpinnings of IPA. As a novice researcher, I found these insights particularly beneficial, and appreciate their suggestion that “the novice [researcher]...sees these guidelines as recommendations for getting started, rather than as permanent prescriptions” (p. 5). I also acknowledge that much credit should be given to van Manen (1990) for his innovations in the phenomenological research method. However, I was more easily drawn to the more recent work of Smith, Flowers, and Larkin (2009) because, as a former student of psychology, I identified with their goal of moving psychological inquiry into a more sophisticated, qualitative realm. Furthermore, the authors provide specific guidelines for conducting an interpretive phenomenological research project, but also reaffirm that this approach is based in philosophy, and is therefore based in common processes and principles that phenomenological researchers might employ, such as “moving from the particular to the shared” and “a psychological focus on personal meaning-making in particular contexts” (p. 79).

Phenomenology, derived from the work of Husserl, Heidegger, Merleau-Ponty, and Sartre, can be defined as “a philosophical approach to the study of experience” (Smith, Flowers, & Larkin, 2009, p.11). Interpretive phenomenology (also referred to as hermeneutic phenomenology) is guided by the philosophical underpinnings of phenomenology (the examination of lived experience), hermeneutics (a theory of interpretation), and idiography (an emphasis on the particular) (Smith, Flowers, & Larkin, 2009). This approach can be described as a methodology that guides the researchers’ interpretation of an individual’s lived experience through an examination of the specific details provided about that experience or event (Smith, Flowers, & Larkin, 2009); for example, the experiences of doulas within the particular geographical and social contexts of St. John’s, Newfoundland and Labrador. Interpretive phenomenology is coherent with my epistemological stance as a feminist researcher, because the acknowledgement of the interpretive role of the researcher is implicit in this approach. While I aim to present my participants’ responses in a way that I feel is authentic to their own understandings of their lived experiences as doulas, interpretive phenomenology makes explicit the role of the researcher in determining which themes are emergent and worthy of consideration.

Interpretive phenomenology is a methodological technique whose practical application has been modelled for qualitative research projects, and particularly in health and caring research (Benner, 1994; Chan, Brykczynski, Malone, & Benner, 2010; Thomson, Dykes, & Downe, 2011). I was drawn to interpretive phenomenology because of its prominence in health care literature, and for its emphasis on the interpretation of individual experiences within broader social contexts. Speaking to the appropriateness of

interpretive phenomenology for qualitative research in midwifery and childbirth, Bondas (2011) states:

The core interests of caring science are closely related to caring and values, and the discipline of phenomenology suits caring science research well. It offers a human science disciplines with its task to create knowledge of caring that has the potential to...promote health. (p. 5)

Generally, this approach can be described as a “focus on personal meaning and sense making in a particular context, for people who share a particular experience” (Smith, Flowers, & Larkin, 2009, p. 45). Some of the specific guidelines involved in an interpretive phenomenological research project include the study of the experiences of a fairly homogenous group, a relatively small sample size, the use of interviews with a fairly flexible protocol, a systematic analysis of interview transcripts, and the transformation of data into “a narrative account where the researcher’s analytic interpretation is presented in detail and is supported with verbatim extracts from participants” (Smith, Flowers, & Larkin, 2009, p. 4). As well, data derived from an interpretive phenomenological study are not considered to be objective and “value-free,” but rather “the researchers’ preconceptions, biases and assumptions are clarified and become an integral part of the study findings” (de Witt & Ploeg, 2005, p. 222).

Feminist Phenomenology

My methodological approach is also guided by feminist approaches to phenomenology that make women’s embodied experiences the subject of inquiry, within a framework in which mind and body are seen as connected in order to constitute a coherent lived reality (Goldberg, Ryan & Sawchyn, 2009). Drawing on Simone de

Beauvoir's (2009) theorization of particular aspects of women's lives within the social world, feminist philosophers such as Iris Marion Young (1980) and Sandra Bartky (1975) brought embodied female experiences into the realm of phenomenology. These theorists interrogate our understanding of what it means to be a woman, and a feminist, and aim to make sense of embodied experiences of female-centred events such as menstruation, pregnancy, and childbirth.

Garko (1999) argues that feminism and feminist approaches to research are harmonious with phenomenology, as both approaches attempt to disrupt the assumption of objectivity in knowledge production, and the dichotomy between subject (researcher) and object (researched phenomenon) – instead viewing the researcher and participants as co-constituents of knowledge production. Feminist phenomenology is particularly relevant for research related to pregnancy and childbirth, as these experiences have been under theorized and require particular attention to subject/object dichotomies not only between researcher and researched, but also between mother and fetus. Oksala (2004) states: “pregnancy and birth are important in challenging the various ways in which male modes of embodiment are privileged in our thought and practices. Feminist phenomenology has an important role in reminding us that there is a whole region of experience that philosophers have failed to think” (p. 17). Female-centred bodily experiences such as pregnancy and birth have historically been absent from the phenomenological project of embodied knowledge production, and feminist phenomenology points to the importance of incorporating these embodied perspectives into philosophy and the interpretation of women's lived experiences.

The experiences of doulas can be understood as existing on the periphery of these female-centred embodied experiences, yet their knowledge of their own experiences as doulas is produced through their embodied experience of caring labour (an overwhelmingly female-dominated role). It is important to be critical of theories of female embodiment, and their potential to produce essentialist understandings of women's experiences, or a necessary association between women's identities and biologically female processes. At the same time, it is also necessary to acknowledge that philosophical interpretations of these events, such as childbirth and caring labour, have been under theorized within an andocentric and technocratic (or, medicalized) model of birth in Western societies (Davis-Floyd, 2003).

Critiques of Experience as a Source of Knowledge

Similar to the critiques posited against feminist standpoint theories, phenomenological approaches to knowledge production have been critiqued by feminist poststructuralists on the basis that there is no authentic female experience that is universal to all women, and that the relevance of an experience lies not in the experience itself, but rather, in its discursive production (Scott, 1991). Stoller (2009) argues that phenomenology, and particularly feminist phenomenology, is able to stand up to these poststructural critiques. Using the example of women's fear of walking alone at night, Stoller states that "discourses of fear can intensify or even produce feelings of fear, but this does not tell us anything about fear as it is experienced by a given subject. At that poststructuralist limit, phenomenology offers a method for analyzing fear as a concrete experience that includes...how fear is experienced by individual subjects" (p. 721). What this suggests is that phenomenological interpretation maintains an important approach to

the study of individual lived experiences, as well as commonalities between lived experiences within a particular time and social context. I employ a feminist interpretative phenomenological perspective in order to gain an understanding of both the individual and group experiences of doulas within specific discursively – and materially – constructed locations (the hospital system, the medical model of birth, the gendering of caring labour, a province with limited birth options, and so on) and insight into both the ways in which individual experiences are produced within these contexts, and how these contexts shape the particular embodied and lived experiences of doulas.

Research Design

My design of the study involves a combination of focus groups and interviews with members of the DCNL, and one doula currently working independently. The study involved eight participants in total, with six of these participants attending the first focus group, seven completing one-on-one interviews, and two attending the second focus group. Below I outline various aspects of the study design, including participant selection, participant recruitment, and data collection tools.

Participant Selection

The participants in this study are individuals who professionally identify as doulas currently working in the St. John's area. I decided to focus particularly on the experiences of doulas, rather than the experiences of both doulas and their clients, not only because the experiences of doulas themselves have been particularly under examined in the academic literature, but also because I feel that their perspectives are important to examine within the context of current birth practices in Newfoundland and Labrador. I felt that I could more appropriately address these gaps in the literature by focusing solely

on the experiences of doulas. This project aimed to incorporate the perspectives of doulas who are members of the DCNL and those who practice independently. My initial goal was to have half of my participants from each of these categories. However, this was not possible as there is only one doula currently working independently in the St. John's area.⁸

As stated previously, seven participants completed an individual interview. Smith, Flower, and Larkin (2009) state that there is no right answer to the question of sample size in an interpretive phenomenology research project, but that between three and six interviews is generally sufficient for a student project (p. 51). My original goal was to complete approximately eight interviews, based on my assumptions about how many members of the DCNL would be interested in participating. Although I attempted to be conscious of conducting a reasonable number of interviews based on my methodological approach, the number of interviews conducted was also guided by my feminist research ethic, and therefore I conducted interviews with all doulas who expressed an interest. It is also important to note that the seven participants with whom I conducted an in-depth interview constitute a large proportion of doulas currently practicing in St. John's, and I therefore obtained detailed insights from nearly half of the entire study population (which includes the 15 birth doulas currently listed on the DCNL website, as well as two doulas who are not members of the DCNL).

⁸ As stated by the independent doula herself, members of the Doula Collective, and the absence of any public advertisements for other independent doulas in St. John's. Interestingly, one of my participants chose not to renew her membership in the Collective sometime between our interview and the final focus group.

Participant Recruitment

I planned to recruit participants primarily through the DCNL, via my email contact with the Chair of the group. As well, I planned to recruit independent doulas through online advertisements, and via snowball sampling from doulas with whom I had already spoken. However, it quickly became apparent to me that almost all doulas practicing in St. John's were affiliated with the DCNL. Nevertheless, I posted an advertisement (Appendix A) on a local website for arts, entertainment, and events in St. John's.⁹ This did not yield any responses. Ultimately, all members of the DCNL who chose to participate were recruited via email that was provided to me by the Chair based on their interest in participating. The independent doula was recruited via her personal website, to which I was directed by my co-supervisor Dr. Sonja Boon.

Data Collection Tools

Focus groups.

While focus groups are a popular form of data collection in qualitative research, they are not generally recommended as a primary data source for interpretive phenomenology. This is primarily because focus groups involve the presence of multiple voices that can make the interpretation of a particular experience more difficult (Smith, Flowers, & Larkin, 2009).

My decision to use focus groups in my research design is more closely aligned to my epistemological perspective as a feminist researcher, rather than my adherence to interpretive phenomenological analysis. My motivation to employ focus groups arose from my desire to conduct research that involved some form of collaboration between my

⁹ www.thescope.ca

participants and myself. Although my interviews represent the primary data source for my examination of the lived experiences of doulas in St. John's, conducting focus groups at the beginning and the end of interviews provided me the opportunity to gain feedback from participants about what issues should be examined in in-depth interviews, and to test the validity of my interpretive phenomenological analysis of the interviews. Wilkinson (1999) argues that focus groups are particularly useful for feminist research, because they provide social context for group discussions, and they can shift the balance of power from the researcher to the focus group participants. Some of the more general benefits of focus groups include the more conversational setting that can be produced among participants, the ability to produce large quantities of data in a short period of time, and the potential for the interactions among participants to generate ideas that may never have arisen from a researcher-led interview (Green & Thorogood, 2004; Kirby, Greaves & Reid; 2006).

Interviews.

Interviews are the primary method of data collection used by interpretive phenomenological researchers (Smith, Flowers, & Larkin, 2009). I refer to the interview style that I employed as an *in-depth* interview, an approach that falls somewhere on the continuum between *structured* and *semi-structured* interviews (Green & Thorogood, 2004; Kirby, Greaves & Reid; 2006). I employed a specific interview protocol, but also allowed for flexibility in altering the ordering of questions based on the progress of the conversation, and utilized spontaneous probes or questions to obtain greater detail or clarification from the participant (Smith, Flowers, & Larkin, 2009). Smith, Flower, and Larkin (2009) state that interviews should involve interview questions that are open to a

lengthy and detailed response from participants and interviewers should provide minimal verbal input (p. 59).

Each interview was conducted with a 12-question protocol. The interview protocol was developed based on the themes that emerged during the first focus group, and how these themes related to my research objectives. The protocol included questions examining membership in a collective and/or professional identity; the construction of relationships with clients; and doula care as resistance, advocacy, or education (Appendix B). I sought to include questions that were open ended, but also specific to particular aspects of doula care. In general, I asked the interview questions in the same order during each interview. In some interviews I altered the order of one or two questions based on the flow of the participants' responses. Generally participants provided rich and lengthy responses to each question, and I did not feel that it was necessary to probe further. However, I did employ probes and asked additional questions when I felt that the participant could provide greater detail about a certain topic, or to clarify the participant's response to a question. Participants were provided the opportunity to make any additional comments after the interview protocol was complete.

Data analysis.

I approached the coding and analysis of my interview data from the guidelines presented by Smith, Flowers, and Larkin (2009). The authors state that, "There is no clear right or wrong way of conducting this sort of analysis, and we encourage IPA researchers to be innovative in the ways that they approach it" (p. 80). However, they provide various techniques that novice researchers might employ for analyzing their data, including reading and re-reading, initial noting, developing emergent themes in the first case,

searching for connections across emergent themes in the first case, moving to the next case (and each subsequent case), looking for patterns across cases, and finally moving to a deeper level of interpretation (p. 82-106).

Implementation of Research Design

In this section I outline the implementation of my research design, including my engagement with participants, my coding and interpretation of the research data, the ethical considerations associated with my fieldwork, and my reflexivity about the research process.

Engagement with Participants

My first contact with the DCNL was in October 2011, when I contacted the Chairperson via email to express my interest in conducting research about the experiences of doulas in the St. John's area. She was enthusiastic and supportive of the research concept, and agreed to my request to introduce myself to members of the Collective at one of their monthly meetings. At the March 2012 meeting, I provided a brief introduction to myself and to the type of research that I planned to conduct. Doulas in attendance at this meeting responded positively; several doulas expressed excitement about the research project and demonstrated an interest in participation.

After becoming aware of the presence of a doula practicing independently of the DCNL in the St. John's area, I expanded the scope of my participant criteria to all doulas currently practicing in the St. John's area. I contacted the independent doula via the email available on her website, provided her with an introduction to my research project, and inquired about obtaining contact information for other doulas practicing independently. She expressed interest in participating in the research, but informed me that, as far as she

was aware, she was the only doula currently practicing in the area outside of the DCNL. Although she chose to participate in an interview, she declined participation in the first focus group. Despite the fact that participation of the independent doula represents an outlier from all other participants affiliated with the DCNL, I felt that her insights were incredibly valuable and warranted inclusion to gain particular insights into her decision to practice independently (after previously being a member of the DCNL), and the particular benefits and challenges of working outside the boundaries of a collective.

Data collection was conducted between January and June 2013. The first focus group was conducted in the community room of a grocery store in St. John's. The Chairperson of the DCNL distributed the consent form to members of the collective, and forwarded me the emails of doulas who had expressed interest in participating. I received eight email contacts, and arranged the date, time and location of the focus group via email based on the availability and convenience expressed by potential participants. Six doulas attended this focus group, all of whom consented to being audio recorded. I provided participants with time to read through the consent form and ask questions. The focus group was an informal discussion guided by three general topics (see Appendix C): why participants had decided to pursue doula work, their experiences of working within a collective, and the unique position of doulas in St. John's, or Newfoundland and Labrador more generally. The focus group was 90 minutes long.

Based on the recurring themes that I heard in the focus group, I amended my preliminary interview questions (Appendix D). To recruit participants for in-depth interviews, I contacted both the independent doula and the members of the DCNL whom I had previously contacted for the first focus group. I arranged interview times and

locations via email based on the participants' availability and convenience. All participants were emailed a copy of the interview protocol (without additional prompts) in advance of the interview (Appendix B). My decision to provide participants with interview protocols in advance was informed by my perspective as a feminist researcher employing collaborative elements in my research design (Gustafson, 2000). I hoped that this would allow participants to reflect on their own experiences in advance of the interview, and to feel more comfortable in an interview setting, since the expectations of the conversation had already been made clear. I asked all participants if they had had a chance to review the interview protocol prior to beginning each interview. Most participants indicated they had looked at them briefly. Several participants asked if they could look at the interview questions once more prior to commencing the interview, and I provided them with time to look at my full interview protocol (Appendix B).

Most participants had already consented to participation in an individual interview when they completed their consent form at the first focus group. I brought the completed consent form to each interview to inquire if the participant intended to maintain their consent to participation in an interview, and to being audio recorded during that interview, and all said yes. Participants who had not previously consented to an interview were provided with time to read the consent form and ask questions. I also obtained oral consent to commence recording each interview.

Two of the interviews took place in the participants' homes and five of the interviews took place in coffee shops in St. John's. At the end of each interview, I informed participants that once all of the interviews had been coded and analyzed, I would arrange a focus group to discuss the themes that I had identified (and the extent to

which participants understood these themes to be relevant to their own experiences). I also informed participants that should a second focus group not be possible to arrange, or if they were unable to attend the focus group, they would still have the opportunity to provide feedback about the validity of the themes I identified via email. Two participants requested that I not include some portion of their response in my research either during or immediately following their interview. I took note of what they requested to be removed, and then specifically clarified what portion of their response they would like to have removed. The interviews lasted between 30 and 75 minutes.

The second focus group was conducted in a seminar room in the Department of Gender Studies at Memorial University of Newfoundland; unfortunately, the community room where the first focus group took place was not available on the date that most participants were available. All participants who had completed an interview were invited to participate in this focus group. Despite six of the seven participants indicating that they were available to participate on the date selected, only two participants attended. Several of the participants who were unable to attend sent their apologies for being absent due to unforeseen circumstances. This demonstrated that participants maintained interest and engagement with this study, rather than simply being uninterested in continuing their participation at this final stage of data collection. The two participants in attendance had already provided their consent to participation in the second focus group, and I obtained oral consent from both participants before I began recording. Participants were provided with a summary of my preliminary research findings (Appendix E) and asked to provide feedback about any aspects of my findings that they particularly agreed or disagreed with. The focus group was 55 minutes long.

Following the second focus group, I emailed the summary of my preliminary research findings to the participants who had completed an interview but were not able to attend. One participant provided detailed feedback, one participant provided brief feedback, and one participant responded indicating that they had no feedback to contribute. The remaining two participants did not provide any response.

Coding and Interpretation

For each interview transcript I began by reading the transcript in full without making any notations. Then, I adopted a notation style recommended by Smith, Flowers, and Larkin (2009, p. 84), which involves reading through the transcript and making descriptive comments (describing the content of what was said), linguistic comments (making note of language used to convey meaning), and conceptual comments (interrogating the broader meaning). As well, I highlighted particular statements that captured the essence of the participants' experiences as a doula, or that demonstrated a particular contribution to my research objectives. I read each transcript for a third time, along with the comments that I had written during the last reading, and made an additional set of notes containing all of my general thoughts about the transcript and my previous notations. Finally, I composed a list of five to eight statements that I felt captured the participants' experiences, along with a list of any potential emergent themes. After moving through each transcript in this way, I reviewed all of the notations and comments previously written for each, and I composed a rough list of themes that I felt captured the nature of being a doula in St. John's, and that addressed my three research objectives. I used this list of themes to compose a summary of my preliminary research findings (Appendix E), about which I asked my participants for feedback during the

second focus group. I interpreted these themes through the lens of my theoretical frameworks of the medicalization of childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour (discussed in Chapter 3), as well as my analytical frameworks of community and resistance (discussed in Chapters 4 and 5, respectfully).

Ethical Considerations

This research received ethical approval from the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University of Newfoundland based on the guidelines of the Tri-Council Policy Statement 2 (TCPS 2). The ethical considerations involved in this research project include the limits to anonymity and confidentiality and the potential harms and benefits associated with participation. Since this research project involved participants recruited through a pre-existing group (DCNL), and other individuals who may already be known to one another, it was not possible for me to guarantee anonymity for my participants. Participation in a focus group precluded the potential for anonymity, privacy, and confidentiality from other individuals participating in that focus group. Interviews offered participants an opportunity to speak privately and confidentially about their experiences; however, because many of the doulas had shared their chosen pseudonyms with one another during the first focus group, it is likely that all participants in the study will be able to identify the statements of other participants. I made an effort to ensure the privacy and confidentiality of interview data by limiting access to this data to my co-supervisors and myself. All audio recordings and written transcripts are stored on a secure computer, and will be stored for a period of five years, per Memorial University of Newfoundland's research policy, after which the data will be

destroyed. I gave participants the option of using their own name, or selecting their own pseudonym to be used in the transcription and presentation of their interview data. All but one participant (the doula practicing outside of the DCNL) decided to use a pseudonym. A list linking participants' names to their assigned pseudonym is stored separately from all other interview data.

The research consent form outlined the potential harms associated with participation in this research project (Appendix F). Harms included limits to participants' privacy. Since this research was conducted with a small, pre-existing group, and with individuals who were likely already known to one another based on their activities as doulas, participants may be able to identify data originating from a specific participant based on their knowledge of that individual. This limited privacy could potentially harm participants if they reveal sensitive information during an interview, and become identifiable to other participants, or to other individuals familiar with the activities of doulas in the St. John's area. Potential benefits associated with participation are limited. Since my research examines the potential to view the activities of doulas as a form of activism or resistance, participants may view their participation as contributing to the advancement of doulas in this context, or may view their participation as contributing to awareness of the activities of doulas in general.

Reflexivity

My approach to reflexivity during this research project has involved an acknowledgement of my personal position in relationship to my research topic and how this influenced all aspects of the research process (Kirby, Greaves & Reid, 2006). The process of reflexivity has been defined as "mak[ing] explicit the power relations and the

exercise of power in the research process. It covers varying attempts to unpack what knowledge is contingent upon, how the researcher is socially situated, and how the research agenda/process has been constituted” (Ramazanoglu & Holland, 2002, p. 118). Feminist researchers are generally credited as maintaining a greater commitment to reflexivity, as feminist research is often interested in the examination of power dynamics, and in questioning what constitutes knowledge production. Correspondingly, Medved and Turner (2011) state that conducting rigorous and valuable research requires that the researcher engage in potentially uncomfortable self-analysis in relationship to the research topic and process. Although I find value in feminist approaches to reflexivity in the research process, I also acknowledge the limits of reflexivity as an equalizing measure between the researcher and the researched.

In contrast to the feminist perspectives on reflexivity described above, proponents of interpretive phenomenological analysis (IPA) describe reflexivity as inherent in the phenomenological approach to knowledge production. Shaw (2010) differentiates between “reflection” and “reflexivity,” wherein reflection describes researcher’s concern for process and verification, and a desire to represent participants accurately, whereas reflexivity “evokes an interpretivist ontology which construes people and the world as interrelated and engaged in a dialogic relationship that constructs (multiple versions of) reality” (p. 234). The double hermeneutic (or, interpretive) process in which “participants are trying to make sense of their world; [and] the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn 2008, p. 53), makes the perspectives of both the researcher and researched explicit in the production of knowledge.

Embodiment is also relevant to reflexivity: Del Busso (2007) states, “all knowledge is produced through bodies...and therefore the practice of reflexivity should extend to a consideration of research as embodied experience, both for the participants and the researcher” (p. 310). As outlined in Chapter 1, I believe that my day-to-day embodied experiences differ significantly from that of the majority of my participants. As well, I conceptualize my position as an outsider to the doula profession in relationship to phenomenology’s negation of the subject/object dichotomy, which acknowledges that the reality of an object (such as doula care) is inherently linked to the subject’s interpretation of its meaning (Creswell, 2007). Therefore, although I characterize myself as an outsider to the doula profession, I acknowledge that my subjective interpretation of the lived experiences of doulas cannot be separated from my own personal experiences, regardless of my outsider position.

I highlight my own positionality in relationship to my participants because my own embodied experiences are not a significant factor in my interpretation of interview data. Rather, I feel that my perspective as a feminist researcher with a desire to critique the medicalization of birth most acutely factors into my interpretation. I aim to be conscious of the ways that my critiques of the medicalization of childbirth impacts my perspective on this research project, yet I make no claims of objectivity or the removal of this belief from my interpretation. This approach stands in contrast to descriptive, empirical, or transcendental phenomenology, which are phenomenological approaches guided by Husserl’s concept of “bracketing,” in which the researcher acknowledges their own experiences and perspectives, and attempts to remove their own views from their interpretation of a phenomena (Creswell, 2007).

Furthermore, though I designed my study to integrate elements of collaboration through the use of opening and closing focus groups, I do not claim that this research project was a true collaboration between my participants and myself. My approach to collaboration with my participants was twofold (and similar to that of Gustafson (2000)): Firstly, I conducted focus groups before and after interviews to gain an understanding of what issues warranted further examination, and to gain feedback from my participants about the validity of the themes I identified. Secondly, I attempted to maintain transparency about the potential for this research to bring awareness to the activities of doulas in the St. John's area, rather than promising unrealistic benefits for individual participants or the DCNL. I acknowledge that my power as a researcher is exerted over all aspects of this research project, regardless of my feminist methodology, qualitative research methods, and reflexivity about my own position within the research process. While these tools attempt to deconstruct positivist approaches to research and the production of knowledge, my interpretation represents the perspectives of my participants that have been filtered through my own lens as a researcher with various personal, social, and political motivations. It is my hope that this research has been respectful of my participants, and that it may contribute in some way to their goals of changing the birth culture in Newfoundland and Labrador.

In this chapter I have outlined my epistemological stance, my methodological approach, and the particular methods that I employed in approaching, designing, implementing, and analyzing this research project. My epistemological perspective as a feminist researcher incorporates elements of feminist standpoint and feminist poststructuralism, while my methodological approach as a feminist interpretive

phenomenologist involves the intersection of interpretive phenomenological analysis, and feminist approaches to phenomenology. These perspectives are tied together by my emphasis on studying the female-centred embodied experiences of pregnancy and childbirth – which have traditionally been under-theorized in the phenomenological tradition – through the lens of caring labour performed by doulas who attend to these female embodied experiences. In the next chapter, I introduce the theoretical frameworks that informed my research.

Chapter 3

Theory: Medicalized Childbirth and the Gendering of Care

[We] remind people like, how has the human race gotten this far...[it] isn't because of, you know, episiotomies and epidurals, and forceps and all that stuff. No...it's because our bodies biologically produce our offspring in this way, right. And they're built to do it and of course there's complications like in anything, but the vast majority are able to do it...without a big problem. And yeah I mean I think that, you know, through the doula care, having...the emotional support, the mental support, and the physical...non-medical support is...a means to empower women into accepting and embracing the fact that they can do this.

Olivia

In this chapter I outline the theoretical perspectives from which I approach the conceptualization and analysis of this research project, including the medicalization of childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour. These frameworks demonstrate a coherent extension of my epistemological and methodological perspective as a feminist researcher and feminist interpretive phenomenologist. The underlying factor that ties my epistemological, methodological and theoretical perspectives together is embodiment, and, more specifically, female embodied experiences of giving birth and providing care to women during pregnancy, childbirth, and postpartum. In addition to the frameworks of community and resistance, the theoretical perspectives outlined in this chapter influence my interpretation of my research data presented in Chapters 4 and 5.

Medicalization of Childbirth

According to Weitz (2010), medicalization refers to the process in which certain conditions become defined in relationship to health or illness, and medical knowledge gains authority over defining and treating the condition. In particular, the medicalization of childbirth has been described as the process by which the traditional model of women

emotionally and physically supporting other women during childbirth was replaced with physicians approaching childbirth as a pathological event requiring specific management and intervention (Ratcliff, 2002). Similarly, Pollock (1999) defines the medicalization of childbirth as “the process by which medical and technical expertise overtook not only both ends of life, birth and death, but [has] changed the way we understand our bodies, making them objects of abstract, anatomical knowledge systems, largely unintelligible except by clinical translation” (p. 11).

Some of the effects of the medicalization of childbirth include an increased discourse of “risk” surrounding pregnancy and birth, increased rates of routine obstetrical intervention, and the decreased presence of midwives as primary childbirth attendants. Within a discourse of “risk,” each pregnancy is assumed to be “at risk,” or dangerous to the mother and fetus, unless proven to be “normal” or “safe” through the use of medical interventions and technologies (Hausman, 2005; Teijlingen, Lowis, McCaffery, and Porter, 2004). “Risk” discourse has also contributed to increased rates of medical intervention during childbirth. It is worth noting, for example, that caesarean section rates in St. John’s (and the rest of the province) are more than double the World Health Organization’s recommended rates (Eastern Health 2012; World Health Organization 2010). Finally, one of the most evident consequences of the medicalization of childbirth in North America is the elimination of midwives as traditional childbirth attendants, or as viable alternatives to physicians. Robbie Davis-Floyd (2003) states that the demise of the midwife and the rise of obstetrics, and “male-attended, mechanically manipulated birth” arose as Western societies began to understand human bodies as machines, and in turn,

female bodies as defective machines requiring intervention (p. 51) or, understood as inherently “risky.”

In the 1970s, renewed interest in midwifery in North America emerged through a grassroots birthing movement advocating “natural” birth, home birth, and midwifery. This movement can be understood as a particular facet of the feminist women’s health movement discussed in Chapter 1. Midwife and educator, Ina May Gaskin, is perhaps the most visible proponent of this movement. Her text *Spiritual Midwifery* (1975) is often credited as igniting attention to midwifery and natural childbirth. In a later work, she (2011) describes the “natural” birth philosophy as “a fundamental respect for nature that recognizes that nature mostly gets it right in birth” (p. 8). However, the concept of “natural” birth has been critiqued as uncritically nostalgic, and as ignorant to the ways that culture defines what can be understood as “natural.” In the context of contemporary Canadian midwifery, the childbirth practices that constitute “natural” birth are constantly shifting and evolving, and midwives increasingly recognize the individuality of each birth experience (Macdonald, 2006).

Recent years have seen a modest cultural shift towards the demedicalization of childbirth in North America. Not only have midwives and other lay childbirth attendants begun to regain recognition and acceptance – as evidenced by the regulation of midwifery in most provinces and territories in Canada, but doulas are also increasingly prevalent as childbirth attendants. However, this apparent shift might be deceptive. Teijlingen and colleagues (2004) argue that contemporary midwifery training has itself become increasingly medicalized, such that it now more closely resembles the training of “medical professionals,” rather than that of traditional or lay birth attendants.

The aforementioned literature suggests that the medicalization of childbirth generally has a negative impact on women's childbirth experiences, as medical technologies and interventions create a sense of detachment between a woman and her own bodily processes. However, Drapkin Lyerly (2006) critiques the notion that modern obstetrics are responsible for women's negative experiences of childbirth. She suggests instead that women are not necessarily disengaged from their birth process due to obstetrical interventions, but due to a more general experience of a lack of agency, dignity, and alienation, originating from treatment by care providers, or a lack of control over one's body and surroundings.

In the same vein, numerous theorists have critiqued the valorization of "natural birth" that has arisen as a result of the backlash against medicalized childbirth. Beckett (2005) critiques the rhetoric associated with the alternative birth movement, including the valorization of "natural birth," the false message of "choice," and the essentialization of women as care providers in discourses surrounding midwifery. Beckett asserts that the natural birth movement "mistakenly seeks to overturn male domination by super-valuing the denigrated categories with which women have long been associated rather than by deconstructing and destabilizing these hierarchical constructions" (p. 258). As well, Beckett asserts that the valorization of midwifery (a profession dominated by women), and the categorization of midwives as particularly caring and empathic, may contribute to an essentialist view of women as inherently caring individuals, which thereby perpetuates the gendered nature of caring labour.

Johnson (2008), meanwhile, highlights the ambivalent position that privileged women hold in relationship to medicalization. Within the context of medicalized

childbirth, medicalization is generally framed more simply as a form of oppression, and for privileged women the goal of “natural” childbirth is a form of political resistance against medicalization. However, this framework of medicalization does not hold when applied to marginalized women in countries in the global north and global south. These women are often exposed to more acute forms of domination by institutions such as the medical community. In areas that experience high rates of maternal mortality within traditional home birth models, greater medical intervention is implemented as a means of improving health outcomes, and is viewed as a form of development and empowerment.

It is important to examine the ways in which medicalization impacts women differently depending on their social position. However, it appears that in a Canadian context of universal health care in which women have access to clean and safe birthing conditions - and in the case of Newfoundland and Labrador, more specifically – doulas can most appropriately be understood as a reaction to medicalization, and to the current treatment of women during pregnancy and birth. As such, I further explore theoretical conceptualizations of the maternal body, and women’s embodied experiences of childbirth, in relationship to doulas’ desire to provide care during these events in women’s lives.

Feminist Theories of Maternal Embodiment

Feminist engagements with reproductive embodiment have focused almost exclusively on the figure of the pregnant or labouring woman (or mother). Little attention has focused on the embodied experiences of those who attend to them throughout this period. However, it is important to situate the activities of doulas within the broader discourse of feminist theorizing in relationship to maternal embodiment. The embodied

experiences of pregnant and labouring women are the experiences that doulas attend to, and it is women's experiences of pregnancy and childbirth that motivate doulas to provide attentive and appropriate care to women during this period.

Feminist theories of embodiment, and particularly maternal embodiment, have arisen in part from modern medical science's fragmentation of the individual body and embodied experience, and its understanding of the human body as a machine that can be repaired through mechanical intervention (Martin, 1987). The body has come to be understood as an entity separate from the human mind, soul and emotional experiences, and the body itself has come to be viewed as a collection of separate, constituent parts rather than as a whole. Within this generalized frame, Martin (1987) argues, "women...suffer the alienation of the self much more acutely than men" (p. 21). As well, Martin asserts that the female body has become more acutely fragmented into individual body parts because women have historically been alienated from the production of science itself.

Numerous theorists have cited medicalization as a locus for disembodiment. The labouring woman may have her bodily authority overpowered by the presiding medical attendants, her movements restricted through the use of monitoring technologies, and a reduction in her awareness of the physical experience of childbirth through anaesthesia. Iris Marion Young (2005) depicts medicalization as forcing women to conceptualize their pregnancies as medical conditions, rather than as healthy events. This may cause women to devalue their birthing experience, as they come to understand their pregnancy within a discourse of fear and risk that must be mitigated through the use of medical interventions. Doulas are generally careful to emphasize their support of women regardless of the type

of childbirth that they plan or actually have. However, medicalization and its disembodied effects can be understood to be linked to doulas' desires to aid women in feeling more comfortable and confident during childbirth than they would typically feel without the care or presence of a knowledgeable, continuous support person.

I discuss theoretical perspectives on maternal embodiment through the lens of Robbie Davis-Floyd's (2003) foundational text, *Birth as an American Rite of Passage*, which describes the medicalization of childbirth as a form of ritual. She argues that the shift from home to hospital birth has led to an increased dependency on rituals, in the form of "standard procedures for normal birth," which reinforce normative values of American society for birthing women and birthing attendants (2003, p. 1). While Davis-Floyd only references the work of feminist theorists Simone de Beauvoir, Julia Kristeva, and Hélène Cixous superficially in her text, her work related to maternal embodiment appears to have been directly or indirectly influenced by them. Her conceptualization of the technocratic model of childbirth and its negative impact on women's childbirth experiences can be examined in relationship to (1) pregnancy and childbirth as a "place of splitting," (2) pregnancy as a state of being "out of bounds," and (3) the stripping of women's bodily authority in the technocratic model of birth. In examining both Davis-Floyd's work, and feminist theories of maternal embodiment, I seek to examine the potential for doula care to fill some of the gaps that exist in a technocratic model of birth, and to aid women in reconciling their experiences of pregnancy as a "place of splitting," a state of being "out of bounds," or a moment when authority and knowledge of their own bodily processes is frequently disregarded. As well, in examining the embodied and lived experiences of doulas as the care providers of pregnant and labouring women, it is

essential to understand the desire that women have to experience, and doulas have to attend to, more engaged experiences of childbirth than those that are currently available within a medicalized model of maternity care.

Firstly, Davis-Floyd (2003) conceptualizes the maternal experience of pregnancy and childbirth as a place, or a moment, of splitting. This splitting occurs in the mechanistic and technocratic splitting of the mind and the body, and in the splitting of the fetus and the mother during pregnancy and at the moment of birth. Davis-Floyd describes the ambiguity of the moment of separation that occurs in pregnancy and childbirth, by acknowledging that pregnancy is “both a state *and* a becoming,” and that the literal translation of the word ‘pregnancy’ is “the state of being before being born” (p. 36). In the technocratic model of birth, the pregnant and birthing woman becomes split into her emotionally and culturally cultivated mind, and her mechanistic yet unruly body that must be controlled through medical intervention. As well, separation of the fetus from the mother is understood as a structured and discrete process, in which a woman comes to accept her pregnancy through increasing levels of obstetrical intervention, which confirm her pregnancy, and the health of her fetus.

This notion of the pregnant and birthing body as a place of splitting has been central to feminist theories of the body. Simone de Beauvoir (2009) describes the pregnant woman as, “both herself and other than herself” and states that “this makes it difficult to know when it can be considered autonomous: at fertilization, birth, or weaning?” (p. 25). Further, Beauvoir conceptualizes pregnancy and motherhood as elements of female bodily experience that serve to oppress women, due to their inherent connection to their biological destiny, as evidenced by her assertion that:

She experiences it both as an enrichment and a mutilation; the foetus is part of her body and it is a parasite exploiting her; she possesses it and she is possessed by it; it encapsulates the whole future and in carrying it she feels as vast as the world; but this very richness annihilates her, she has the impression of not being anything else. (p. 551)

Similarly, Hélène Cixous (1976) depicts the fetus as a foreign entity that women may feel disconnected from, and a state from which “woman will return to the body which has been more than confiscated from her, which has been turned into the uncanny stranger on display” (p. 880).

Perhaps the most appropriate theoretical perspective from which to examine this sensation or act of splitting is through Julia Kristeva’s (1982) theory of abjection. This theory involves the human reaction of horror or disgust to the blurring and degeneration of the separation between subject and object, or self and other. The abject is that which reminds us of our own relationship to the horrifying “other,” and the experience of abjection occurs within ourselves, as we come to see ourselves as inseparable from the abject. The horror associated with encountering the abject leads us to cast it away, as a means of avoiding its horror, even as the reality of the abject exists within our own body. Drawing on the insights of Mary Douglas (1966), Kristeva states, “it is thus not lack of cleanliness or health that causes abjection but what disrupts identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite” (p. 4). The fetus, or the pregnant female body, can be understood as the abject, as the fetus represents an “other” from which the pregnant woman must disassociate herself, or

must negotiate as existing within the liminal space between self and other. Kristeva describes this border between the self and the abject thusly:

We may call it a border; abjection is above all ambiguity. Because, while releasing a hold, it does not radically cut off the subject from what threatens it...I experience abjection only if an Other has settled in place and stead of what will be "me." Not at all an other with whom I identify and incorporate, but an Other who precedes and possessed me. (p. 10)

The pregnant body itself is also abject, as it has come to be understood as unpleasant, disgusting, or degrading to women's emancipatory engagement, and therefore has become rejected, hidden from view, and controlled within the technocratic model of birth.

Secondly, Davis-Floyd (2003) conceptualizes the ways in which pregnancy literally does not fit within the spatial and temporal boundaries of Western society, and is seen as "out of bounds" within the technocratic model of birth. This understanding of the pregnant and birthing body as outside of the boundaries determined to be appropriate evolved from the model of the human body as a machine. In comparison to the male body, which conforms more easily to structures requiring regularity and consistency, the female body is understood to be much more variable and unpredictable (due to the hormonal and lifespan fluctuations associated with menstruation and menopause, for example), and therefore understood as a dysfunctional machine. Obstetrical routines have been developed as a means of constricting the birth process to accepted cognitive categories, which would allow birth to appear to occur in an orderly way. Davis-Floyd asserts that the female body, and the process of pregnancy and childbirth, forced society to confront the reality that "it is nature, not society, that controls the creation of new

human beings” (p. 25). Since the moment of childbirth is generally a period of heightened awareness and emotionality for a woman, society has “take[n] advantage of her extreme openness to ensure that she will be imprinted with its most basic notions about the relationship of the natural to the cultural world as these two worlds meet in the act of birth” (p. 40). The notion that the female body exists outside of the normative constraints of society is reinforced through the rituals of the birth process, in which this process is reaffirmed as being “abnormal, inherently defective, and dangerously under the influence of nature” (p. 51), rather than fitting neatly into the cognitive boundaries determined by society.

Simone de Beauvoir (2009) examines how the birthing body exists outside of societal boundaries through her acknowledgement of the variability that exists in individual birthing processes. Beauvoir states, “the fact that delivery sometimes lasts more than twenty-four hours and sometimes is completed in two or three hours prevents any generalization” (p. 562). She acknowledges the different affective experiences of labour, which some women experience as painful and traumatic, and others experience as sensually pleasurable – deriving creative power from the process, and from the feeling of accomplishment. Hélène Cixous (1976) echoes Beauvoir’s acknowledgement of the multiplicity and unquantifiability of the birth process, in stating,

there are thousands of ways of living one’s pregnancy....Each body distributes in its own special way, without model or norm, the nonfinite and changing totality of its desires....You, the defenders of “theory,” the sacrosanct yes-men of Concept, enthroners of the phallus. (p. 891)

Cixous argues that the experience of pregnancy is not cohesive, regardless of theoretical constraints that have been placed on the process through male-centred theoretical perspectives.

Julia Kristeva (1986) presents a different but complementary view of the cohesion and cognitive structuring of the birthing process. Rather than rejecting the *manner* in which the birthing process has been constructed by the technocratic model of birth, she rejects the feminist depiction of maternity as necessarily traditional and contradictory to feminist objectives. Kristeva states:

Now, when feminism demands a new representation of femininity, it seems to identify motherhood with that idealized misconception...The result? – A negation or rejection of motherhood by some avant-garde feminist groups. Or else an acceptance...of its traditional representations by the great mass of people, women and men (p. 161).

The construction of pregnancy, childbirth, and maternity as necessarily existing in a particular way, and fitting into a particular cognitive schema, is evident in the critical work of these theorists, and in Davis-Floyd's attempt to disrupt the cognitive categories implicit in the technocratic model of birth.

Thirdly, Davis-Floyd (2003) interrogates the ways in which the technocratic model of birth leads to the stripping of bodily authority from pregnant and birthing women, as they lose control of their own birth process and instead become subjected to the authority of medical professionals. Additionally, the emphasis on the health of the fetus, rather than on the health and well being of the mother, creates a perception that the fetus and the mother have competing, rather than complementary, interests; or, that what

is beneficial to the mother is not necessarily understood as beneficial to the fetus. In reference to the presumed authority within the technocratic model of birth, Davis-Floyd states:

Implicit in this model are the assumptions that the baby develops mechanically and involuntarily inside the woman's body, that the doctor is in charge of the baby's proper development and growth, and that the doctor will deliver (produce) the baby at the time of birth. (p. 28)

This model imagines the pregnant and labouring woman as nothing more than a passive container, rather than an autonomous individual.

Although this understanding that authority over the birth process rests in the hands of physicians rather than pregnant and birthing women themselves is certainly significant, Davis-Floyd points to the "deeper political and feminist issue of information as power, and of the centuries-old efforts of men in Western society to shut women out of access to intellectual sources of power" (p. 30). The shift of pregnancy and childbirth care from the home, the family, and the tradition of midwifery – to the authority of medical professionals in the hospital – conveyed the message both to women and to society in general, that "these forces of nature are now 'under control,' and society has lost some of its fear of them" (p. 26). On a cultural and societal level, it has been determined that women are not sufficient or appropriate authorities of knowledge of their own bodies, and the biological processes occurring within them.

Simone de Beauvoir (2009) describes the sense of alienation that pregnant women feel as the fetus grows inside of her, independent of any power that she may exert over the process. She states, "Then she knows her body has been given a destination that

transcends it...she is the prey of the species that will impose its mysterious laws on her” (p. 554). Beauvoir points to the ways that women may experience a sense of helplessness or powerlessness, as her gestation appears to happen *to her*, regardless of her level of engagement in the process. She understands this helplessness to be inherent in the biological process of pregnancy. For some women, this feeling of vulnerability to the forces of nature may only be increased through the additional stripping of their bodily authority through obstetrical technologies.

By contrast, Hélène Cixous (1991) describes the awe she has for women who take control of the uncontrollable process that is childbirth, and make the experience their own. Cixous conceptualizes an exertion of control over this process as “giving birth to the self,” stating:

She is *there*. Entirely. Mobilized, and this is a matter of her own body, of the flesh of her flesh. At last! This time, of all times, she is hers, and if she wishes, she is not absent, she is not fleeing, she can take and give of herself to herself. (p. 30)

This suggests that a biological mother is always connected to her own bodily experience of motherhood on some level, and in writing her own life experiences she is “writing in white ink” (Cixous, 1976, p. 881), or writing in harmony with, and in control of, the physical reality of her own motherhood, including the processes of childbirth and lactation.

Whereas Beauvoir and Cixous highlight the ways that women’s bodily authority can be experienced as alternately alienating (Beauvoir) or empowering (Cixous), without reference to certain technocratic interventions, Julia Kristeva (2000) describes the way that the maternal body has slipped away from the mother, and into the realm of biological

and social examination. She states: “it does make of the maternal body the stakes of a natural and “objective” control, independent of any individual consciousness; it inscribes both biological operations and their instinctual echoes into this necessary and hazardous *program* constituting every species” (p. 179). The maternal female body has moved into the realm of “objective control,” that is understood outside the realm of nature, emotion, and personal experience. Lay women are understood as inexpert in relationship to their own bodily processes, as the power of technology and science is seen as imperative to interpreting the maternal body.

In response to the gaps and silences that exist in relationship to childbirth experiences, and the lack of control, disembodiment, and alienation that many women experience in the face of systemic medicalization, many theorists argue that the retelling and examination of birth experiences can fill these gaps, and provide women with models from which to make sense of their own birthing experiences (Pollock, 1999; Prescott, 2011). My research contributes to the filling of the gaps and silences surrounding childbirth, as the personal experiences of doulas will aid in demonstrating why women seek out alternative forms of maternity care that are more engaged and emotionally significant, and how woman-centred childbirth practices can contribute to a sense of empowerment for both mothers and care providers.

Gendered Nature of Caring Labour

Overwhelmingly, women are the providers of care in both paid and unpaid positions, both in and outside of the home. As well, the qualities associated with providing care are closely tied to stereotypical female gender roles. I refer to the activities of doulas as both “caring labour” and their role as “care providers” to denote their

activities as work that is typically financially remunerated, albeit minimally (or for some doulas who actively choose not to charge for their services, not at all). Members of the DCNL charge a maximum of \$800 for their services.¹⁰ These services typically involve meeting with clients during their pregnancies, being available to them via telephone for a certain period prior to their labours, providing continuous support throughout labour and delivery, and then meeting with them again postpartum (Doula Collective of Newfoundland and Labrador, n.d.). The gendered nature of caring labour is an important lens through which to examine doula care, since doulas provide care to women, by women, and for minimal financial reward. Doula work can therefore be understood within an essentialist framework of care giving, one that considers women to be inherently inclined to provide care.

This assumption was reflected in one participant, Melissa's, depiction of her relationship to other doulas:

one of the great things about a doula is that we're drawn to this work because we're very caring nurturing people at heart anyway, and so, one of the great things about being a doula, and knowing doulas, is that um...they're very nurturing caring people so...they're the kind of people that you go to if there's other issues in your life that you're having trouble with...whether it's childcare issues, or whether it's, you know, something going on in your life that's stressful or whatever. What I find is...doulas are just naturally built to be supportive in any aspect really, and are great friends as well.

¹⁰ The fees charged by members of the Doula Collective of Newfoundland and Labrador are discussed in further detail in Chapter 1.

While most participants did not describe their work and their provision of care in particularly gendered ways, it is important to consider that doulas are, in my experience, depicted solely as women. Since doulas provide care during the woman-centred events of pregnancy and childbirth, it is not surprising that women would be the providers of this care. However, it is important to consider the ways that the work of doulas is valued (or undervalued) financially, publicly, and institutionally, and how the marginal position of doulas can be understood within an essentialist framework of care work.

“Caring” has been defined in numerous different ways. Himmelweit (1999) states that “caring is a difficult concept to pin down because it means two different things: both caring for and caring about another person” (p. 29). Caring labour has been characterized as combining the often disparate activities of caring, which is frequently performed by women based on a presumed intrinsic desire to improve the wellbeing of others – with labour – which is often done only for extrinsic reward. Since caring labour is not necessarily financially remunerated (as in mother work), the rationale for providing care is often conceptualized as disparate from the rationale for labour, and providing care becomes understood as an inherently female activity (Himmelweit, 1999). Pettersen (2011) highlights the problematic categorization of caring as an inherent desire and states that, “By denominating care as a selfless act – which is what the altruistic understanding does – one avoids having to deal with the many ethical and political dimensions of care work” (p. 370). The gendered nature of care giving demonstrates broader cultural understandings of the nature of both femininity and masculinity, and therefore women’s abilities as care providers come to be understood as inborn (Husso & Hirvonen, 2012).

Gustafson (2010) draws a connection between the gendered nature of nursing and mothering. Doula work is not entirely comparable to either role, although doulas provide some forms of emotional and physical support to their clients that a nurse might also provide, and doulas have described as “mothering the mother” during labour (Klaus, Kennell, & Klaus, 2002, p. 22). Nevertheless, Gustafson’s points are relevant in the context of this study. Gustafson states:

Women are believed to be well suited to perform the moral, instrumental, emotional, and relational labour of mothering and nursing. Educational, religious, and other social narratives reinforce the naturalness of these expectations. Nursing students are schooled in Nel Nodding's ethics of care. The prescription for being a caring and moral nurse is strikingly similar to that of the good mother ideal: authentic and engaged, empathetic, concerned, gentle, kind, warm, compassionate, and good humoured. (p. 929)

These qualities can also be attributed to doulas, who are presumed to be inherently empathic and warm towards their clients. Although training and certification of doulas may negate these assumptions somewhat (on the basis that women receive training to learn how to provide care in appropriate ways), it is certainly possible to draw a connection between essentialist discourses of women as inherently predisposed to care, and the work performed by doulas.

Lanoix (2013) highlights the importance on conceptualizing caring labour as a form of “embodied practice.” She proposes that conceptualizations of caring labour as primarily emotional – and therefore immaterial – ignore the corporeal reality of providing care. As she observes:

The caregiver has to respond to the one receiving care, which cannot be done by verbal acts only. This can entail touching them or smiling warmly; words may be superfluous or inadequate. There is a way in which simply touching means that trust can be established. This is an embodied response that comes from a bodily encounter with another being. (p. 95)

Here, Lanoix emphasizes the important position of the body within a care giving interaction. Although the provision of verbal, emotional support is an important element of care giving, a large portion of care giving is corporeally produced, through supportive touch (such as massage provided by doulas), as well as other embodied practices such as feeding and bathing, or household chores such as cooking and cleaning. The corporeal production of gendered care exists within the frameworks of “the power of institutions, possibilities for communication, the actions and the functions of society and the economy” (Husso & Hirvonen, 2012, p. 34). In other words, women’s embodied experiences of performing caring labour should be conceptualized within the broader frameworks of institutions (such as the hospital system), societal understandings of women as inherently caring, and the economic benefits afforded through women’s unpaid or underpaid labour. Furthermore, it is important to examine the ethics that underlie the provision of care, alongside the social factors that dispose women to perform the majority of caring labour that is both paid and unpaid.

In this chapter I have outlined the theoretical perspectives that frame this research project, including the medicalization of childbirth, feminist theories of maternal embodiment, and the gendered nature of caring labour. I have demonstrated the coherence between my epistemological and methodological perspective, and the theoretical

grounding of this thesis, as they each relate to embodiment, and particularly, female embodied experiences of giving birth, and the provision of care to women during pregnancy, childbirth, and postpartum. I now turn to my analysis chapters.

Part 2: ANALYSIS

Introduction

With [clients] that I don't have a relationship with already, it's really neat cause it's such a strange intimate experience that you are present for...It's neat 'cause you get this little window in on people.... There's, you know, this really unique bond, but then kinda can dissipate again...And it just, I guess impacts how I look at people as a whole and it makes me think about them more than I did [before] becoming a doula, and what's behind everybody, and what their stories are, and why they are this way. So it's definitely like, the relationships I have with clients has changed my perception of people as a whole, for the [better].

Stella

In the second half of this thesis I present my analysis of the research data, which is derived from the first focus group, individual interviews, and the second focus group. The following two chapters explore the lived experiences of the doulas in this study in relationship to my three research objectives: (1) to investigate if membership in a collective provides doulas with particular forms of support, (2) to examine how doulas construct the significance of their relationships to their clients, and (3) to explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth. In Chapter 4, I explore the lived experiences of doulas in terms of the relationships that constitute their role, including participants' relationships to other doulas in the community, and particularly the DCNL, as well as to their clients to whom they provide care during pregnancy, childbirth, and postpartum. In Chapter 5, meanwhile, I examine the lived experiences of doulas in relationship to questions of activism and resistance. I stress that the doulas who participated in my study conceptualize doula work as a continuum of resistance behaviours, ranging from the overt to the subtle. I argue that this continuum of resistance can be understood as a way of

exposing the medicalization of childbirth, and the associated limits upon women's birth options in Newfoundland and Labrador.

Description of Participants

My analysis incorporates data contributed by all eight participants: Edie, Melissa, Devi, Laura, Maeve, Stella, Olivia, and Katie (who decided to use her own name, rather than a pseudonym, in my presentation of the data). As described in Chapter 1, there appeared to be an implicit assumption that doulas in St. John's were heterosexual, cisgendered, and middle-class. Furthermore, I infer that all participants would identify themselves as members of the dominant white settler population of Newfoundland and Labrador, and most participants indicated that they were either born in the province, or had lived here for a substantial period of time.

Most participants had been practicing as doulas no earlier than 2008, when the DCNL was formed. However, Melissa indicated that she had been practicing for "a year or two" prior to the formation of the Collective (and cited her independent practice as an impetus to form the group), and Laura described attending two births in 2004, prior to her training as a doula. None of the participants indicated that their work as a doula was a primary, or even substantial, part of their income. Rather, all of the participants in this study made reference to engaging in other forms of paid employment, such as massage therapy, yoga instruction, and social work. Almost all participants mentioned having children; Katie was the only doula who made explicit reference to being childless (and, further, to being one of the *only* doulas without children). Participants who spoke about their own childbirth experiences indicated that they had taken place in Newfoundland and Labrador.

Edie, Melissa, Devi, and Laura described themselves as founding members of the DCNL. Melissa indicated that she had travelled to another province to complete her doula training, while Devi and Laura indicated that they had been part of the initial group of doulas who had completed a DONA training course together in St. John's. Because Edie only attended the first focus group, she is referenced least frequently in the analysis. At the time of her interview, Melissa appeared to be fairly active in practicing as a doula, and was very involved in running the Collective. Devi and Laura, meanwhile, spoke of practicing very infrequently. Other DCNL members, Maeve and Stella, joined the group after it had been established. Maeve spoke of practicing infrequently, while Stella has been practicing as a doula for one year. She has had many clients during this period, and is active in running the Collective.

Two other doulas had more complex relationships with the Collective. Olivia began practicing as a doula through a volunteer doula program in another province while attending university. She was a member of the DCNL at the time of her interview, but decided not to renew her membership in the Collective sometime prior to my recruitment for the second focus group. She spent the majority of her time as a member of the DCNL practicing outside of the St. John's area. Interestingly, her first face-to-face contact with other members of the Collective occurred during the first focus group.¹¹ Finally, Katie, whom I have described throughout this thesis as the only independent doula, is a former member of the DCNL. She described herself as the youngest doula practicing in St. John's, stating, "they're all like 10, 15 years older than I am" and also made reference to

¹¹ Olivia did not attend the second focus group and, unfortunately, due to the design of my study, I was not able to conduct a follow up interview to gain more information about her decision to leave the Collective.

attending university while practicing as a doula. Katie left the Collective in order to practice independently, practices frequently, and has aspirations of becoming a midwife.

I stress at the outset of my analysis that this analysis is not representative of all of the members of the DCNL, or, indeed, of all doulas in St. John's (or other parts of Newfoundland and Labrador). Rather, it is a reflection of the conversations that occurred among the specific group of doulas who chose to participate in this study. The results of this study are, furthermore, tied to this particular time and place and cannot be extrapolated to the experiences of doulas in other places. To the best of my ability, I have synthesized both the similar and dissenting opinions presented by the participants in order to provide as accurate a reading of the lived experiences of my participants as possible.

Feminist Interpretive Phenomenology

As outlined in Chapter 2, I describe my methodological approach as feminist interpretive phenomenology. My approach to coding and engaging with my data – in order to uncover recurring concepts and themes – was heavily influenced by applied approaches to interpretive phenomenology, as modelled by Smith, Flowers, and Larkin, (2009). However, my written analysis and discussion of my data is more heavily influenced by a feminist phenomenological approach that both addresses the under-theorization of women's lived and embodied experiences, and insists on the conceptual weight of the subject/object dichotomy on women's lives and bodies (such as the dichotomies of public/private, nature/culture, and mother/fetus). Elizabeth Grosz (1994), for example, highlights the particular ways that phenomenological inquiry can be useful for feminist theorists:

[Merleau-Ponty's] emphasis on lived experience and perception, his focus on the body-subject, has resonances with what may arguably be regarded as feminism's major contribution to the production and structure of knowledges....But it is clear that experience cannot be taken as an unproblematic given, a position through which one can judge knowledges, for experience is of course implicated in and produced by various knowledges and social practices. Nevertheless, I would argue that without some acknowledgment of the formative role of experience in the establishment of knowledges, feminism has no grounds from which to dispute patriarchal norms. (p. 94)

Grosz argues the importance of examining women's lived experiences in reference to the various social factors (such as the medicalization of childbirth) that shape these experiences in a particular way. My analysis of the data ties the experiences of doulas themselves, with my own particular worldview, both of which I examine in relationship to various social, political, and theoretical factors. My goal in this analysis is to disrupt the normative and patriarchal perception of childbirth and the provision of care.

Correspondingly, Iris Marion Young (2005) suggests that her essays on the phenomenology of female bodily experiences do not "[take] bodies as objects or things to observe, study or explain. Rather, [they] aim to describe subjectivity and women's experiences as lived and felt in the flesh" (p. 7). In my analysis of the data, I aim to interpret the lived experiences derived both through the embodied experience of providing doula care, and from attending to women's childbirth experiences. Although the issue of bodily experience is not directly explored, my analysis contributes to

theoretical engagement with woman-centred and embodied phenomena of childbirth and the provision of care during the pregnancy, childbirth, and postpartum periods.

Chapter 4

Doula Work and Relationships

I met with the current Chair of the Doula Collective who offered to meet with me just to tell me about [it] and I liked what I heard, and I point blank asked if there was any reason that I wouldn't want to be part of the Collective. And yeah, based on what she told me I just thought it was an easy decision to go with the Collective because the benefits are great. I don't know about, you know, the disadvantages of it I guess are, if you feel like it's too constrictive. And I personally don't, I agree with the way that it works.

Stella

In this chapter, I examine my first and second research objectives: (1) to investigate if membership in a collective provides doulas with particular forms of support, and (2) to examine how doulas construct the significance of their relationships to their clients. I discuss the ways that doulas' identity and their provision of care to women during pregnancy, childbirth, and postpartum, are shaped by their relationships to the DCNL, and to their clients. I situate my examination of doulas' relationships to the DCNL, and to their clients, in relationship to the paucity of previous literature examining doulas' understandings of their relationships to their clients, and to other doulas, and the prevalence of doula collectives across Canada. This examination is situated within the framework of "community" and the insider/outsider discourses created by them.

Doulas and Relationships in the Literature

As outlined in Chapter 1, the literature examining the lived experiences of doulas, from their own perspectives, is very limited. Even more limited is research examining the relationships that doulas develop with their clients, and particularly, the relationships that doulas develop with one another (including the dynamics involved in the formation of doula collectives). In this chapter I contribute to filling this gap in the literature by

exploring the ways that my participants perceive their relationships to their clients, and other doulas in St. John's (and more specifically, the Collective as a whole).

The phenomenon of doulas organizing themselves into collectives appears to be prominent across Canada, and the DCNL is a part of this trend. After conducting a Google search for "doula," along with the name of each Canadian province and territory, I quickly found doula collectives, organizations, and/or associations in Nova Scotia, Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, and Yukon.¹² Though the structure and mandate of these collectives are not necessarily comparable to the DCNL, there is a clear tendency for doulas to form collectives in order to advertise their services in a particular geographical area; to provide one another with support and backup if they are unable to attend a birth; and, in some instances, to advocate for awareness and change around women's childbirth options.

The DCNL serves to address all of these factors. Laura, a founding member of the DCNL, described the formation of the group thusly:

It was not a decision so much as it was, as a group we said that we needed to um...I'm not really sure. Did we join together to be a group to talk about our experiences? Or was it to raise awareness? Or was it to be social? Or was it to be activists? I guess it was a little bit of all of it.

Laura demonstrates that the initial members of the DCNL decided to form a collective and work together for numerous reasons, including their desire to obtain support from one another, and to promote their work as doulas in St. John's area (and the rest of the

¹² While I did not find information about doula collectives in New Brunswick, North West Territories, and Nunavut, it is certainly possible that collectives do exist in these areas.

province). Nevertheless, the comments made by my participants suggest a much more complex reading. It is this complexity that I seek to examine in the sections that follow.

A Framework of Community

“Community” is a highly contested term, but can be understood as made up of “[the] things which people have in common, which bind them together, and give them a sense of belonging with one another” (Day, 2006, p.1). I employ Anderson’s (2006) foundational theorization of “imagined communities,” along with other theories exploring the nature of community – and the construction of insider/outsider discourses within them – to examine the formation of the DCNL, and the broader doula community, in St. John’s. My aim is not to definitively describe the nature of the DCNL, or the defining characteristics of the insiders and outsiders to the Collective. Instead, I aim to investigate how individual members determine the boundaries of the DCNL, and their own position in relationship to these boundaries.

Anderson’s understanding of community acknowledges community as a site of both inclusion and exclusion. Although Anderson’s (2006) work explores the nature of community as it relates to nationalism, the DCNL and the alternative birth community in St. John’s can be understood as “distinguished...by the style in which they are imagined” (2006, p. 6). That is, the DCNL is more closely defined by the ways that members, or outsiders, imagine the nature of the Collective, than by the actual activities of the Collective itself. Moreover, Anderson states that nations are “imagined as a *community*, because, regardless of the actual inequality and exploitation that may prevail in each, the nation is always conceived as a deep, horizontal comradeship” (p. 7). While the active exploitation of members is not relevant to the DCNL, it is worth examining the ways that

the Collective imagines itself as relatively cohesive and equitable, despite participants' awareness of its exclusionary potential.

According to McBride (2005), community is inherently paradoxical. As well, she demonstrates the disconnect between the presumed existence of communities, and the impossibility of defining their qualities or boundaries. The boundaries of who belong and do not belong in the DCNL are clearly defined, as doulas in St. John's are either members or non-members of this group; however, the particular perspectives affiliated with being a member of the Collective (beyond simply identifying as a doula) are much less clear. Additionally, the boundaries of what constitutes the "birth community" in St. John's are not immediately clear, although it appears that this community is synonymous with the notion of "birth activists;" that is, individuals who have come together to agitate for change in relation to women's reproductive health.

Theorizing about the nature of community has emphasized how membership within a community contributes to personal identity. McBride (2005) proposes that while independence from a community may have previously been a more distinctive identity marker, it is currently preferable to formulate an identity in relationship to one's belonging to a particular group. She states:

One of the most appealing aspects of the common understanding of community today is that it delivers socially constituted identities without a loss of freedom and without coercion. Communities are where we can choose membership and have our selves reflected back or recognized in a favourable light. (p. 24)

McBride highlights how individuals use their relationship to a community as a means of defining their own identities – individuals can simply adopt the traits or behaviours

associated with a particular group and identify with them, without establishing these traits on an individual basis. This assertion is particularly relevant to this study, as several participants strongly identified as members of the DCNL, and as doulas, even though they attended births very infrequently.

Furthermore, the notion of community is frequently invoked as a way of unquestionably promoting unity between individuals with apparently shared interests or goals. The ideal of community is often adopted by social justice movements, including feminism, as a means of creating change through collective action (Joseph, 2002). This understanding of community ignores the inherent potential for all communities to be exclusionary. Joseph (2002) states “fetishizing community only makes us blind to the ways we might intervene in the enactment of domination and exploitation” (p. ix). She speaks to the potential for communities to diminish the production of social change via gate keeping mechanisms (such as the DCNL requirement that members have completed doula training with DONA International or a comparable doula certifying organization). While specific guidelines surrounding membership allow collectives and communities to present themselves as a cohesive group that is distinctive from the general population, the adherence to these guidelines may represent a perpetuation of the dominant societies’ exclusion of different or deviant members. In this vein, Ristock and Pennell (1996) state, “the goal is not to discard communal connections but to make room for the differences that separate us” (p. 18). These authors use the term, “inclusive communities,” in quotations to emphasize that communities are inherently exclusionary, and also emphasize the importance of communities negotiating their own politics of inclusion and exclusion. While the idea of community has been heavily critiqued for its potential for

exclusion, DeFilippis, Fisher, and Shragge (2010) reaffirm that community is also inherently logical, and that community is where individuals formulate political ideologies and learn to participate in political life. Indeed, they argue that “social movements need communities” with the potential to enact change within and beyond the communities’ boundaries (p.22).

Nevertheless, the data from my study indicates a need for a close attention to insider/outsider relations. Naples (1996) has interrogated insider/outsider discourses through a qualitative, feminist standpoint lens, stating:

Rather than view insiderness/outsiderness as identifiable and relatively fixed social locations, the concept of “outsider phenomenon” highlights the processes through which different community members are created as “others” – a process in which all members participate to varying degrees – and by which feelings of “otherness” are incorporated into self perceptions and social interactions. (p. 85)

Naples emphasizes the fluidity of “insiders” and “outsiders” and emphasizes that these identities are discursively constructed through the ways the individuals not only perceive themselves in relationship to a particular community, but also, how they understand the interactions that take place among them. This is particularly relevant in the case of the DCNL. Although the participants in this study emphasize the nature of belonging and building community with one another, these discussions are inherently tied to the nature of the community or the Collective. And yet, the Collective itself is defined both by who is – and who is not – a member.

In this chapter, then, I examine the paradoxical and contradictory nature of community as it plays itself out within the DCNL. I am interested both in the forms of

support highlighted by a majority of my participants – support that make membership in the DCNL an important part of their abilities to work as doulas in St. John’s – but also in the ways that the Collective creates and maintains boundaries – and therefore, an insider dialogue about who doulas are and how they should practice in St. John’s and the rest of the province. The insights of Katie and Olivia, who at the time of writing were both former members of the DCNL, are invaluable in this regard.

Relationships to The Doula Collective of Newfoundland and Labrador

Participants’ relationships to the DCNL are described in terms of the supports that they receive as members of this group, the ways that the group negotiates and resolves (or, for individuals who have left the Collective, is unable to resolve) conflict, the creation of an insider/outsider discourse of doula care in St. John’s, and affiliation with DONA certification (and the certification of doulas more generally).

Receiving Support

Most participants describe the Collective as providing doulas with important supports, such as sharing knowledge, providing backup to one another if someone is unable to attend a birth, debriefing after births, staying current with hospital policies, advertising one’s doula services, and creating change through collective action. Participants also highlight some of the supports that the Collective purports to offer, but does not effectively provide in practice.

Most participants spoke about the friendships, companionship, and sense of community that they gain from being a member of the Collective, and from having a community of like-minded individuals from whom they gain support. Melissa, one of the

doulas who initially founded the DCNL, describes her motivation for forming the Collective in this way:

I probably was one of the people that sort of founded it in the sense that I was already practicing as a doula when it came about and um, I guess...the reason why I was part of that whole formation...of the Collective is that I was probably practicing being a doula for maybe a year or two before the Collective started, and I found it kind of very lonely to be the only doula practicing...not really having the support of other doulas to understand what it was like to support women in birth, [and trying] to build those relationships with the hospital. So for me, it was about kind of building community and, um, having a support network to...talk about your experiences as a doula, to talk about how we can make it more known in the community.

Similarly, Maeve describes her motivation to join the Collective, which was already established when she began practicing as a doula:

Well [the Collective] had already started when I started going down [this] road. Um, and so it made sense to me to join this group of people who were, you know...working towards the same thing as I was. Um, I know there are some girls that have felt that it [was]...too confining, or that...maybe it's more so the confines of DONA itself has not really fit with their vision of what a doula can be. Uh, for me, because this is a very part time thing....I kind of feel I really benefit from having that group of people with me to share information with, to learn from, to share my information with....At least with the Collective um, I feel I'm connected with an entity, which is working towards promotion of the service.

Both Melissa and Maeve describe the ways that forming or joining the Collective have been beneficial to them, and has made their work as a doula easier. Maeve touches on some of the issues that other members have had with the Collective around DONA International and their certification guidelines, but states that she does not share these concerns, and that her own membership in the Collective is – and has been – very positive.

Maeve also spoke explicitly about the unique relationships she has developed with other doulas through the DCNL, and the importance of having the support of individuals who share a common interest in doula work, and alternative birth in general, and stated:

I feel I learn from everybody, they're very supportive, we listen to each other's stories, we answer each other's questions...we're always all there to provide backup to a mom, or like if needed by another member...and because we all think similarly in certain ways...it is nice to have this group of women that have this little bond in common, so that's nice. So, I mean, for people who might think similarly to this, but are within a mainstream society, [it] might be harder to find common, like-minded people. So, it's nice.

She also spoke to the ways that having doulas in her life allows her to talk about birth with other interested individuals: "it's also a social outlet as well I mean, you know, 'cause...this is a group that has...shared interests. Whereas, let's just say, I won't be sitting down discussing placentas with my Mother-in-law." Here, Maeve reinforces the importance of having the social support of other doulas who share her outlook and can engage in conversations that other people in her life may not be interested in discussing.

Most participants spoke directly about the emotional support system that they access via the DCNL, particularly when they need to debrief after a difficult (or even a joyous) birth experience. Melissa expressed this sentiment thusly:

A lot of the doulas that I'm close to I could call up and just say "Oh my God I just had like a really disheartening birth experience and I really need to kinda talk it through" and they're there for that, and I've been there on the other end of that conversation for other doulas who've been through the same thing, and it's good to be able to talk through that and for them to say, you know, um "...it doesn't sound like there's anything that you coulda did, you know," ...just remind you of things you already know. Like we can't control how a birth experience will go, and...just kind of putting it in perspective a little bit and being that shoulder to kind of lean on.

While Olivia expressed hesitancy to get very involved in the DCNL (a point that I will discuss further later in this chapter), she did acknowledge that simply by attending the first focus group for this study, she gained insight into the types of support that she could access if she needed them:

I think that, you know, even when I was there in the focus group it was really nice to sit down and to be having that kind of round table conversation with people who do such similar work, do that same work. Um, you know, because you have that sense of community and understanding right where you can swap stories and, you know, share experiences and these people really know what you're talking about right...and what you're going through. So, you know, while it's not something that I've really embraced or sought out from the Collective, I think that

if I were to, you know, look for that kinda support it would be there very readily.

Just, you know, from speaking to them for the, you know, hour or so that we were talking.

In these instances, Melissa demonstrates the tangible ways that she makes use of emotional supports derived from the Collective, while Olivia speaks to her awareness that these types of support are available, but that she simply has not chosen to make use of them.

One of the reoccurring themes brought forth by many of the participants was the importance of having a backup doula in case they were unable to attend a birth for an unforeseen reason, and the ways that this backup is most easily obtained through the Collective. Devi stated:

Being part of the Collective means that you have a close relationship with everybody who's active...and who's taking births, and whenever you take a birth you really do need a backup...anything could happen and you simply could not be there. And you really want to make sure that any mother that you choose to support is not left without a support. So being a part of the Collective means you're able to connect with the other doulas and find a backup.

Devi describes the Collective as an easily accessible database of doulas who are currently practicing, which makes arranging backup for a birth much easier. Edie reaffirms the importance of having a prearranged backup, observing:

I think we've probably all learned, I've certainly learned the hard way that, um, sometimes if you don't have a backup, or sometimes if the client, the couple chooses not to have a backup, they're like "no, I just want you and if I can't have

you I don't want anybody else," and then, suddenly, you can't make it, or you're out of town, or something, you know....I won't do a birth anymore without having backup and I actually really like the idea of having a trio of doulas.

Eddie argues that having a backup is extremely important, even if the client is not interested in having another doula attend their birth if necessary.

Conversely, Katie (the doula who practices independently) describes having difficulties in finding a backup, but states that this is common for all doulas practicing in St. John's:

I also find it hard to get backup, 'cause you should always have a backup doula in case, you know, someone's sick or whatever. Um, but I think that's pretty common for doulas even in the Collective because there aren't that many doulas actually practicing. There are a lot of doulas in the Collective, but actually taking births, there aren't very many. 'Cause a lot of them have young, young kids. And so, I mean it's just not doable, or their husbands work away or whatever. Um, so I think even doulas in the Collective have trouble getting backup but I find it particularly a pain in the ass.

Katie underscores the fact that the number of doulas actively taking on new clients is much lower than the number of doulas affiliated with the DCNL. Therefore, the challenge to find a backup is great for doulas regardless of their membership in the Collective, even though membership in the Collective may make this process somewhat easier.

Another recurring theme was the importance of advertising doula services via the DCNL website. This may appear to be a somewhat insignificant form of support afforded to members of the Collective, but it is clear that some of the participating DCNL doulas

saw their website as the medium through which potential clients and the general public could gain information about the group and its services. As such, advertising is a crucial part of presenting the DCNL as a cohesive group. Stella emphasized this in her comments:

The website I think is a big one because people don't really know much about the doula community then if you search it you'll find the Doula Collective website right away and clients get to us that way all the time. So, you know, that's a big one. Um, again I think that the website could have a lot more going on with it. But time, resources, all that stuff, it's a bit limiting. But I think a lot of us get our clients from the website and from word of mouth.

Although Stella proposes that the website could benefit from some changes and provide more detailed information, she cites its existence as an important way that doulas reach individuals in the community, and are contacted by potential clients. Olivia, whose involvement in the Collective did not reach beyond her payment of membership fees and presence on the website, cites the website as a crucial element of her membership in the Collective:

I was in [Central Newfoundland] and I was looking for a means to get my name out there, um, just in the sense that, you know, make people aware that, you know, there's a doula in the area if they want these services so, you know, I saw that there was the Collective and, uh, you know, signed up to get my name on the website so that I would be searchable, you know, for people who were looking for those kinds of services. And that's really been the extent of my involvement with the collective.

Indeed, Olivia's first face-to-face meeting with members of the Collective occurred during the first focus group, a fact that highlights the tenuous position that some members of the DCNL hold.

Stella and Devi address this issue, and indicate that there appears to be divide between the doulas who practice frequently and are more active in the Collective (in terms of attending meetings and making policy changes) and those who have less time (or motivation) to invest in the running of the Collective. Stella stated:

I've gone to every meeting and so there's a population of doulas I know because they also go to every meeting. And then there are people who I've see once at a meeting or never at a meeting so I don't, I just don't have a relationship with them, you know....I feel like the ones who do meet all the time are kind of all, they're more on the same page anyway....And the group I see meet all the time seems to have a really good dynamic, you know. They're all the ones who want to get stuff done, I guess, and move things forward and whatever....Some are more outspoken than others, some are more conservative than others, some are more out there than others, and I think that's all good. So, um I feel like my relationship with everybody is good.

Stella's description of more active members of the Collective almost represents a "sub-Collective" made up of individuals who are interested and able to attend meetings, are motivated to create change both inside and outside of the Collective, and are bound together through shared beliefs and understandings. Her depiction of a "sub-Collective" might appear to suggest a dividing force within the group. However, Devi describes the Collective as a protective community for doulas who are not able to practice or attend

meetings as frequently, because it provides a method for doulas to stay informed about doula care in St. John's:

If you're taking a break but you don't want to lose your connection to being a doula support, then coming to the Collective means you can come to the meetings and you can get, um, continuous updates about what's happening, and birth stories so you know routines and...you're benefiting from the experiences of the people who are practicing, so that when you go back you don't feel like you're really out of touch.

Therefore, participants portray the Collective as a community that accommodates both those individuals who are interested in being very active as doulas, as well as those who have less time to devote to their role as doulas, but still want to stay connected to alternative birth culture in St. John's.

Several participants highlighted the ways that the DCNL provides some forms of support more effectively in theory than in actual practice. Stella was the most vocal about the discrepancies between the supports that the Collective claims to provide, and the supports that actually benefit its members. Stella commented:

Some things that I think the Collective can kinda offer in theory but I think that in practice we have a little bit of work to do [are], just in terms of emotional and professional support...I think we could do better. For example, mentorship to new doulas. You know, I came on the scene...more than a year ago now, but I kinda wish that...I could have sought someone out and said, you know, "will you be my mentor"...Um so it's not, you know, it's not a criticism of the Collective by any means, but I think that's...an important support that we could do, is sort of pair

people up, inexperienced and experienced, so that with each birth experience that you have, you can process it better, you can learn from it, you can unload when you need to in that professional and safe capacity.

Furthermore, Stella also spoke to the potential benefits of sharing different emotional and physical support techniques between members of the DCNL, in order to improve their practice as a doula:

I'd also like to see more of an exchange of technique, in terms of comfort measures and stuff like that, like 'cause everybody comes from a different background and with different expertise and probably this person over here could tell me a whole lot more about using acupressure points.

As well, Stella stressed the failure of the Collective to adhere to a meeting structure of one meeting for business and one meeting for sharing birth experiences per month:

I think that logistically speaking it's just difficult to get a lot done sometimes, because almost all of us have other jobs and young families. You know, so it's just kinda hard....We have the idea of having like a business-y meeting once a month and then a more social thing once a month where you get that opportunity to exchange stories, but the success rate of having that happen is limited.

Stella referenced the need for greater space to discuss birth experiences, and to improve emotional supports provided to one another during both the first focus group and her interview. For Stella, these types of supports are important elements of her involvement in the Collective, but her desire for these forms of support has not, to this point, been sufficiently fulfilled.

Negotiating Conflict

The Collective can also pose certain challenges. Challenges can arise in numerous areas: negotiating different opinions while still acting as a united front, navigating criticisms of DONA policies (which may be interpreted as criticisms of the Collective itself), and managing the complexities of membership itself – complexities that emerge as a result of what can be interpreted as the Collective's gate-keeping function. That is, the mechanisms by which the Collective determines who can be a doula and how doulas should practice in St. John's. In this section, I discuss instances when members of the Collective successfully negotiated conflict, in addition to the issues that led Katie, and presumably Olivia, to leave the Collective.

Melissa, Laura, and Devi discuss some of the ways that the Collective works to negotiate minor conflicts. Melissa offered the following general insights:

I guess one of the biggest challenges about the Collective and being part of that is that um...we're all very passionate women and...we have different views on many different issues, uh, there tends to be some hot debates about what's important, what the Collective should focus on...so sometimes what one doula believes to be very important, another doula may think that we need to go in a different direction...Just not really being on the same page and...trying to kind of accommodate.

This statement provides a broad overview of the types of conflicts that members of the DCNL must overcome; namely, the necessity to negotiate the varying opinions that individual doulas might hold about how the Collective should function. Laura described

the ways that these tensions have arisen as a result of growth and change within the Collective, stating:

I think we're having some growing pains in that...we're trying to get more organized in terms of leadership and things like that but yeah. I don't even know if everybody knows exactly how involved they want to be or, you know...I haven't been to a meeting in ages with having the new baby so...I'm not really sure exactly what's happening with it right now.

As well, Devi provides a specific example of a minor conflict that the Collective has negotiated in relationship to determining the types of training required to become a member of the DCNL:

We're still working out the standards...we're torn between this being a really good person who possibly can't afford to pay for the training and they need to be part of it with, ok how are we ever going to look professional if we don't have some standard of training? So that's a little bit difficult right now, so we're working through that.

These quotes demonstrate some of the minor conflicts that members of the Collective must confront and negotiate in order to present the group as a united front within the birth community, and to the general public, but also within themselves as a group.

Conversely, Katie and Olivia discussed some of the more challenging conflicts they experienced as members of the Collective. These conflicts were not easily negotiated, and ultimately contributed to their respective departures from the group. Katie was explicit about her decision to leave the Collective in order to practice independently, while Olivia expressed several criticisms of the Collective, and subsequently opted not to

renew her membership. Katie's most significant conflict with the Collective related to the group's affiliation with DONA policies and certification, to which she did not want to adhere (a point to which I will return later in this chapter). Katie was ultimately unable to negotiate her concerns about certification with the rest of the Collective:

I didn't want to certify so by the Collective's rules I had to charge the lower rate. My problem with that is that I've done the most births out of everybody in the Collective, and so I felt like my experience, even if I hadn't certified, warranted me choosing to charge whatever I wanted to charge.

Katie also emphasized the differences between herself and other members of the DCNL, and cited these differences as contributing factors in her conflict with the Collective. She noted:

Some people think that I'm being young and foolish and making reckless decisions because they're all like 10, 15 years older than I am. You know, so I'm in a very weird position. I'm the only one practicing outside of the Collective, I'm the only one without kids, [and] I'm the youngest one by far. Yeah it's, I don't know if there are benefits to practicing independently. Um, I guess not having rules to follow but...there aren't rules to break really...I don't have that hierarchical structure governing how I practice.

Although Katie frames her disagreements with the function of the Collective as motivation for leaving, Olivia, who was still a member of the Collective at the time of her interview, describes her concerns about the Collective in terms of her hesitancy to become more involved in the group. Olivia commented:

When I first moved to St. John's I was thinking that...maybe I'll become more involved, you know, going to meetings and stuff and even in January I had, I had intentions of going to a meeting and then I forgot, of course. But I, there's a big part of me that's kind of hesitant about getting extremely involved in the Collective. Part of that is from things that I've heard from other doulas and from other people in the community.

She elaborated on this sentiment of hesitancy and described an interaction with other members of the DCNL following the first focus group. Olivia, who has made a conscious decision not to accept payment for her doula work, felt pressured by other members of the Collective to charge for her services. She recalled:

But it was the interaction that uh, was a little too, a little too intense for me at the time, you know, to really feel like I very strongly wanted to be associated with the Collective and wanted to be a part of the Collective. And I've heard that from other people that there have been doulas to deliberately leave the Collective because they disagree with decisions that are being made....So, having that snippet of, that personal experience I can really appreciate uh, I guess the other things that I've heard through hearsay about some of the reasons why doulas may not want to be associated with the Collective. That being said, for my purposes, you know, having my name out there, it serves its purpose; it does what I'm looking for it to do. Which is simply to, you know, make my information and contact information available for people to contact me.

During this "intense" exchange, Olivia felt that other members of the DCNL were not respecting her approach to doula work. While I cannot confirm my suspicions, I speculate

that this interaction contributed to Olivia's decision not to renew her membership in the Collective. Indeed, it is clear from her commentary she could no longer imagine her own approach to doula work fitting within the framework of the DCNL. Olivia's decision not to charge for her services as a doula appeared to be integral to her identity as a doula; however, this doula identity was not recognized by some members of the Collective, who promoted very different parameters for membership and belonging.

Insider/Outsider Discourses

The tensions that arose in relation to Katie's and Olivia's experiences point to the presence of insider/outsider discourses in the Collective, even as participants were, for the most part, not explicit about this. I argue that the language used around decisions to join or leave the Collective points to a nuanced understanding of how individuals come to belong, or to be excluded from the DCNL. Katie, for example, pointed to her current situation on the periphery of the doula community in St. John's, stating:

There are a lot of drawbacks. Um, I don't have the tight community of doulas that I once had. You know, I had that comfortable, or that comfort and familiarity with all the doulas because we had a meeting every month and there was lots of dialogue, but after I kept bringing up my issues with DONA in meetings, things kinda started to shut down. And people were never mean but...some people were certainly condescending and, you know, really patronizing.

Although Katie frames her current position as a loss of community, she also maintains that she still has friendly relationships with other doulas in the city, in addition to the doulas with whom she is not comfortable interacting. In this way, it seems as though the

community of the Collective has restructured itself in new ways. Nevertheless, these friendships also highlight the exclusions. She stated:

I have a lot of friends who are doulas who are in the Collective so it's not like I don't have anybody to consult with or, you know, debrief with. Um, but I do miss that familiarity with everybody, like there are some people now in the Collective that I don't feel particularly comfortable talking to, because I know that they think I made the wrong choice in not being part of the Collective...And so, you know, they'll still be really nice to me and still ask me to do backup or whatever, but there's definitely not that relationship that was there before. So that sucks.

Regardless of her current outsider position, and her discomfort with some members of the Collective, Katie maintains her commitment to providing backup to other doulas, which ultimately benefits clients' and their quality of care.

Laura is one of several participants who made indirect reference to Katie's decision to leave the Collective. She frames this decision as being related to what she sees as Katie's understanding of her "own scope of practice" as a doula, a framing which is not necessarily consistent with Katie's own portrayal of her decision to leave. Laura commented:

Well we have at least one who's decided not to be a member of the Collective because of the way she views her scope of practice. But I mean we're all different people that are sort of, uh fitting doula work into our lives in different ways, so. For me that kinda made sense because I liked the idea of having a large group that sort of laid out...how a doula was gonna work.

Although Laura doesn't explicitly describe an insider/outsider dynamic, she certainly frames Katie's decisions about her own approach to doula care as being different from the rest of the Collective, even as she acknowledges that every doula has the right – and need – to determine the best ways to fit their work into their lives.

During the second focus group, I asked about the potential for the Collective to indirectly define what doulas are, and how they should practice in St. John's (that is, could the Collective perform a gate-keeping function similar to that of DONA, which has subtly created boundaries around the definition and scope of practice of doulas). Katie responded, "I don't think anybody can determine who can be a doula and who can't be," thus reconfirming earlier observations she had made during her interview. She was followed by Maeve, who took a somewhat different stance:

Yeah...we have certain standards that people have to maintain to stay a part of the Collective, but if they decide to leave the Collective we can't say one thing or another about what they decide to do outside of that. But...to be a member of the Collective then yes.

Katie's rejection of this proposition may speak to her own ability to practice independently, without concerning herself with the opinions of other doulas in the community. It may also reflect her rejection of what she experienced as an arbitrary fee structure, a structure which actively defined a hierarchy within the Collective.

Nevertheless, despite both Katie and Maeve's assertion that the DCNL has no control over how doulas practice in St. John's, I am left to ponder how these dynamics might play out if more doulas practiced outside the realms of the DCNL, and what might happen if more radically different approaches to doula work began to emerge.

Melissa, while not present at the final focus group, also provided feedback on this topic, writing:

As for the 'gate-keeping' aspect, I think this could be viewed as a challenge AND a benefit. The Collective certainly doesn't determine who can be a doula but it does determine who can be a member of the Collective and what standards they are meant to uphold while being a member. I personally see this as a benefit because it holds [us] all to the same standards and protects our reputations, as well as the clients we serve. But I can see how some might view this as negative or challenging.

Melissa views the Collective's (somewhat hypothetical) capacity to influence how doula work is performed beyond its boundaries as a benefit, particularly in relation to standards of practice. These standards of practice can help to protect the reputations of all doulas in St. John's – presumably because the activities of doulas working far beyond the scope of practice that the Collective maintains could negatively impact the reputation of doulas in general. However, in her final sentence, Melissa does illuminate the potential for the Collective to more explicitly maintain an insider/outsider discourse, both in relation to doulas who disagreed with the parameters, and in the event that they do distance themselves from the activities of (and again, hypothetical) "rogue" doulas.

DONA International and Doula Certification

As discussed in Chapter 1, the DCNL exhibits a certain level of affiliation with DONA International and their certification guidelines. Participants expressed a range of different opinions about DONA and the certification of doulas in general, ranging from full support of DONA certification, to some criticism of DONA policies with an

appreciation for certification in general, to a rejection of DONA along with the expectation that doulas should become certified. While DCNL policies cannot be understood as synonymous with DONA policies, it is clear that varying opinions about DONA have been a source of tension in the Collective, and also heavily influenced Katie's decision to leave the Collective in order to practice independently. Katie made this link between DONA and the DCNL explicit during her interview. In reference to the Collective's association with DONA standards for practice and certification, Katie said "it's not a Doula Collective, it's a DONA Collective." However, Melissa offered a different reading of the Collective's affiliation with DONA and wrote:

The Collective has since formulated its own policies around scope of practice, code of ethics, and expectations of a doula's role, so I think there is a lot less risk of DONA policies being lumped in with the Collective – although there are many similarities between DONA policies and the ones adopted by the Collective.

Melissa reveals that the Collective has, in the course of its evolution, made an effort to govern itself based on its own parameters, rather than simply adopting the ones that DONA has set out. Nevertheless, it is clear that these parameters remain highly influenced by DONA's guidelines about how doulas should practice.

Although several participants expressed support for DONA International, Melissa was perhaps the most enthusiastic. She stated:

The way I feel about DONA is that their goal is to promote accountability and credibility with the [doula] profession and to standardize it so that doulas stay within the scope of practice and make sure that doulas continue to be educated on up to date information and um, in essence protect all of us DONA members by

doing that because um, if there's a doula who's certified with DONA that steps out of that...scope of practice...and then it is discovered that they're a DONA member, then it reflects badly I think on DONA and therefore anyone associated with DONA.

Melissa views DONA as promoting the professionalization of doulas and ensuring that doulas practice in a particular way. She also said:

Unfortunately right now, um you can call yourself a doula and not necessarily be certified by any one organization. But, I think that by certifying, and having those credentials after your name...what you're saying really to the public is that...I'm accountable to an organization, and I have gone through the process of trying to be the best doula that I can be. I'm not saying that you have to be certified in order to be a good doula, there's lots of great doulas out there that are choosing not to certify that are wonderful...So, personally I think that um, there's huge benefits to the certification process, and I would hope that most doulas would want to go through that.

At the same time as she is accepting of doulas who have explicitly chosen not to certify, Melissa does demonstrate a strong disposition towards professionalism for doulas. She views the DONA certification process as ensuring that a doula has received the highest level of training, adheres to particular standards, and is accountable to a certifying body.

Several other doulas echoed these sentiments. Laura, for example, stated:

I always kind of figured that I'd certify because I think it does sort of impart to clients and potential clients that there's something that's backing you up that's bigger than just yourself, which kind of appealed to me, thinking of if I was

looking for a doula...and yes back in the day when I first started learning about it I was looking at some of the different certifying groups and DONA sort of seemed like the one I would have gone with anyways.

Laura suggests that her motivation to become certified comes from putting herself in her clients' place, and determining that she would be more inclined to hire a doula with certification credentials. Stella, too, expressed an appreciation for thorough certifying guidelines. She also explained why the majority of doulas in St. John's are trained or certified through DONA, rather than another certifying organization:

When we have a training session...and somebody comes from DONA to train them, well then everybody ends up certifying with DONA, right? There are others that are equally thorough and equally, you know, good about that kinda stuff. And then there are others that have a different way of going about it. I'm on the team with DONA and CAPPA¹³ and those ones that are really thorough about it. Why not? You know, it forces you to learn more, it forces you to do more intense training sessions, uh recertification I think is really important because you need to stay on top of it, and you need to be reminded of all of the good reasons that you do it.

In addition to demonstrating approval for certification based on thorough training guidelines, Stella also views certification, and the re-certification process in particular, as being particularly beneficial for giving doulas renewed interest in their work, because the demands of their work may cause some individuals to lose sight of their original enthusiasm for becoming a doula.

¹³ Childbirth and Postpartum Professional Association.

Several doulas discussed the question of certification in relationship to the particular case of Newfoundland and Labrador. Participants expressed different views about whether certification was particularly beneficial in an area where doulas are not well known. For Devi, affiliation with DONA was a strategic choice that could have particular benefits in a city like St. John's, where many people are unfamiliar with doulas. She stated:

We've chosen DONA because it's the biggest organization, it's the more recognized organization, and really that's what we need now in a city where nobody knows that a doula is, is to sort of go with the biggest.

Maeve, while agreeing with Devi to a certain extent, nevertheless presented a range of perspectives on this topic throughout her participation in this study. During her interview she observed:

In an environment such as St. John's where sometimes I feel that people are kind of skeptical about the services a doula can provide anyways...those letters behind a name at least provides maybe a little bit of relief, or um security that a person has fulfilled a certain standard that's uh, been set [up] by this governing body.

But later, at the second focus group, Maeve went on to critique this exact point:

I mean it might be more beneficial in a large, large city where it is more known in a way, I guess...whereas if I put those letters behind my name here I still will have to explain it, right? So maybe it is something that say, working in Toronto [it] would mean more for somebody there, but I'm not sure.

In the course of her reflections on this point, Maeve came to question whether having certification in a place where people are unfamiliar with the role of a doula itself would

actually be beneficial, since the general public would presumably also be unfamiliar with the certification process that doulas undergo. She went on to say:

I know originally the thought was that it would...bring up our credentials with, you know, in the case room and what not. I've never been asked for anything um because I'm, as far as I'm concerned, I'm just one of the two people who are allowed to be in there. So, it may be if...they did change the case room rules so that there was two people plus a doula then it might.

Here, Maeve indicates that certification was viewed as being particularly beneficial for establishing the legitimacy of doulas' presence in the hospital, but that, in her experience, medical professionals have never asked her about her certification status. As described in Chapter 1, the DCNL has recently announced on their website that doulas can now attend hospital births in addition to two family members or friends, rather than holding one of these two spots. Maeve's comments, which gesture to the possibility of hospital policy change, appear to have foreshadowed this development. Since this is an extremely new development for doulas in St. John's (and the particular parameters around who can be considered a doula under this policy are not clearly defined on the DCNL website), the impacts of this policy have yet to be seen.

Olivia, having practiced outside of the St. John's area, expressed a unique concern about doula certification in Newfoundland and Labrador:

you need to have a certification process that's more compatible with, you know, what's available for people to work with. And the practicality of learning and

developing your skills, you know, if somebody up in St. Anthony¹⁴ walks in and says they're a doula...I don't think it's gonna be received that well.

Speaking of the requirement for doulas to obtain an evaluation of their work from a nurse and doctor, Olivia highlights the unique challenges a doula would face in an extremely isolated area where the concept of a doula is completely foreign. An individual's ability to obtain certification is constrained by their ability to receive approval from medical professionals, to the extent that they recognize their work as valuable and consent to complete their evaluation. This speaks to the question of privilege, a point to which I will return in the next chapter.

In general, Olivia expressed support for the concept of certification of doulas. However, she found the DONA guidelines for obtaining certification to be problematic. She stated:

Yeah, you know, by having a certification process it ensures that, you know, people who are claiming to be trained and knowledgeable in this area actually have, you know, some training to support that, right? And it also helps people who um, may be looking for doula services but don't know a whole lot about it. You know, it helps them to see if someone's certified, there's a certain level of assurance that they have with that. Um, the DONA certification process I don't have a whole lot of respect for overall.

And she went on to elaborate her concerns with this process:

¹⁴ A town located on the northernmost tip of the Northern Peninsula, on the island of Newfoundland.

My main beef, my only beef I think with the certification process is the way that they request you to document your three births. And you've probably heard this endless times because all of us doulas just kind of just bitch and complain about it. Um, and it's that your evaluation [of] your three births that you use for your certification is done by nurses and physicians in the hospital setting...but that's a big problem particularly for people in smaller areas, or in areas where doulas aren't as mainstream, primarily because, you know, physicians and nurses don't know who the hell these people are, what the hell you're supposed to be doing and, you know, it's really of no concern to them...whether you get your certification or not. And even when they're filling out the forms...they don't really know what to be looking for and so they can't even fill them out in the best way possible. It's asking somebody to fill out a form to evaluate somebody in an area that they themselves have no training [or]...really in depth knowledge about, right. So it's very ass backwards in that way.

Despite Olivia's assertion that certification can be beneficial for imparting to clients that doulas are trained in a particular way, and possess a certain level of knowledge about childbirth, she feels that the obligation to have nurses and physicians evaluate a doula's performance is not an accurate evaluation of a doula's work. This process involves medical professionals evaluating a role that they might not be familiar with, and may create a boundary against certification if medical professionals are particularly resistant to doula work in some areas. Interestingly, this approach, which requires mainstream medical professionals to act as "gate-keepers," appears to situate doula work within,

rather than outside, the medicalization of childbirth, although none of the participants explicitly voiced their concerns in this regard.

Several participants were more explicitly critical of DONA International, their certification guidelines, and the certification of doulas in general. Katie was the most vocal in her criticisms of DONA, and she cited these criticisms as part of her motivation to leave the Collective, an organization which, she felt, adhered too closely to DONA policies. She stated:

just like certain policies that DONA has that I don't necessarily agree with. Like for example, you have to have three certifying births, to certify as a DONA birth doula, but only certain births count towards that certifying....But, the one that really rubbed me the wrong way is that they require a doctor or a nurse's signature...to evaluate how well you did at the birth...which really gets under my skin because that's not their job to do. Especially like, the nurse I can understand, they're around more, but the doctor generally comes in like just before the baby is about to come out. And then comes in, and catches the baby, and leaves again. You know? So if I'm in there with someone for, you know, 24-hours and he's there for a half an hour, how on earth would he know how well I did my job? Or how would he even know what my job entails as a doula? Let alone be qualified to evaluate that. Or, no more than one birth can be a c-section to count towards your certifying births...I think that really discounts somebody's birth. "Oh well your birth doesn't count, this kind of birth doesn't count."

Furthermore, Katie expressed concerns with DONA on a more fundamental level, based on their lack of attention to difference in their training workshop. She stated:

I don't feel like the DONA workshop prepared me to be a doula. You know like it taught me how labour works and what steps happen and...how to rub a back and how to massage, but it didn't teach me what to do in, you know, unexpected situations. I've had moms go into labour really, really early. You have no idea what to do. You know, I've worked with single moms, which is very different [from] working with someone who has a partner; DONA didn't prepare me for that. You know, I've worked with moms who don't speak English, DONA didn't prepare me for that, you know. Different socioeconomic statuses, and you know, different family situations, skin colour, sexuality, you know.

Outside of teaching prospective doulas about the fundamentals of childbirth, Katie argues that no attention is given to the particular social locations of clients, or to working with clients who do not fit the normative framework of white, heterosexual, married, and middle-class. In her comments, Katie presents some of the critiques of the normative discourses surrounding doula care that were discussed in Chapter 1.

Along with some support for certification in general, Maeve expressed several criticisms of DONA, including their requirements for certifying births, and their failure to process her certification documents in a timely manner. She stated:

These are some of the other [issues] that I do have with DONA actually. Is that you have...to be present at [the] labour prior to five or four centimetres. Which for some, you know, like what if the mom doesn't get in there until six centimetres...but yet you still spend time with her...technically they wouldn't accept that birth because at the start of the sheet....the first...cervical check is at six centimetres and they wouldn't consider this as one of [the] births.

Maeve also critiqued DONA's emphasis on the care provided on the day of the birth, with no regard for the important education and support doulas provide during pregnancy:

They don't really ask any of that stuff. How do you prepare the parents for this whole thing? It's all, everything for certification purposes is all based on that, the day of the birth. And how dilated she was at the time, and whether or not she had a c-section.

This statement also echoes Katie's concerns about DONA's emphasis on particular types of births, and their rule that only one certifying birth can involve a caesarean section.

These criticisms, along with Katie's criticism of DONA's normative framework, demonstrate the ways that DONA influences not only who can be a doula, but also, who can be perceived as a doula client, and what their birth should look like. For Katie, the Collective's uncritical association with these policies were part of her motivation to leave the group to practice independently in order to distance her own work as a doula from DONA guidelines and perspectives.

Finally, Maeve spoke to some of her practical concerns with DONA; namely, that she had completed her certification paperwork and forwarded it to DONA in order to receive her certified designation, but had still not heard back from them eight months later. She described her frustrations in this way:

Well I'm actually getting a little bit pissed off at the whole certification process because I finished mine back in November and I haven't heard from them. No, I've contacted them several times [and] I finally managed to get a hold of them after I don't know, five times, and they managed to tell me they do have my file. That's all they could tell me and I know they changed offices...and this is

probably what happened with you, Katie, is that...the more experience you get the less you need [certification credentials] behind you right...as you get to make relationships within the hospital and with your clients and what not, right.

But...I'm still taking on clients and it doesn't seem to make a difference. You know, I mean I haven't put up my fees or anything in awhile because I was kind of waiting for that to come through so I don't know, I might eventually anyway.

DONA's failure to award her with her certification credential, despite her diligent completion of their requirements, led Maeve to question the value of certification. While she had previously felt that certification would improve her reputation with potential clients, this was not the case. Indeed, her lack of certification had no apparent impact on her work as a doula (besides her hesitation to increase her fees). As she has continued to practice, she has discovered that certification credentials were not as valuable as she once thought.

In this section I have outlined the various ways that doulas in St. John's understand the DCNL as both a site where doulas access various forms of support, and one where doulas must negotiate conflicts – including the potential for the DCNL to create an insider/outsider discourse around doula work in St. John's. Doulas' perspectives on DONA International and doula certification is an important element of this insider/outsider discourse, because the Collective's association with DONA policies has been a source of contention for some doulas.

Relationships to Clients

In this section I discuss the special bonds and unique relationships that doulas develop with their clients, as well as the necessity to set and maintain boundaries with

some clients. Participants in this study developed unique relationships with their clients, regardless of whether or not this relationship was maintained after their duties as a doula had been fulfilled. The doulas in this study described being deeply involved in a very emotional and personal moment in their clients' lives, and attempted to build rapport and close relationships very quickly, due to the intimate nature of their interactions. Doulas make a concerted effort not to pass judgment about the choices that their clients make, and are adamant about their commitment to supporting a woman regardless of her choices about her birth experience. Participants demonstrated differing opinions about what level of professionalism they should exhibit with their clients, but did not clearly define what this meant, at a practical level. Doulas sometimes experience difficulties in setting and maintaining boundaries with their clients, particularly when clients demand more from them than they are comfortable providing. Since doula work is an ungoverned profession, the parameters of their care are sometimes not clearly defined, and it becomes difficult for both doulas, and their clients, to determine when doulas' responsibilities have ended.

Special Bonds and Unique Relationships

Most participants spoke of their relationships with their clients as a special or unique bond that is unlike any other relationship. Doulas play an intimate role in providing continuous emotional support during childbirth and are witness to what is considered, by most, to be a very important life event. Melissa spoke of her relationship with her clients in this way:

there's a very special bond I think that forms with a doula and...the mother...that has had the baby. And then another bond that forms between, sort of, the baby and the doula, because I remember all the clients that I've had and I remember all the

babies that I've watched come into this world and there's just something about being a part of that moment that I think bonds people.

Melissa describes the bond she forms with her clients as being emotionally significant both because she witnesses a mother giving birth, but also because she witnesses the moment when a new life enters the world. She says that she remembers of all of her clients, and their children, a fact which demonstrates that the relationships she forms with clients are important and momentous occasions worthy of her memories and recollection.

Laura echoed these sentiments and spoke specifically about one client who requested that she be her doula for a second birth:

Well I can think of one client um, she called me back for her second baby so...

I've done two births with her and now she's really interested in doing doula training so I feel like she, not only do I have two doula babies with her but she's a doula baby too. Which is really, really cute. And um yeah, she and I are friends now I'd say, like we don't talk all the time but when we see each other it's always really kinda special and there's an extra sorta warmth there 'cause it's a pretty big thing to be a part of to start with, and then to be honoured to be called again because she said it had gone so well the first time she thought it would absolutely, you know, be important for me to be there. I mean, I always feel like there's a certain amount of fondness that I have for these babies and yeah, I'm always so proud of the moms.

Laura feels a special honour from her client's request to support her in childbirth a second time, which can be read as evidence of the emotional significance that particular birth experiences hold both for clients, and for doulas. She describes their relationship as

developing into a friendship, and further, as inspiring the client to take up doula work herself, demonstrating the profound impact that experiencing Laura's care during labour has had on her life. Her articulation of a special "fondness" speaks to what she perceives as the uniqueness of the bond that forms between doula and client.

Devi expressed a complementary, but not exactly similar, view. She described doulas as having a more general appreciation for the relationships with their clients; relationships that are perhaps less individually focused than a client's would be on their doula. She said:

Well I think, inevitably [for] a woman whose only had one or two children...of course they're gonna be more vivid in your memory than the other way around, where as a doula you're doing one a month...the time that you can invest in thinking about each relationship has to be spread out a little bit more. It doesn't mean that it's less important but it's kind of like being a schoolteacher or anything like that. Each individual student remembers the teacher quite vividly but it's hard for that teacher to remember all 45 of their students with that same...kind of focus....I think that a mother appreciates that one experience that they had in their lives, whereas the doula appreciates that one connection, but in general appreciates that whole connection between a birth support and a mother in a big umbrella kind of way.

Devi later added:

I think that if it wasn't an appreciation for that relationship and love for that relationship, I don't think anyone would do it. 'Cause, you know, it's not like you're gonna make a lot of money doing it.

Here, Devi acknowledges that although doulas – like teachers (and presumably others in the so-called ‘caring professions’) – certainly appreciate the individual relationships they develop with their clients, they are more interested in the relationships that develop between clients and doulas as a result of their journey through pregnancy and birth together. She points to the lack of financial remuneration as evidence to support her view.

Olivia and Maeve, meanwhile, spoke of instances when they knew that they had improved their clients’ birth experiences; instances that highlighted the unique nature of the doula/client bond. Olivia spoke of being a grounding force for clients at moments when they became overwhelmed. She described her role as:

really being a person to focus on the mother, where you know you look at them, [and] you insert some control. And I don’t mean that in a negative sense but, you know, sometimes when people are getting, you know, pushed and their um, emotions are getting elevated, they need a grounding force, right. And...it can be rewarding to be able to be that for somebody where you look at them and you say “no let’s breathe,” and you breathe with them and your eyes lock and they’re focused on you and they’re listening to what you’re saying and you can see, you know, there’s no longer the frantic lost, you know, “I’m just in so much pain, I don’t know what I’m doing,” kind of thing. And you can see, you know, very physically and you can feel it with their energy that they can, you know, calm down and...they can get through that contraction, right.

Olivia feels rewarded by her ability to bring a sense of calm to her clients, just by being present and helping them to breathe and relax. Completing Olivia’s observations, Maeve reveals that the doula/client relationship extends beyond the mother-to-be and the doula to

include the client's partner. She describes obtaining fulfillment from being able to help a client's partner be a better support person, stating:

I actually took his hands and...made him do it. So, had I not been there, he wouldn't of known to do like, hip squeeze. Who knows what the frig a hip squeeze is, right? He wouldn't have known to try this, or to recommend this maneuver or to help her with breathing with this particular technique...And at the end of the day, he really felt that...he played a role there and he was very helpful and this is a guy who was really squeamish beforehand.

In addition to improving the experiences of women giving birth, Maeve highlights the potential benefits doulas can offer to their partners as well. Maeve describes this experience as being fulfilling because providing the partner with information about how to provide support was more significant for that couple than if she had provided these supports herself.

Several doulas spoke about attending the births of clients with whom they were already familiar, or that they already considered to be their friends. Stella, for example, outlined the different types of relationships that she has with clients based on how well she knew them before becoming their doula. She proposes that this dynamic might be unique to a place like St. John's, where the community of individuals interested in alternative birth care is relatively small. She said:

Well, I think it's...interesting doing this in St John's, you know, where...I don't know what it would be like in a bigger city and maybe you'd have more clients that you don't know. Like the clients that I've had, I've known half of them for sure. So there's a difference between clients who hire me and that's the first time

that we meet, like we decide that I'm the doula for them. So that's one kind of relationship. And then I have...friends of friends, and acquaintances and I know of them and then obviously, you know, our relationship goes from there. And then I've been a doula for people that I'm really, really close with. So it's hard to then separate your previous relationship from, you know, the professional doula relationship.

Stella spoke to the need for doulas to maintain a certain level of professionalism with their clients, but does not allude to what the parameters of professionalism might be. She demonstrates that doulas develop relationships differently with each client, depending on their previous knowledge of one another, and the direction that their relationship will take after she has been hired.

Melissa spoke of similar experiences:

There are also friends that you've had before you're a doula um, that get pregnant and then ask you to be their doula, so that again is another layer of, how do you be that professional support for them when you're still their friend, and I think that, in a lot of ways, you end up just being their friend that knows a lot about birth and not so much their doula. But in terms of people that hire you and don't really know you um before...I think that like I said, it's just really important to kind of remember that you're in a professional relationship with that couple and with that woman, and to be aware of things like self disclosure and not kind of making it about you when you're doing your work with clients. I personally try very hard not to talk about my own children or not to talk about my own birth experiences with clients unless it's helpful to them.

Melissa echoed Stella's concern for professionalism, and from her perspective, this appears to involve creating boundaries around her own self disclosure to her clients, and being sure not to make her own birth experiences a part of their interactions, unless it would be beneficial for some reason. Neither Stella nor Melissa spoke in further detail about providing doula care to their respective friends, but it appears that both doulas are comfortable working with clients regardless of their previous relationships with them.

Finally, Melissa, in particular, spoke extensively of taking on the emotional states of her clients; she felt joyful when a birth experience was positive, and disappointed when a birth experience turned out very differently than her clients had hoped. This shared emotional bond stands as a further testament to what doulas describe as the unique relationships they develop with their clients. In reference to a particularly positive birth that she attended, she stated:

She had a water birth, was feeling very supported, did amazingly well, pushed her baby out beautifully, and after she just cried and cried from...having such a wonderful, incredible, life changing experience and it was so moving that, of course, I cry at a lot of births, but that was...soul wrenching sort of crying [for] joy for her. You leave a birth like that, when you know that that woman's life is forever changed by that experience, you leave that birth feeling so blessed that you were given the opportunity to be a part of it.

Conversely, Melissa also spoke about taking on her clients' pain when their birth experiences were difficult or did not turn out how they had planned:

I think in a way you almost take on your client's pain a little bit? Like, 'cause you want them to have the birth experience that they want very badly....And so when

it doesn't go that way...and when it takes a turn that's very much not what they wanted and they're very upset about it, you leave feeling like you didn't do a good enough job. Or, you feel like the work is too hard, that it takes too much. I think in a way um, it takes a little piece of you when you have a birth like that. I also walk away sometimes feeling like those are the clients that need the doulas the most. Not the ones where everything goes smoothly and perfectly and there's no issues and within six hours they push the baby out and everything is candy and roses. Like, those are the births that are joyous and you leave there feeling ecstatic and wonderful, but it's those births that leave you feel[ing] disheartened where they need the doula the most.

Here, Melissa suggests that her clients' negative birth experiences can impact her own belief in her professional abilities. However, she also identifies these births in particular as the ones that might benefit most from doula care. This is because these women require support in order to make sense of their experiences, and to mourn the loss of their previous visions of their birth. Both of Melissa's quotes demonstrate how deeply she cares for her clients, and how intimate the relationships she develops with them are. When caring for a woman during birth, Melissa becomes connected to their emotions, and therefore holds the double role of coping with her own emotions about a birth she has attended, and helping her clients debrief and reflect back on their birth experience positively.

Setting and Maintaining Boundaries

However, even as my participants indicated that intimacy was integral to the doula/client relationship, some spoke of the challenges they have experienced with

maintaining boundaries with some of their clients. While both Katie and members of the DCNL spoke of meeting with their clients before their birth, caring for them during their labours, and meeting with them after their births, neither of them mentioned any specific guidelines that dictated the length or frequency of care that clients could request during pregnancy or the postpartum period. Katie described an experience that she found particularly difficult to navigate. In this case, a client gave birth extremely prematurely, and was unsure if the baby would survive. Katie recalled:

it got really draining and I guess I cared so much that I didn't know when to say no, when to say you know like, I'm busy right now or you know, can you call me another time I'm in school, you know. But I just felt like this woman needed me so I had to be there, and it wore me out and stressed me out and made me sick and, you know, I was like "do I really want to do this"? But, I mean, not all births are like that, and not all clients are like that and, you know, that was a particularly extreme case...But, it was also one of the ones that make it the most worth it, you know? After that baby got out of the hospital I was able to, you know, go see him in the NICU¹⁵ and they got me to be their Godmother to the baby.

Katie described this instance as simultaneously one of the best and worst experiences she has had with a client. The client demanded an unusually high level of attention from Katie in order to cope with the stress of having a premature baby. However, Katie felt unsure about how to create boundaries with this client, both because she felt very deeply that the client required her support, and also because the client demonstrated a strong appreciation

¹⁵ Neonatal intensive care unit.

for this support by naming Katie as Godmother. Katie reflected on this experience again during the second focus group:

When do you stop being someone's doula? After they have their baby? What if they have problems after their baby's born? For how long can they have problems and you can still be their doula? If they're still coming to you in three months are they still your client? Are they not your client anymore? Where does your responsibility end, and how much do you feel obligated to help this person, and how much of yourself are you going to give in helping this person?

Katie spoke explicitly of the lack of guidelines around how much care doulas should provide before their roles have been fulfilled. For Katie, this occurred in relation to what ended up being a high-risk premature birth. However, this also appears to be particularly difficult to navigate if the relationship between the doula and their client becomes more like a friendship, where conventional professional boundaries are not so neatly maintained. Olivia described a similarly challenging relationship with a client:

I've had an interaction or a relationship with clients that was um, very, very challenging for me because I had to be very, not necessarily stern, but direct and clear with what services I provided and what services I didn't provide. And...I think a part of it might have been a language barrier on one of the partner's side, um and I'm not sure why else there seemed to be you know, some troubles communicating or understanding the communication but, you know, I had to be very clear as to what was acceptable and what was not acceptable and, you know, got to the point where I was getting texts at 10 and 11 o'clock at night...and this was with a couple who [was] 25 weeks along.

Similar to Katie, Olivia felt pressured by her client to provide care that went beyond what she understood as acceptable expectations. Olivia's situation was particularly interesting given her professional doula background. She had started working as a doula in a hospital-based volunteer program in another province, where the parameters around the nature and extent of the care doulas provided were clearly established and maintained through the program itself. However, these guidelines did not exist for her when she started practicing in Newfoundland and Labrador, and, as a result, she found it more difficult to adhere to the boundaries with which she felt comfortable. In relation to this, it is also important to consider that Olivia does not charge for her doula services. Therefore, she was navigating obligations to clients to whom she completely volunteered her time.

Melissa, who, if we recall, appears to have a clearer sense of how boundaries operate within the doula/client relationship, spoke about her concerns regarding these types of interactions between doulas and clients, stating:

There's definitely a huge risk of sort of boundaries being blurred sometimes when you're doing this work. Um, and I think that that can be dangerous. Like any profession I think that it's important to build rapport with your clients but that's very different than becoming friends with them. Um and I don't know if all doulas kind of get the difference, you know. Now, that said, there are definitely clients that I've had that I've gone through this process with...and the bond has been so strong that after that professional relationship is over...there's certainly people that I've kept in touch with and would now consider friends.

Again, Melissa attempts to draw a line between friendship and professionalism with clients, but it is not immediately clear from her comments how this should be achieved.

The challenges that doulas have faced in setting and maintaining boundaries with clients seems to point to the necessity for individual doulas, or the Collective, to establish specific parameters around the care doulas provide during pregnancy, labour, and postpartum.

In this chapter I have explored the nature of my participants' relationships to the DCNL, and to their clients. I have situated my analysis in relationship to the paucity of previous literature in this area, the prevalence of doula collectives across Canada, and a framework of "community" and the insider/outsider discourses created by them. Doulas both receive support and must negotiate conflicts within the DCNL, a fact which highlights the Collective's potential to create or perpetuate insider/outsider discourses of doula care in St. John's. Doulas' opinions about DONA International and doula certification are an important part of their belonging to, or independence from the Collective. Doulas describe their relationships in terms of the special bonds and unique relationships that they form, due to the intimate nature of their caring work. However, they also described the challenges they faced in setting and maintaining boundaries with some clients who demanded levels of support that they were not comfortable providing, and that seemed to extend beyond reasonable obligations and responsibilities – perhaps highlighting the gendered expectations of care. In the next chapter, I examine the question of activism and resistance in relation to doula care.

Chapter 5

Doula Work as a Continuum of Resistance

I think that's probably par for the course with any grassroots movement as well, right. I mean you can't be all words and shouting and stuff without the action on the inside, in the background as well, right. If everything [is] just words with no actions then...things don't happen that way...But at the same time, if everything is happening on the inside, and nobody hears about it from the outside, then that makes change slower to occur. It can still occur, but slower.

Maeve

In this chapter I explore my third research objective: (3) to explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth. Since the current presence of doulas in Newfoundland and Labrador can be understood both as a continuation of women's health movements, as discussed in Chapter 1, and as a reaction to the limited childbirth options currently available in the province, I have, based on my conversations with my participants, conceptualized doula work in St. John's as a continuum of resistance behaviours. I situate my conceptualization of this continuum of resistance within previously literature related to doulas, activism, and resistance, and a Bourdieuan framework of resistance in relationship to the concepts of *habitus*, and *doxa*, *orthodoxy*, and *heterodoxy*.

Conceptualizing a Continuum

In this study I sought to examine the potential for doula work to be understood as a form of activism or resistance against the medicalization of childbirth. While I found that it is possible to understand the activities of doulas in this way, the connection between doula work, resistance, and medicalization is far more complex than I had initially imagined. In this chapter I discuss my conceptualization of my participants' resistance behaviours as falling along a continuum, and explore the different ways that

doulas perform resistance both inside and outside of their roles as doulas. I argue that medicalization is the underlying factor against which doulas perform resistance, but I also suggest that this continuum of resistance behaviours is performed in relationship to the hospital setting in which they practice, to governmental control over childbirth options in Newfoundland and Labrador, and to societal perceptions of childbirth as “risky.” My goal, in this chapter, is to tease out the various forms of resistance that doulas in this study perform. To accomplish this, I introduce doula resistance as it emerges in pre-existing literature before moving into a discussion of different forms of resistance as they emerged in the course of my study. These include overt and subtle forms of activism, as well as resistance from within the Collective, the necessity for doulas to be activists in Newfoundland and Labrador, and finally, a troubling of doula work itself as a form of resistance.

Throughout my interviews I saw two different approaches to resistance being brought forward: an understanding of doulas as individuals who also engage in activist behaviours outside of their work with clients (such as attending rallies for the legislation and regulation of midwifery in Newfoundland and Labrador), and an acknowledgement that the mere act of performing doula care within the hospital setting in St. John’s (or other parts of Newfoundland and Labrador) could be understood as a form of activism.

During the second focus group, I brought these two types of resistance behaviours forward, telling the two participants in attendance that I was looking for a way to understand these behaviours as different but complementary, without creating a hierarchy among them. Maeve’s response to my comments was insightful:

I guess it's kind of a spectrum...I guess you could consider them activism even if it's not a conscious effort to do that but even in the words we've been choosing tonight...our job is to empower women, you know those are activist words but that's not necessarily, you know, like we're not carrying our signs...so it is a spectrum and I guess in order to make change you have to do both. Because there's only so much of the population that's going to see or be affected by one, and the same with the other, right. I mean, and that helps to make that picture whole, if a portion of the population is seeing us in our roles as a doula in the hospital or what not, and then they can make that connection with us doing the other, you know, and learning about what it is that we're trying to educate people [about]...then that helps to make that connection more, I guess, tangible for them and more real, right.

The other focus group participant, Katie, stated:

People are just generally inclined to be on certain ends of the spectrum. Some people are never gonna be the hold out your sign, yell on CBC kind of people. That's why I'm around. And then some people are going to be more subversive and be more, you know, that quiet change...that becomes bigger and bigger and bigger and actually effectuates big change without anybody realizing and anybody really saying anything. And I think that's just as valuable as being out there and loud and activist-y. I think it just depends on how each individual feels most comfortable effecting change.

I am indebted Maeve's and Katie's insights, which have contributed strongly to my current conceptualization of the resistance behaviours performed by doulas as existing

along a continuum. This continuum encompasses a range of different forms of activism (ranging from the mere presence of doulas within the hospital system to petitioning the government for increased birth options for women in Newfoundland and Labrador), and avoids the creation of a hierarchy in which one form of activism is understood as a more effective form of resistance than another. Katie's proposal that different individuals feel comfortable effecting change in different ways certainly rang true in relation to my participants: when I reflected back on my interview transcripts, I noted that many of my participants indicated that they felt most comfortable enacting change in more quiet or subtle ways, but appeared to differentiate these behaviours from – and perhaps represent them as less valuable than – louder and more obvious forms of resistance such as lobbying the government, speaking to the media, or engaging in protests or rallies.

My reflections caused me to consider carefully the terms “resistance” and “activism.” The relationship between these terms is not always evident. For the purposes of this thesis, I conceptualize activism as a particular method of performing resistance. Thus, activism can be defined as “the policy or action of using vigorous campaigning to bring about political or social change” (Stevenson, 2010, para.1). Resistance, meanwhile, can be understood as “the refusal to accept or comply with something” (Stevenson, 2010, para.1). This refusal to comply is oriented towards some form of social justice and may involve subtle activities – activisms – aimed at either disrupting or maintaining some element of the status quo.

It is important to note at the outset that participants did not necessarily label their behaviours as “activist” behaviours, even as I, myself, would have considered them in this light. Given this, I have elected to include in my continuum of resistance not only those

behaviours that the doulas themselves identified explicitly as “activist,” but also those more subtle but equally meaningful forms of resistance that, while not necessarily claimed as “activist behaviours,” nevertheless contribute to broader social justice goals.

Doulas Performing Resistance in the Literature

Doula work as resistance is very prominent in the work of Miriam Pérez, who identifies herself as a “radical doula.” As discussed in Chapter 1, *The Radical Doula Guide* is the most prominent doula resource that explores the relationship between doula work and activism (Pérez, 2012). Commenting on the increase in doulas in the United States, Pérez (2012) explains that:

Activists saw an urgent need for doulas because of the medicalization of pregnancy and childbirth, its move from the home to the hospital, and the challenging conditions present in hospital settings in the U.S. Having a trained emotional support person provided the reinforcement that family members could no longer offer, initially because they weren’t allowed to be in the birth room, and later because they lacked the knowledge about pregnancy and birth (p. 1-2).

Pérez (2012) identifies doula work as an explicit form of activism through which doulas attempt to make their services accessible to individuals who could not otherwise afford or access doula care. According to Pérez, this type of activism might include providing doula care on a sliding scale, at a reduced cost, or through bartering with clients; in other words, approaches that resemble those espoused by my participant, Olivia. Additionally, Pérez (2013) argues that doulas should work to confront issues of racism, classism, ableism, homophobia, and transphobia in their work, and states “It’s about providing non-judgmental and unconditional support to pregnant and parenting people, ultimately in

service of social justice” (para. 11), ideas that also emerged in the course of my encounters with another participant, Katie.

Basile’s (2012) doctoral dissertation affirms the positions taken by Miriam Pérez (as well as the Boston Women’s Health Collective, as discussed in Chapter 1). In it, Basile conceptualizes doulas as mediators of social change, arguing that, “doulas are increasingly bringing a new political consciousness into birth work...[and] this movement among doulas represents a new paradigm in birthing rights activism, which connects childbirth choices to a larger reproductive justice agenda” (p. v). Basile asserts that doulas’ social justice involvement goes beyond medicalization, which is often a focus of childbirth activism, to broader issues related to women’s reproductive rights. The participants in my study did not explicitly contextualize their work within broader discourses of reproductive rights. However, Basile’s work has made me conscious of examining the activities of doulas beyond a straightforward understanding of resistance against medicalization, and towards a more nuanced approach to women’s birthing rights (particularly because participants in my study spoke frequently about improving childbirth “options” rather than dismantling the medicalized construction of childbirth).

Additionally, a study by Torres (2013) – previously discussed in Chapter 1 – has described doula work as a form of resistance against medicalized model of birth. Torres suggests that doulas take a “back-door” approach, employing this subtle entry into the hospital by emphasizing their role as a support person to their clients, and minimizing their activist motivations. Nevertheless, Torres argues that this approach enables doulas to perform resistance in subtle ways, for example, by “illustrating to medical professionals that women can give birth without medical intervention, and...exposing clinicians to

different ways of giving birth” (p. 934). These particular insights also emerged in my own study; however, my work shifts the focus by imagining these resistance behaviours on a continuum, and by examining these acts of resistance in relationship to the particular geographical context of St. John’s, Newfoundland and Labrador. In order to better understand how the participants in my study enact change through both subtle forms of resistance, and overt activism, I begin by offering a framework of resistance.

A Framework of Resistance

Feminist theory has been described as “grounded in the issue of resistance,” and highlighting politics of difference, agency, and oppression (Thomas & Davies, 2005, p. 713). Currently, an emphasis on less overt forms of resistance that challenge hegemonic structures and discourses has arisen in feminist theory and elsewhere. This focus on less overt forms of resistance has “drawn attention to the importance of appreciating resistance not only as collective, overt acts, but also as subtle, routine, low level forms of struggle and challenge” (p. 720) and also highlights how feminist theorizing has troubled the idea of what “counts” as resistance.

The work of Pierre Bourdieu offers a productive way of understanding resistance as an embodied form of practice. Bourdieu’s (1977) *theory of practice* has been described as beneficial in relationship to feminist theory, and to caring labour and care ethics. Lovell (2000) states “Contemporary feminisms of difference and Bourdieu’s sociology of practice share a common focus upon ‘the body’” (p. 12). Bourdieu’s theoretical construct, *habitus*, refers to the structures that determine an agent’s ability to act in a particular way within a particular circumstance. Furthermore, it refers to “the product of the work of inculcation and appropriation necessary in order for those products of collective

history...to succeed in reproducing themselves more or less completely, in the form of durable dispositions...lastingly subjected to the same conditionings” (Bourdieu 1977, p. 85). Bourdieu’s theory of *habitus* demonstrates how corporeality is implicated in social structures. Furthermore, he argues that power is reproduced through the *habitus* of individuals, and through the presentation of this *habitus* as arbitrary and self-evident. In other words, Bourdieu understands individuals’ actual bodily engagement as implicit in the reproduction of power. For example, as outlined in Chapter 3, the embodied labour performed by female care workers is undervalued and underpaid based on the assumption that women are inherently predisposed to care work. The gendered nature of caring labour became evident in Chapter 4, in some doulas’ difficulties maintaining boundaries around acceptable expectations of care with their clients. Husso and Hirvonen (2012) argue that Bourdieu’s work is particularly relevant to the theorization of caring labour, because “women’s skills in care represent their internalized dispositions, their gendered, bodily and intellectual habitus ” (p. 33). In this way, *habitus* demonstrates care providers’ unique bodily experiences of providing care through thinking, talking, and acting with their peers and patients (Husso & Hirvonen, 2012).

Bourdieu’s concepts of *doxa*, *orthodoxy*, and *heterodoxy* are particularly useful for theorizing subtle forms of resistance. *Doxa* represents the assumed normalcy of a given phenomenon, such as the medicalization of childbirth – a normalcy that appears to be self-evident and is rarely acknowledged or questioned. The arbitrary nature of *doxa* can be exposed when individuals who are typically oppressed by the dominant society in a particular way “[push] back the limits of *doxa* and [expose] the arbitrariness of the taken for granted” (Bourdieu 1977, p. 169). Therefore, *doxa* exists in the realm of unquestioned

phenomena, and when the arbitrary nature of *doxa* is exposed through various forms of resistance, the phenomenon can then enter into the realm of argument – constituted by *orthodoxy* and *heterodoxy*. In Bourdieuan terms, *orthodoxy* can be understood as “the official way of speaking and thinking the world” while *heterodoxy* represents the critique of this official discourse (Bourdieu, 1977, p. 169).

Although critiques of the medicalization of childbirth have been prominent throughout the women’s health movement (as discussed in Chapter 3), I argue that the medicalization of childbirth currently remains a *doxic*, or rarely questioned phenomenon in the eyes of medical professionals, and the general public in St. John’s, the rest of the province, and elsewhere. That is to say, even though the *orthodoxic* position can be understood as the belief that childbirth is “risky” and thus requires particular forms of medical intervention in order to mitigate this risk, medicalization can be understood as *doxa*, because the medical justification for numerous interventions during pregnancy and childbirth are not well justified.¹⁶ The dominant class in this case represents medical professionals and the medical system. This “class” serves to construct pregnancy and childbirth as complex and dangerous events that require specific expertise and medical intervention. Doula help to expose the arbitrary nature of the medicalization of childbirth, as even their subtle presence in the hospital system allows them to highlight the ways in which women’s bodies are imagined as being inherently incapable of safely delivering a child. Allowing medical professionals to observe births during which women’s capacities to give birth are appropriately honoured helps to demonstrate the

¹⁶ See Davis-Floyd, 2003.

arbitrary nature of this *doxic* medicalization, which assumes that all childbirth is at “risk” unless mediated by a physician or obstetrician.

Doulas’ presence, and their work in the hospital system, highlights the contrast between medical treatment of pregnancy and childbirth, and its potential to be understood as a healthy, woman-centred event. In this way, the medical treatment of childbirth can become not only seen, but questioned, and the medicalization of birth can shift from *doxa*, to *heterodoxy* (a conscious critique of the *orthodoxic* understanding of childbirth as “risky”), and subsequently, into a new *orthodoxy* (or, a new model of woman-centred birth). This shift from *doxa* to *heterodoxy* may lead to further and more explicit resistance behaviours, such as advocating for increased access to, and provincial funding of, a range of childbirth options (such as midwifery, home birth, and birthing centres). However, in order for overt activism for particular birth options to be effective in this context, it is first essential that critiques of medicalization, and the potential to improve women’s birthing experiences, become more visible.

Doulas and Overt Forms of Activism

When asked about the relationship between doula work and activism, most participants stated that overt forms of activism are often associated with doula work, but emphasized that explicit activism for women’s birthing rights should not take place while providing care to clients. As well, most participants acknowledged that many doulas participate in forms of birth activism outside of their roles as doulas. However, only Katie provided specific examples of her overt activism for women’s birthing rights. These included her advocacy for midwifery regulation in Newfoundland and Labrador. She stated:

I'm pretty big into the activism and advocacy and that definitely transfers over into birth for me. Um, I don't think that every doula has to be advocating loudly for you know, women's birthing rights and I don't think they all do, but I think it's a really important part of being involved in the birth community, because it's such a small community and there aren't a lot of people saying things, so I think somebody has to advocate for women. You know, women can certainly advocate for women, and I'd much rather they do that for themselves, but I mean there is definitely a role for me to advocate for better birthing conditions for women, and that's something I feel really strongly about and not something I feel uncomfortable involving myself in.

In addition to proudly identifying herself as a birth activist, Katie provided specific examples of her activism, including her coordination of the Friends of Midwifery consumer lobby group for the regulation of midwifery in Newfoundland and Labrador, and appearing on the local CBC¹⁷ news to discuss placental encapsulation. She associates these forms of activism with her doula identity, but they exist outside of the direct realm of providing care to women during pregnancy and childbirth. Rather, they can be clearly understood as activist behaviours aimed both at raising awareness around women's birthing choices and advocating for provincial government support of midwifery regulation.

Despite Katie being the only doula who made explicit reference to her overt activism for women's birthing rights, most of the participants indicated that there is a strong link between doula work and activism. Olivia stated:

¹⁷ Canadian Broadcasting Corporation.

I mean I think it would be very fair [to say] that there's a high correlation between...people who are doulas and people who are activists, right...I think that's because of the type of people that...[the] doula profession attract[s], right. People who have an interest in this and who have a passion for it.

Despite Olivia's acknowledgement that doulas are often involved in activism outside of their work, she also expressed displeasure with the perceived *necessity* for doulas to be involved in activist ventures:

The fact that doulas here have to be, you know, trying to advocate for women's rights and, you know, labour rights and all this stuff and, you know, talk to health care providers about what they are and what they do, other options and all that stuff. I think that's ridiculous and, you know, I really hope that changes.

However, Olivia's position shifted as she spoke through her feelings about the connection between doula work and activism, later commenting:

I've convinced myself right now that I need to be an activist...yeah, you know I think yeah, professionally, to completely contradict what I initially said, I think that there should be a certain level of responsibility on [doulas] to be, you know, information providers for, you know, the activism, but also to lend support to it.

The contradictory opinions that Olivia expressed throughout her discussion of activism demonstrate the tenuous position that doulas hold both within mainstream understandings of birth as well as within the medical community itself. I argue that doulas can be understood as existing somewhere between certified professionals and grassroots activists. Olivia's earlier hesitancy to depict her work as necessarily tied to overt forms of activism highlights the vague boundary between professionalism and activism that doulas

must continually negotiate. I will discuss her opinion that doulas should not feel obligated to advocate for women's birthing rights in further detail in relationship to the unique position that doulas hold as activists in Newfoundland and Labrador.

Maeve, Devi, and Stella presented similar approaches to activism and seem to propose that activism is more fluid than the overt forms of activism that Katie engages in. Maeve stated,

any movement that is outside of the mainstream is, you know, kind of takes on a bit of a, an activist piece. Because that's what you're trying to do, is to educate people, right? And that's what, you know, that's what an activist does is tries to change the status quo.

Here, Maeve hints at a broader understanding of doula work as activism, and presents the idea that doula work itself is inherently a form of activism because it exists outside of the mainstream culture of childbirth. Devi provides a similar understanding of activism.

Arguing that the activist role is not specific to doulas, she insists that it can be performed by any individual who wants to improve women's birth experiences, stating "I mean I think nurses can be activists and doctors can be activists and everybody, anybody who reads the information and anybody who wants to try and work towards making birth better for everybody can be an activist." I appreciate Devi's assertion that anyone can engage in activism. However, I argue that individuals (such as doulas) whose professions do not perpetuate a medicalized model of childbirth can more effectively perform resistance against medicalization, since medical professionals remain implicated in the reproduction of the biomedical model of childbirth.

Stella, meanwhile, was more explicit in her rejection of an understanding of activism solely as highly visible protests. She characterized her own activism as more subtle, while also expressing an interest in becoming more involved in typical activist activities:

I guess the activist in me just wants people to open their eyes and notice it, you know. I'm not gonna be marching down the street with placards saying open our birth centre now, I think it's ages and ages and ages to get our birth culture challenged. But I recently attended a Friends of Midwifery meeting for the first time, and I could see being a bit, a little bit more active about that as well.

These participants hint at the ways that doula work may be read as a form of activism, even as this activism may not be easily identified as such by the general public. Their work is aimed at improving women's birthing experiences; nevertheless, the general public may not easily connect their activities with resistance against medicalization, governmental control of childbirth options, and the perception of childbirth as "risky." These statements therefore demonstrate the potential value in subtle forms of resistance, because these acts hold the potential to create social change, regardless of whether the general public perceives them as forms of "activism" or not.

Activism Versus Client Care

When asked about the link between doula work and activism, most of the participants prefaced their response with a firm assertion that activism – as they understood it – should not take place within the same space as providing care to their clients. In these instances, it was clear that the participants were conceptualizing the more

overt forms of activism discussed above, rather than the subtler forms of resistance that will be discussed later in this chapter. Melissa stated:

I think that first and foremost, um, there's a certain level of advocacy that we do, but I think doulas really need to be aware and really need to be cautious about being advocates in the birthing room. I don't think that...is the place for it. I don't think that we should be advocating for um, changing our birth culture, or promoting any kind of agenda, when we're trying to support a woman in her birth experience.

Melissa was perhaps the most assured in her declaration that doulas should not engage in activism while performing their roles as doulas, and, in her words, she demonstrated repeated concern that some doulas may not understand or acknowledge the necessity to separate these behaviours. She went on to say, "Our role in the birth room is to support the woman and her partner and to leave any kind of advocacy agendas that we have at the door and kind of pick 'em up when we leave." It is clear that Melissa's understanding of activism for women's birthing rights is very separate from what she understands as the doula's dual role of supporting women during childbirth and helping them achieve positive birth experiences.

Melissa proposed, for example, that most doulas, based on their training and experience, would disagree with Eastern Health's¹⁸ policy against eating and drinking during labour. Although she stated that doulas would support a woman's choice to eat or drink during labour if they came to that decision autonomously, she also insisted that doulas should not justify this decision to the medical professionals present, because this

¹⁸ The Regional Health Authority for the Eastern portion of the Island of Newfoundland.

could create undue tension for the labouring woman. She further asserted that explicit dispute of that rule should take place outside of the client's birth experience. In making these statements, Melissa demonstrates both her desire to question particular medical regulations, and her primary concern for the comfort of her clients during their childbirth experience.

Devi and Stella presented similar perspectives, with Devi articulating her views as follows:

Whoa. We are not activists during the birth...you're providing the information so that you're supporting the mother and the, and the partner if there is one, to advocate for themselves. Um, I suppose we can be activists kinda quietly, like, you know, they're probably gonna suggest this so here are some questions you can ask. But in general, I mean, we don't speak for the client....I mean, right now we're activists, I don't know if in an ideal world we'd need to be.

Although Devi rejects the intersection of activism and doula care while providing care to a client during labour, she nevertheless alludes to the potential for doulas to be "activists kinda quietly," while being sure not to speak for the client or explicitly advocating for particular birthing rights. Similarly, Stella stated:

I think that some people who are, you know, louder about things and louder about their activism are people who are attracted to this kind of job, and therefore, like, I don't know how they sort of incorporate that into their work and how separate they keep it. To me it's really important to keep it separate and to not bring your political views about it or your activism into the work that you're doing.

None of the doulas advocated for approaching doula work with a particular activist

agenda. However, Katie acknowledged that she has engaged with medical professionals about what might appear to be unconventional recommendations for her clients. She said:

No, I mean doulas don't speak for clients. Doulas, you know, help clients get the information to empower themselves to make their own decisions. You know, and very rarely do I have anything to say particularly to a nurse or a doctor. You know, they do their job and I do my job. And, you know, if they're questioning what I'm doing...then of course I'll explain. You know, I had a nurse one time come into a room and I had a mom in the bathroom sitting on the toilet in the dark, by herself. And so the nurse came in and was like, "Why is she sitting in the dark by herself with no lights on?" and she's like "What's wrong with you? Turn on the lights." And I was like, "Well, you know often women progress better in labour when they're on the toilet because they're used to relaxing and their, you know, contractions can just happen and, sometimes hospitals are too stimulating you know, all these bright lights and all these noises and machines beeping"So, like, in that case, I would explain to the nurse and would they agree? I don't know. But, you know, I at least explained what I was doing and, you know, a lot of the time have to explain that, you know, I don't see myself as a medical practitioner, I don't do anything medical, I don't want to do anything medical, at least not as a doula.

Though it appears that Katie's discussion with this nurse did not impact negatively on her client, I am left to speculate whether this type of engagement with medical professionals is the type of explicit engagement with activism during labour that most of the other doulas so strongly rejected. In this situation, Katie advocated for her client's ability to

engage in non-normative behaviours during her birth experience, while also highlighting some of the potentially negative aspects of birthing in a hospital, such as overstimulation from medical equipment that could interfere with a labouring woman's ability to relax.

In general, my participants' rejections of performing activism while providing care to a client spoke not to their adherence to the biomedical status quo, but rather to their desire to create as positive a birth experience as possible for their clients. Doulas hold what is already a tenuous position within the hospital system. Therefore, for most doulas, the assertion that activism should not be performed while caring for a client spoke to their desire to avoid confrontation or tension with medical professionals. Although the notion of avoiding confrontation might vary somewhat between doulas – with some being more willing to engage in discussions with medical professionals about their role as others – it is clear that their clients' comfort (or, more specifically, what doulas perceive as their clients' comfort) is always at the forefront of my participants' minds.

Doulas and Subtle Forms of Resistance

Although overt forms of activism were identified by some of the doulas as an important part of their roles as doulas, all participants demonstrated ways in which their doula work can, in and of itself, be understood as a form of subtle resistance. However, while I would personally describe many of the participants' activities as forms of activism, my participants themselves did not characterize them as such. Nevertheless, I argue that their actions can be understood as forms of resistance to normative, medicalized birth practices, as well as to the absence of birth options available in Newfoundland and Labrador.

For example, language such as “empowering,” “educating,” and “creating awareness” were used frequently to describe the important role that doulas hold in St. John’s, in relationship to clients, medical professionals, and the general public. As well, participants revealed the ways in which their work as doulas contributes to filling gaps in care that pregnant and labouring women currently receive at the hospital, and were explicit about the need for a greater variety of childbirth options in the province. Although doulas framed their roles as supporting women and their partners and/or families during pregnancy and childbirth, regardless of the choices that they make about their childbirth experience, all participants agreed that childbirth has become medicalized and is erroneously understood as a dangerous medical event. Although many of the doulas did not see themselves as traditional activists, they did exhibit an understanding of their work as creating change in quiet or subtle ways. These understandings are captured by Pérez (2013), who has aptly described the work of some doulas as being inherently motivated by social justice, stating “I’ve noticed that for some doulas, simply being a doula, trying to change the culture of birth, in and of itself is a radical act” (para. 2).

My participant, Laura, noted:

Um I personally don’t feel like [activism]’s a big role for me just ‘cause I’ve got so much going on in my life. And uh...I’m not the one who’s gonna get up and make a speech. I’m probably more the person that’s gonna be in the background helping out. So yeah, I’m personally not the most activist-y. But I certainly do see that there’s a lot of it.

Additionally, when directly asked if subtle activities that doulas engage in could be involved in the idea of activism, Laura replied: “Yeah a little bit, I think, the support

that's there....Being a quiet voice too...to give people information, I guess, to help them see the world a little bit differently, maybe." Stella echoed this understanding of her position as a doula, stating "I'm just not that personality, like, I'm more in the middle ground and of making change in a more quiet way." She went on to say:

The more clients I have, the more people are out there talking about it, the more, you know, expecting parents are going back and forth saying "Yeah, we had a doula this is our experience..." the more times I'm in that hospital care room and people are seeing me do what I do. You know, that's quiet education, that's quiet activism to me for sure.

Stella demonstrates the ways that her mere presence in the hospital can be read as a form of both education and activism and that these quiet forms of resistance can effectively contribute to awareness and change around choices in childbirth. Melissa reaffirms this assertion, stating:

I mean, I certainly think just being a doula in and of itself is a certain level of advocacy, because what we're doing is kind of, without really doing anything, we're kind of promoting women's choice and the people that they choose to support them.

Although these doulas did not immediately identify their work as a form of activism, most participants agreed that their work as doulas was in fact related to activism in some way, and seemed content to label their subtle activities as contributing to social change.

Surprisingly, despite her adamant refusal to charge any fee for her services – something that Pérez (2012) associates directly with the notion of activism – Olivia was hesitant to categorize her doula work as form of activism. When asked directly about the

relationship between her decision not to receive payment, as well as what constitutes the role of an activist, she conceded that this decision could in fact be understood as a subtle form of birth activism, stating:

Yeah maybe on a very micro scale and that's, you know, one of the reasons why I don't charge is, yes, because I don't want to deal with, you know, the whole charging thing, I don't wanna be recording my income and my revenues and I'm not making this a business, that's just, ugh, don't want to do it. But a lot of it, a lot of it came from, you know, the fact that I started off working in a volunteer organization, and the whole point of that organization is making the services accessible to anybody who can't necessarily afford it. Um, and I think that, yeah, that in itself is really important to me...that's kinda what I'm about and I'm not about being free just to take away the clients that would, you know, have money to pay and all that stuff. No, it's about...[somebody] looking for doula support and they can't afford to pay for doula services because they aren't covered by MCP.¹⁹

Olivia's tentative categorization of her work as a resistant act, even in the face of her background in volunteer and community work and her insistence on matters of accessibility and social marginalization, demonstrates the ways that the concept of social justice is so inherently tied to a doula's role for some individuals, that it is difficult to explicitly characterize it as such. Olivia's comments were perhaps the most illuminating with regards to the discrepancy between participants' understanding of their own work as

¹⁹ "Medical Care Plan" – the provincially funded medical insurance plan in Newfoundland and Labrador.

doulas, and the production of social change – and furthermore, their general modesty about the importance of their work on a societal level.

While many participants acknowledged that their work can be understood as a form of quiet activism or subtle resistance in general, their actual performance of this resistance can also be read into their discussions of empowering women and supporting their clients' abilities to make choices about their childbirth experience, filling gaps in care that are currently not being filled at the hospital, and actively critiquing the biomedical model of childbirth.

Empowering Women and the Discourse of "Choice"

Resistance can be conceptualized in relationship to participants' emphasis on empowering women, by providing them with the education and confidence necessary to make their own choices about their childbirth experiences. Most of the doulas were explicit in stating that their roles as doulas are to inform women about the childbirth process and hospital policies, but that these roles do not include speaking for clients, or attempting to influence their decision-making processes. Although I argue that this approach to doula care represents a feminist approach to the empowerment of women and the exertion of control over their own childbirth process, I also think it is important to acknowledge that the rhetoric of "choice" can sometimes be problematic if the social factors influencing women's abilities or propensities to make particular choices are not adequately interrogated. However, several participants did acknowledge the constraints around making choices around birth in St. John's, because they recognized that hiring a doula is one of the only choices a woman can make about the care she receives during labour, while birthing within the health care system.

Katie, Devi, and Olivia present the various ways that doula work serves to empower women in their own pregnancies and childbirth experiences. When asked about the connection between feminism and doula work during the second focus group, Katie stated:

I don't think I do anything without a feminist frame behind it. Um, I don't know, like, I've never, my website doesn't say that I'm a feminist doula or anything, but I think doula work is very feminist work. And you're teaching women to empower themselves and make informed choices. Um, and I think, yeah, helping women to learn that they have autonomy over their own births is inherently a feminist thing.

Katie describes doula work as "inherently feminist" in its attempt to provide women with the tools necessary to empower themselves, and to act autonomously in their decision making and approach to their childbirth experience. As well, Katie highlights the importance of educating her clients, which presumably would involve providing clients with information that they might not otherwise be able to access via their doctor, or through media representations of pregnancy and childbirth. Devi echoes this sentiment, saying "I think a doula's role is to provide information to the mothers so the mother can set up a situation so that she's able to succeed in having births that look a little bit different than what have become mainstream." This statement emphasizes the ways that doulas can help their clients achieve a childbirth vision that is different from typical depictions of birth. Without attempting to influence her clients' decisions, Devi views her work as helping women achieve particular experiences that might be more difficult without an educated and compassionate caregiver.

Olivia frames her doula work as empowering women by helping her clients to perceive childbirth as a normal and healthy phenomenon, stating:

You kinda just like remind people like, how has the human race gotten this far, right?....this isn't because of, you know, episiotomies and epidurals and uh forceps and all that stuff. No, right, it's because, you know, our bodies, biologically, produce our offspring in this way, right....And yeah I mean I think that you know, through the doula care, having the support there, the emotional support, the mental support, and the physical but non-medical support is, you know, in a big way a means to empower women you know, into accepting and embracing the fact that they can do this.

Olivia's approach to empowering women is to move clients away from an understanding of childbirth as inherently dangerous and risky, while not necessarily advocating any particular approach to childbirth.

Nearly all of the participants were careful to emphasize that doulas do not make choices for their clients. Nor do they attempt to speak on their behalves. Katie stated, "doulas don't speak for clients. Doulas, you know, help clients get the information to empower themselves to make their own decisions." Similarly, Laura stated:

[We] kind of make it a point to learn a little bit about why certain procedures might be recommended so that we can say, "Well, they're suggesting this because of this, now what do you think about it?" Um, you can't come at it though with the, "Well I need to convince this mother that she shouldn't do x, y, and z." Even if in your own personal pregnancy and delivery you wouldn't have chosen those things.

Laura emphasizes that even though doulas provide clients with information that can help them make choices before or during their labours, doulas do not aim to influence client choices in any particular direction. Indeed, Melissa expressed frustration that doulas have become synonymous with the goal of achieving a natural childbirth, and said:

there certainly has been some thinking...[that] the purpose of a doula is to kind of push your own...wishes of what a birth should be like on to other women or um, there's a misconception out there that doulas are all about natural childbirth, and they don't support women who choose other options....And while each individual doula is different and has their own way of practicing...for the most part, I think a doula should be someone who supports women in their choices, no matter what those are.

Here, Melissa indirectly addresses the potential critiques of “making choices” and reaffirms that doulas should in fact be providing their clients with information about childbirth from a range of different sources, so that the choices they do make can be well informed. She stated: “our role is not to necessarily push them in any one direction, but to make sure that they have the facts so that they can make educated choices that are best for them.” An examination of the constraints of “choice” may emphasize that, apart from the information provided to women by their doulas, the majority of the messages women will receive about childbirth will present it as dangerous, painful, and terrifying. Therefore, their choices will remain highly influenced by the normative majority depiction of childbirth as “risky.”

However, doulas walk a fine line between attempting to provide women with information that they might not otherwise obtain from other sources, while also being

respectful of any choices that are made during their care. This desire to be respectful of birthing women's choices may, in fact, reflect on doulas' understanding that women's birthing choices *are* highly influenced by various social factors, including the biomedical representation of childbirth as frightening and hazardous (unless mediated by medical intervention and obstetrical expertise).

Highlighting Gaps in the Hospital System

The care that doulas provide to their clients can be understood as both highlighting and filling certain gaps in the care provided from nurses and doctors at the hospital. Many participants made reference to the ways that the care they provide is unique, noting that certain elements of their care would not have been provided had they not been present.

Devi was perhaps the most explicit in her comments, stating "I think doulas play a role when medical interventions are necessary, there's still a role for a doula, because there's that little gap that's not being filled." Devi recalls a particular instance when a client had a caesarean section and wanted to be able to look at her baby after the birth:

she wanted me to hold the baby next to her just so she could look at her baby's face while they were doing all this other stuff. And there was no nurse who was going to sit and hold the baby so that the baby would look at her face. And these are all, they're small things, but I think that it's these small things that mean that, um, you know, that having a doula present means that you're 30% less likely to have all these interventions. It's because there's an intangible here, something that's not recognized. That the value of being next to the mom and having her feel

like, you know, you have someone to do these little things, it's really valuable and it's hard to put it down on paper.

As well, Devi spoke to the broader issue of the quality of women's birthing experiences appearing insignificant to some medical professionals, whose main priority is not women's experience, but the production of a healthy infant:

and this woman I talked to last week, crying her head off because she had an epidural at the end of it....Many doctors and nurses would have no understanding of why she was upset about that. Because she had her birth, they had the baby vaginally, she was fine, the baby was fine. So I think that is a huge gap.

Devi argues that there is a discrepancy between how doulas and some medical professionals define a successful and positive birth experience, thereby emphasizing the way that women's emotional experiences during childbirth are sometimes regarded as irrelevant within the hospital system.

Stella, meanwhile, spoke to the ways that the attendance of a doula at a birth can have a substantial impact on a woman's experience, even when the care being provided is very subtle:

[The birth] ended with such a dramatic climax that uh, the one feeling that I really held on to....was that this is still making a difference, you know. And I was hardly doing anything, but like, this little tiny bit that I'm doing, this just being here, I could feel was making a giant difference.

Stella perceives the mere presence of a doula as being a reassuring force for her clients, and others. She suggested further that this presence can then contribute to increased relaxation and, in turn, improved birth outcomes. She said:

that's the thing for me with being a doula is that, it's about making childbirth feel safe, and therefore they don't feel fear and therefore they don't feel stress and pain and it all...just escalates right....[and] it can just be that steady gaze, or that calm presence, or that confidence, and that belief in the mom and their birth....And when women have to do something a certain way that can make them feel really vulnerable, and it can escalate to all those other emotions....Which can totally change the course of labour, so if we had birth choices I feel like we would have much better statistics for our birth outcomes.

Stella's commentary demonstrates the ways that doula care can provide measurable effects that would be recognized by medical professionals as significant, even if the care that they are providing does not appear to be necessary or beneficial.

Maeve and Devi, meanwhile, articulate how doulas fill gaps in education for both their clients, and for medical professionals. They provide their clients with information about what childbirth is like in order to prepare them for the birth experience. At the same time, they demonstrate how the types of care provided by doulas can contribute to improved birth experiences, something that would be of interest to medical professionals. Maeve stated, "The medical model doesn't prepare people for what's coming up." She then went on to say:

It's the only thing they know is what they've seen on TV, what they watch on *A Baby Story*. Right, that's where their education comes from. And that's why they watch it, because they're looking for the education. They may not realize it, but they want to know what's going to happen. So they watch this, right? The doctor doesn't provide it. Then they go to the classes at the, at the Health Sciences

Centre,²⁰ and they do provide education there, but they provide a very slanted view of the medical model of birth as well.

Maeve argues that the childbirth education provided to women by their doctors and by childbirth education classes offered through the hospital is not sufficient in preparing women to give birth. She suggests that in this province, doulas must fill this gap in order both to provide a more balanced view of childbirth and to prepare their clients for their birth experience.

Similarly, Devi argues that the presence of doulas, by performing a continuous model of care in the presence of medical professionals, can also educate the medical profession itself not only about alternative approaches to birth, but also about the positive benefits deriving from them:

So, yes, it's a big role in educating doctors, um, and nurses and I think, because there's that little gap in care, having a doctor or nurse see that because that woman in there standing next to her and whispering to her and she's totally there for her...I mean look at how she's birthing, you know. Educating by not just passing over information on doulas, but educating by showing the care we provide, and seeing what the result is, for women.

Melissa and Laura stress the ways that doulas help to fill some of the gaps in childbirth options available in Newfoundland and Labrador. They accomplish this by offering services that women can exert some control over, while still receiving primary medical care within the pre-existing hospital system. Melissa stated:

²⁰ The hospital in which women give birth in St. John's (as discussed in Chapter 1).

I think that, by having [access to] doulas here in the province, um, and so many other limiting factors, like not really having a lot of control over where you have your baby, not really have a lot of control over your care provided, I think that being able to choose a doula and interview doulas and hire a doula does give women a certain element of control over what they do have control over in their birth....[If] she'd rather a midwife but she has to have an OB/GYN I think that um, being able to kind of have a doula and hire a doula that she has a um, a rapport with, and a connection with, does make that a little bit of an easier pill to swallow, maybe? Um, it gives her some choice in a land of lack of choices.

Melissa describes a woman's ability to choose a doula as a way that women can regain some control over their birth experience. This choice can serve to lessen their disappointment about having limited options for their primary care provider and the location of their birth. Laura also spoke to the potential for doulas to improve birth experiences within the current reality of birth in St. John's, and said:

in the actuality of birth in St. John's, Newfoundland you're gonna be in the hospital. And my vision of my work is uh, how can I make that the very best experience that it can be....And uh, yeah, I can't recreate something like a home birth in the hospital, but I can make it the best hospital birth that I can.

Laura accepts the reality that currently, and for the foreseeable future, the majority of women in St. John's will be giving birth in the hospital. However, even as the presence of doulas in the hospital system fills the gaps in care that might otherwise be more easily obtained under the care of a midwife or at a home birth, this is true only for those women

who are financially capable of accessing this care, a point to which I shall return later in this chapter.

Olivia describes an instance when she observed a woman birthing in an operating theatre (due to complications with her delivery of twins). Olivia felt that the obstetricians were blatantly ignoring the woman in labour, and she remarked:

no one was communicating with the mother, nobody was telling her whether she should be trying to push now, or whether she needed to relax now or, you know, anything like that. And so there was a distinct point very vivid in my head where the mother was there looking around wide eyed and was saying like “Do I push? Am I supposed to push now? What am I supposed to do?” You know....it was horrible to see and you know, so at that point even though I was supposed to be observing I stepped over to her...and I said “Yes that’s right, yep, you know, you’re supposed to be pushing now they’re getting the babies out”all she needed was somebody to hear what she was saying, acknowledge what she was asking, and give her a response.

Despite being unsure about whether she should interject, Olivia felt that it was necessary to acknowledge her client’s concerns, and help her feel informed about what the obstetricians expected her to do. Olivia demonstrates how, in complex situations, the needs of birthing woman can quickly become secondary, or almost irrelevant to the birth process. In these instances, medical procedures are simply being enacted upon her passive body. In this particular case, Olivia’s care filled the enormous gap in the breakdown in communication between the presiding medical professionals and the birthing woman.

Interestingly, Katie spoke about her experiences providing care to a client that she suspected was suffering from postpartum depression. In our conversation during the second focus group, we spoke about how doula care might also emphasize some of the gaps in care in other areas, such as mental health care, since most women do not have a continuous relationship (from pregnancy through the post partum period) with a medical professional. As a result, there is no one who might pick up on these issues. She said:

I knew she had postpartum depression, nobody had to say anything. But she wouldn't, you know, sit and say "Yeah, that's what's going on with me." And I felt, if I just drop out of this woman's life, what's gonna happen to her? If something ever did happen, how could I possibly live with myself knowing that I had left her in that situation with no support? I didn't, but at my own expense. I don't have any psychology background, I don't have any, you know, training in mental health...I just didn't have what she needed...and I was trying to give something that I didn't have. And that's a problem when it's outside of the role that you expected or agreed to take on.

When I proposed that her work also exposed gaps in care in other areas of our health care system, Katie went on to say: "And with no sort of continuity of care in obstetrics and in birth here, nobody is gonna pick up on it." While doula care does not serve to fill this gap in mental health care in any way (other than being a supportive presence to their clients), it does bring to light some of the other ramifications of not having a continuous health care provider who might pick up on depressive symptoms postpartum.

Disputing the Biomedical Model of Childbirth

I argue that the medicalization of childbirth is the underlying factor against which doulas perform a variety of resistance behaviours. Several participants made direct reference to the medicalization of childbirth as problematic, and most presented critiques of the biomedical model of childbirth. Many participants presented medicalization as an issue that doulas acknowledge and attempt to mitigate by providing woman-centred care within the hospital. Katie's comments reflect this perspective:

I definitely think childbirth is too medicalized. I think that's why doulas do what they do. It's all about bringing it back to the mom and bringing it back to her body and its power and what it can do and that it doesn't need anything else to help it do it. You know? To get women to believe in their bodies and believe that they're made to birth and that this is a normal thing and that they're not sick and there's not anything wrong...just re-normalize birth and get to a place where people aren't terrified about giving birth.

She went on to say: "I would think that all doulas would at least in some degree [be] trying to mitigate the medicalization of childbirth." Katie cites medicalization as one of the reasons that individuals pursue doula work, and views her work as an attempt to return the focus to the woman giving birth, rather than being solely on the health of the fetus or infant.

By emphasizing the importance of supporting clients in all of their decisions about medical interventions, Melissa provides a unique framing of the medicalization of childbirth. In doing so, she frames a discourse of "risk" around medical interventions, rather than the birth process itself:

In terms of the medicalization of birth....First and foremost I think that our job as doulas is to support a woman and her partner in the decisions they make about their childbirth, and to help make sure that those are informed decisions. Um, so I think that part of our role is to kind of be educated on things like, the pros and cons of an epidural, and the side effects of certain drugs, and um, you know, what the statistics are around what the likelihood of having a caesarean is if you get an epidural, or if you're induced or whatever ...[and how] might those things affect a woman's ability to have a natural childbirth, a natural vaginal birth.

Without attempting to influence her clients' choices, Melissa feels that it is important for women to understand the risks associated with particular medical interventions, risks that might not typically be emphasized in mainstream childbirth discourses.

Maeve and Devi referenced the situation in Newfoundland and Labrador in particular, in relation to medicalization. Maeve observed:

[the] medicalization of birth, especially in Newfoundland, is a huge issue, I mean if you look at our c-section rates it's pretty crazy and um, if you look at breastfeeding rates afterwards...they can be kind of depressing as well. So, there's definitely room, but that's not just for doulas, that's for a uh, a whole overhaul of the birth system, of the birth culture here. Doula is just one piece of that.

Maeve discusses the particularly high intervention rates that exist in this province, and while she acknowledges that doulas themselves will not be able to make substantial changes to the frequency of routine intervention, she insists that doulas are one part of the solution required to make substantial changes to the birth culture.

Devi describes an instance when a physician erroneously linked the high caesarean section rates in this province to women's body size:

I've heard a doctor...say "Oh, you know, the caesarean rates are high because the women here are more overweight," I mean I just, I don't believe that...especially when caesarean rates vary from doctor to doctor. You know, I mean obviously it's not because women in general are overweight in Newfoundland.

Devi depicts this rationalization of intervention rates as ignorant to the real factors that influence the likelihood of caesarean section in this province. She critiques this physician's statement for placing blame on women and their deficient bodies, rather than on increased rates of intervention that can be attributed to the medicalization of childbirth.

Stella and Olivia discuss the notion of medicalization in terms of control; Stella describes doulas as a tool that helps women avoid unnecessary medical intervention, while Olivia describes medical interventions as a means of artificially controlling the birth process. Stella stated:

the doula has been hired by the clients to, I guess, keep it more towards normal birth, and keep it away from the medicalization. Or even if they have a reason to be having a very medical birth, if they're high risk or if there's some reason that they need to have a specialist, that's probably why they're bringing a doula in is to return some normalcy to the situation.

Stella describes the choice to hire a doula as an explicit attempt to reduce the level of medical intervention, or as a way to make a birth that requires particular types of medical intervention more comfortable and engaging. In parallel with this assertion, Olivia stated:

[medicalization is] used as a means of control right for everybody there, including you know, parents sometimes, right. Um, a means of control of what's going on so, you know, it can meet with expectations as much as they can make it right? This is whether it's physicians' or nurses' or families' sometimes, and I think it's because there's this shift in thought that you know, things have to be controlled, right....I think the biggest downfall you know, that's come from that is that, in our culture in our society, is there's been basically a stripping of women's confidence in their ability to give birth.

Olivia describes how medical intervention can be employed to control birth and construct it as an orderly process (as described by Davis-Floyd (2003)), while emphasizing that interventions may be employed to meet both medical *and* parental expectations of the appearance, or ideal length, of labour.

These comments demonstrate the ways that doulas engage directly with the issue of medicalization. They reveal doulas' understandings about how it impacts the birth process in general as well as their own work as doulas. In general, doulas present their role as attempting to normalize the birth process, whether that involves attempting to reduce routine medical intervention, or to simply creating a more comfortable and engaging environment when medical interventions are chosen or necessary. Participants offered a very nuanced understanding of medicalization. For my participants, medicalization was not entirely positive or negative, but was, rather, a potentially problematic force that has undue influence over women's perceptions and experiences of childbirth.

Necessity for Doulas to be Activists in Newfoundland and Labrador

When speaking about the relationship between doula work and activism, several doulas proposed that this link is integral in Newfoundland and Labrador, compared to other parts of North America, due to the current lack of childbirth options in this province in particular. In areas with a variety of provincially-funded childbirth options (such as Ontario), doulas may not hold (or be expected to hold) an activist position. Olivia stated:

So, you know, again I think that that's I think that the advocacy is, is something that has fallen on the doula, a doula's lap, right....I don't think as a doula I have a responsibility to advocate for, you know, this or that, um I think that it's something that a lot of doulas do because, they do it because they care about their work.

Olivia demonstrates some degree of resentment towards the obligation for doulas to be both birth attendants, and in this role, to be explicitly advocating for women's birthing rights in additional ways. She describes this necessity as "falling in the doulas' lap," since doulas are the most prominent group of individuals in St. John's committed to demonstrating an alternative approach to childbirth. Devi makes a similar assertion, stating:

if we were in Seattle somewhere we'd be less like activists because the birth culture is so diverse, and doctors see everything and maybe they'd be more receptive to it but I think here we need to be activists yet we need to walk a very, very um, careful line of not alienating anybody because uh alienating the birth supports and any of the medical birth supports is not serving the woman that you're supporting, so, you know, if we're gonna be activists, we have to make

sure that we're trying to change birth culture in a way that doesn't impact on the quality of the birth of the woman we're supporting.

Devi describes the difficult position that doulas hold: they are necessarily activists for women's birthing rights, but they must also ensure that they do not create tensions with the hospital or medical professionals in ways that might adversely impact their clients. My speculation is that even in areas where a variety of childbirth options are available, doulas may take on additional activist or resistance behaviours related to particular aspects of women's birthing or reproductive rights. Indeed, Miriam Pérez (2012, 2013) indicates that doulas may adopt a more intersectional approach to birth activism that considers various social locations, such as the impacts of race, gender, sexuality, ability, and/or immigration status on women's birth outcomes and experiences.

Troubling Doula Work as a Form of Resistance

I have spent the entirety of this chapter, to this point, demonstrating the ways that doula work can be understood through the lens of resistance. However, I think it is also important to acknowledge the ways that doula work may actually be *difficult* to categorize as resistance, in that the presence of doulas in the hospital system may serve, paradoxically, to perpetuate the status quo. The ease with which doulas fit into the current biomedical model of childbirth, and the possible downloading of the cost of alternative birth options onto women themselves, may actually *reduce* pressure on the provincial government to financially support midwifery services, as women interested in this model of care may already be financing doula care themselves within the presently existing system. The implications of this scenario are worthy of further consideration.

Laura provided the clearest insight into this view of doula work as potentially working *against* resistance and activism for childbirth options, stating:

I feel like having the doula humanizes the medicalization to some extent. That sounds...hm. Are we getting to be just another part of the machine there? Or are we sort of softening the machine or are we like, the oil on the gears or something like that? Right, just make it all move a little bit more smoothly.

She went on to say:

I was thinking about, trying to remember all that stuff about Marxist machines and I've read the theories...Yeah. So what are we doing, are we part of the machine? Is that what you're asking, or do you want my take on that?

These statements trouble a straightforward understanding of doula work as a site of resistance, as Laura emphasizes the possibility that doulas may in fact be contributing to perpetuating, rather than challenging, the status quo. The presence of a doula during hospital births may simply allow the existing system to run more smoothly, by, for example, decreasing demands on nurses' time, and may thus represent a neo-liberal approach to health care in which women become responsible for accessing their own alternative forms of care. Devi also noted:

doulas...fit beautifully within the model of care that's become standard and that's fine, and there's nothing wrong with that as long as there's some recognition for the woman who comes in and says ok...this is kinda what I'm looking for, and there's a space for that to be respected.

Similarly, Devi hints at the ways that doula work fits seamlessly into the currently existing system, rather than disrupting it or resisting against it. Her desire for more space

for women to have childbirth experiences that differ from mainstream or biomedical models may be more difficult to achieve if doula work can be understood as allowing the existing medical system to function more efficiently, and thereby perpetuating the current medicalized approach to birth.

As well, it is important to consider that doula work – which is not covered under provincial health care insurance plans – is predominantly performed by and for middle-class white women; that is, for women who are privileged enough to know about doula care and further, to pay for it. If resistance is in fact a product of doula work in Newfoundland and Labrador, and elsewhere, this begs the question of who might actually be benefitting from this resistance. The potential benefits to women who are unable to access doula care are more difficult to quantify, and reflect the broader reproductive injustices against women (or otherwise marginalized) women in North America. Olivia, the doula who refuses to charge for her services, encountered tension with other members of the DCNL on this issue, and I have previously speculated that this encounter may have influenced her decision not to renew her membership in the Collective. She stated:

one thing that was really frustrating, you know, about my conversation with other doulas when I was very distinctly being pressured, and not even subtly, I was being told outright the I need to charge for my services....And I just think it's absolutely ludicrous, you know, they were saying "Well, you know you can always work with the Association for New Canadians or whatever if you wanna help people who can't necessarily afford it" and I'm like "Ok, that's a valid option, right? But what about all the Canadians who've lived here their whole lives and can't afford to pay for a doula, right?"

Olivia highlights the ways that particular approaches to doula care may constrain its potential to be understood as a form of resistance. In particular, she expresses concern that some doulas appear to be advocating gate-keeping mechanisms against poor women, by blocking their access to care that she is content to provide without financial remuneration.

In this chapter I have conceptualized the activities of my participants within a continuum of resistance behaviours, encompassing various overt forms of activism, and subtle forms of resistance. Because my participants did not immediately identify their work as a doula as a form of activism, or a disruption of the medicalization of childbirth, I have teased apart the various aspects of their work that can be read into the continuum of resistance. Katie was the only participant to explicitly tie her work as a doula to over activism, particularly related to her advocacy for midwifery regulation in Newfoundland and Labrador. Many of the participants explicitly emphasized that activism should not take place while providing care to a client because they feared that this could create unnecessary tension with medical professionals. Some of the activities that doula performed that I have identified as subtle forms of resistance are their emphasis on empowering women (which I have cautiously examined in relationship to the notion of “choice”); highlighting the gaps that currently exist in the hospital system; and providing critiques of the biomedical model of childbirth. Furthermore, I have also discussed the necessity for doulas to hold activist roles in this province due to the lack of childbirth options currently available, and I have closed with a troubling of doula work as a form of resistance, as it demonstrates the potential to replicate the medicalized status quo.

Conclusions

There's just so much value in somebody saying, "yup, that's what [the doctor is] suggesting and it's ok, we can work with that." Like...when an IV line has to go in or something like that, and that is part of the hospital policy for whatever reason, and is a result of the choices and the medical assessment of the situation, and if the mom's uncomfortable about that. Um, yeah, it's nice to have the doula there to say, "That's alright we can manage it, we're gonna...be taking this IV pole around while we do everything we were doing before."

Laura

Overview of Findings

In this thesis I have presented a feminist interpretive phenomenological examination of doula work in St. John's, Newfoundland and Labrador. In it, I sought to examine the lived experiences of doulas in relationship to three research objectives: (1) to investigate if membership in a collective provides doulas with particular forms of support, (2) to examine how doulas construct the significance of their relationships to their clients, and (3) to explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth.

Although I aim to present the unique ways that individual doulas understand their own lived experiences, I have identified four key findings:

- 1) The DCNL primarily acts as a system of support for its members, including the ability to share knowledge and birth experiences; connect with other like-minded individuals; and present a cohesive model of doula care in St. John's. However, members of the Collective must also negotiate several challenges, such as honouring the opinions of individual doulas while still acting as a united front, and navigating criticisms of DONA International, with whose policies the DCNL has come to be affiliated.

- 2) Doulas create meaningful relationships with their clients, and express a unique fondness for the mothers they have cared for during labour. While some doulas have encountered difficulties with setting and maintaining boundaries around the expectations of doula care with their clients, all participants described a deep affection for the relationships they develop with clients, regardless of if they had known them previously, or continue a relationship with them after their professional responsibilities have been fulfilled.
- 3) Because of the lack of childbirth options available in St. John's, doula work has come to be associated with overt forms of activism for women's birthing rights. Generally, doulas in this study associate overt forms of activism with such activities as advocating for midwifery regulation in the province, or disputing hospital policies. However, doulas are careful to maintain that they do not perform overt activism while providing care to their clients.
- 4) Doulas are hesitant to categorize the typical behaviours associated with doula care as forms of activism. Nevertheless, it is possible to conceptualize many of their activities as forms of subtle resistance, which fall along a continuum ranging from subtle to overt acts.

It is important to contextualize these key findings within the background literature discussed in Part 1. Firstly, this study provides a contemporary addition to the unique history of childbirth attendance outlined in Chapter 1. The care currently provided by doulas in St. John's echoes much of the community-based and continuous care provided

historically by lay and trained midwives in Newfoundland and Labrador. Secondly, this study contributes to a gap in the literature examining the lived experiences of doulas, particularly in relationship to doulas' formation and membership in collectives, associations, and organizations; the meaningful relationships that doulas develop with their clients; and the potential to understand doula work as both a continuation of feminist women's health movements of the 1970s, and currently as a form of resistance against medicalized models of birth. Thirdly, this study provides a unique analysis of the lived experiences of doulas through the methodological perspective of feminist interpretive phenomenology. Through this perspective I aim to produce knowledge relevant to women's embodied experiences of female-centred events, such as pregnancy, childbirth, and caring labour, and through a lens in which researcher and researched are necessarily understood as co-constituters of knowledge. Finally, this study contributes to the theoretical frameworks discussed in Chapter 3, as it highlights the ways that medicalization has limited women's embodied experiences of childbirth, and how doulas attempt to diminish women's alienation from their own childbirth experiences, and encourage more engaged approaches to pregnancy and birth. As well, this study examines a care-providing role that is highly gendered, in that it is solely performed by women, holds a liminal position within the medical system, and nets minimal financial remuneration.

Directions for Future Research

Much more research is required in order to gain a greater understanding of the lived experiences of doulas. There are several areas related to doula work in particular that are worthy of further consideration, which I was not able to address within the constraints of this study. Since I focused only on the experiences of doulas, I was not able

to speak with individuals other than doulas (such as doula clients, medical professionals, and birth activists), who would have important insights into the current position of doulas in St. John's. As well, I was not able to compare the particular position of doulas in St. John's to doulas currently working in another Canadian city where midwifery is regulated and fully implemented. This could provide important insights into the different roles that doulas hold depending on the birth options available. Furthermore, I had hoped to examine the ways that doulas understand their own identities as doulas within my own research data. However, since I had not addressed this issue directly with my research objectives or interview questions, I was not able to examine the elements that constitute doula identity, such as certification status, membership in a collective, or working solely on a volunteer basis. Finally, I remain interested in the limitations to understanding doula work as activism; that is, I think it is important to interrogate the neo-liberal language of "choice" and to examine how the current framework of doula work can be understood to sustain, rather than challenge, the medical status quo. In particular, I am interested in the ways that doula work fails to adequately address the needs of marginalized (rather than already privileged) women, and can appear inattentive to issues of race, class, gender, sexuality, and ability.

It is my hope that this study may bring some level of awareness to the activities of doulas in St. John's. The enthusiasm that my participants hold for their work as doulas should not be diminished, as doulas make sacrifices to their time and to their freedom in order to provide women with the continuous care that they know is so vitally important to a positive and healthful childbirth experience.

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Appendix A

Advertisement

Wanted: Doulas currently working independently in Newfoundland and Labrador who are interested in participating in a research project at Memorial University of Newfoundland. Participation involves interviews and/or focus groups. I will be conducting a focus group with doulas at the beginning of the study to become acquainted with the issues before meeting with individual doulas. I will follow up individual interviews with another focus group at the end of the study to discuss and confirm my findings. I invite you to participate in all three components but you are free to consent to be involved in an individual interview and/or one or two focus groups. Individual interviews will take approximately 60-90 minutes, and focus groups will take approximately 90-120 minutes. I will make a sincere effort to schedule interviews and focus groups in locations, and at times, that are most convenient for you, and for other participants. For more information, please contact h95cmy@mun.ca.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICHER at icehr@mun.ca or by telephone at 709-864-2861.

Appendix B

Interview Protocol

Note: Additional prompts are *italicized*.

General Introductory Questions

- 1) Can you tell me about your decision to become a doula? *How do you describe your work as a doula to anyone who asks? Tell me about a day in the life of a doula.*
- 2) During the focus group I heard some of the doulas talk about the stigma of working as a doula in St. John's, or in Newfoundland and Labrador more generally. How do you feel about this?

Membership in a Collective/Professional Identity

- 3) Tell me about your decision to become (or not to become) a member of the Doula Collective of Newfoundland and Labrador.
- 4) What kind of support do you receive as a member of this collective? *What are some of the benefits of working within a collective? What are some of the challenges associated with working within a collective?*
OR
Can you tell me a bit more about your decision to practice independently? *What are some of the benefits of working independently? What are some of the challenges associated with working independently?*
- 5) How would you describe your relationship with other doulas in the collective?
OR
How would you describe your relationship with other doulas in the community? *Can you tell me about a time that interacting with another doula either positively or negatively impacted your work?*
- 6) How do you feel about the organization DONA International, and their certification process? How do you feel about the certification of doulas more generally?

Construction of Relationships with Clients

- 7) How would you describe your relationships with your clients?
- 8) Can you tell me about an important moment that you have experienced with a client that made you feel like your work is worthwhile, or made you question if your work is worthwhile?

Resistance/Advocacy/Education

- 9) The literature often talks about the 'medicalization of childbirth'. What does this mean to you? Where do you see doulas (and/or other birth attendants) fitting into this?
- 10) How do you feel about the current status of birth options available to women in Newfoundland and Labrador?
- 11) During the focus group I heard some of the doulas describing themselves as educators (*of birthing women, their partners, medical professionals, government, and the general public*). What do you think about the connection between doula work and education?
- 12) I've also read that some birth attendants have been regarded as activists or advocates. What do you think about that?

Appendix C

Focus Group #1 Protocol

Today I would like to hear about your experiences as a doula in Newfoundland and Labrador, and about what aspects of your experience you feel are worthy of being studied in-depth. I'd like to begin by having each of you give the group a brief introduction to yourself, and then tell us a little bit about why you chose to become a doula, and a description of your work as a doula. Then, we will move into a group discussion about which aspects of working as a doula in Newfoundland and Labrador are most important, and that you feel should be discussed further in individual interviews. For example, what are some of the personal benefits of working as a doula; what are some of the unique challenges associated with working in a collective, or independently, as a doula in this province; what gaps does doula care currently fill for women in this province, etc.

Appendix D

Preliminary Interview Questions

General Introductory Questions

Can you tell me about your decision to become a doula?

How do you describe your work as a doula to anyone who asks? Tell me about a day in the life of a doula.

Membership in a Collective

Tell me about your decision to become (or not to become) a member of the Doula Collective of Newfoundland and Labrador.

What kind of support do you receive as a member of this collective? What are some of the benefits of working within a collective? What are some of the challenges associated with working within a collective?

OR

Can you tell me a bit more about your decision to practice independently? What are some of the benefits of working independently? What are some of the challenges associated with working independently?

Construction of Relationships

How would you describe your relationship with other doulas in the collective (or in the community)?

Can you tell me about a time that interacting with another doula either positively or negatively impacted your work?

How would you describe your relationship with your clients?

Can you tell me about an important moment that you have experienced with a client that made you feel like your work is worthwhile, or made you question if your work is worthwhile?

Resistance to Medicalization

The literature often talks about the 'medicalization of childbirth'. What does this mean to you?

Where do you see doulas (and/or other birth attendants) fitting into this?

How do you feel about the current status of birth options available to women in Newfoundland and Labrador?

I've read that some birth attendants have been regarded as activists or advocates. What do you think about that?

Appendix E

Preliminary Research Findings/Focus Group #2 Protocol

Research Objectives

These are my three research goals:

- 1) To investigate if membership in a collective provides doulas with particular forms of support.
- 2) To examine how doulas construct the significance of their relationships to their clients.
- 3) To explore the potential to conceptualize the activities of doulas as a form of resistance against medicalized models of birth.

Preliminary Analysis

After conducting my preliminary analysis, I found two main themes: 1) Doula as identity and 2) Doula work in relationship to others (including the Doula Collective, clients, and the hospital/medical system/medicalization).

Theme 1 – Doula as Identity

Please answer any of the following questions that you feel are relevant to your identity as a doula.

- Do you describe yourself and/or your doula work as feminist?
- Is certification an important part of doula identity?
- Do you view doulas as part of a grass roots birthing movement, as a certified profession, or both?
- Is your identity as a doula tied to the location in which you practice (St. John's)?

Theme 2 – Doula in Relationship to Others

Please read the following statements (organized in relationship to my Research Objectives) and make note of any aspects of the statement that you particularly agree or disagree with.

Objective 1 (The Collective)

The Doula Collective provides doulas with important supports (such as the sharing of knowledge, providing backup to one another, debriefing after births, staying current with hospital policies, advertising one's doula services, and creating change through collective action).

The Collective can also pose certain challenges (such as the necessity to negotiate different opinions while still acting as a united front, some criticisms of DONA policies may be interpreted as criticisms of the Collective itself, and the Collective may act as a gate keeping mechanism to determine who can be a doula and how doulas should practice in St. John's).

Objective 2 (Clients)

Doulas develop unique relationships with their clients, regardless of if this relationship is maintained after their duties as a doula have been fulfilled. Doulas become deeply involved in a very emotional and personal moment in their clients' lives, and must build rapport and develop intimate relationships very quickly. Doulas make a concerted effort not to pass judgment about the choices that their clients make.

Doulas have differing opinions about what level of professionalism they should exhibit with their clients. Doulas sometimes experience difficulties in setting and maintaining boundaries with their clients, particularly when clients demand more from them than they are comfortable providing.

Objective 3 (Resistance and Medicalization)

When asked if doula work is a form of activism or advocacy, doulas describe their resistance behaviours in two separate ways: as overt and subtle.

Overt: Doulas say that overt activism for women's birthing rights should not take place with their clients during their birth experience. Many doulas identified with overt forms of activism for women's birthing rights, such as advocating for midwifery care, or other birth options, for women in the province.

Subtle: Many of the doulas described a resistance against the medicalization of childbirth, and felt that their work as a doula produced social change in a quiet way by highlighting and filling intangible gaps in care that exists in the hospital, by educating medical professionals about their work, and by making women's childbirth experiences better.

Do you view these overt and subtle forms of resistance and/or activism as similar?
Different? Complementary?

Appendix F

Consent Form

Title: Caring in Community: The Doulas of Newfoundland and Labrador

Researcher: Christina M. Young
Master of Women's Studies Candidate
Department of Gender Studies
Memorial University of Newfoundland
christina.m.young@mun.ca

Co-Supervisors: Dr. Sonja Boon
Assistant Professor
Department of Gender Studies
Memorial University of Newfoundland
(709)864-2551
sboon@mun.ca

Dr. Diana L. Gustafson
Associate Professor
Faculty of Medicine, Division of Community Health and Humanities
Memorial University of Newfoundland
(709)777-6720
diana.gustafson@med.mun.ca

Introduction

I am a Master's candidate in the Department of Gender Studies at Memorial University of Newfoundland, and I am asking for your participation in this research project, entitled "Caring in Community: The Doulas of Newfoundland and Labrador". Your participation is being requested based on your membership in the Doula Collective of Newfoundland and Labrador and/or because you have professionally identified yourself as a doula currently working in Newfoundland and Labrador. This form is part of the process of obtaining informed consent from research participants. This form will provide you with information about this research project, including what would be involved in participation if you choose to participate. You will be provided with a copy of this consent form.

Purpose of Research Project

This research project aims to examine the personal experiences of members of the Doula Collective of Newfoundland and Labrador and doulas currently working in Newfoundland and Labrador who are not affiliated with the collective.

Research Procedures

I will be conducting a focus group with doulas at the beginning of the study to become acquainted with the issues before meeting with individual doulas. I will follow up individual interviews with another focus group at the end of the study to discuss and confirm my findings. I invite you to participate in all three components but you are free to consent to be involved in an individual interview and/or one or two focus groups.

Individual interviews will involve being asked a predetermined list of questions, and engaging in a conversation based on your responses to these questions. Focus groups will be more informal discussions, guided only by certain themes or topics.

If you choose to participate, you may withdraw from this study at any time. Should you choose to withdraw, I will ask if you would allow me to use the data that you have already provided, or if you want it to be destroyed. Data from individual interviews can be withdrawn for up to **one month** after the interview has taken place. However, if you choose to withdraw from the study, it will not be possible to remove or destroy any data associated with your participation in one or more focus groups, as it will not be possible to separate your contributions from those of other participants.

Anonymity

Since you are a member of the Doula Collective of Newfoundland and Labrador, and/or professionally identify as a doula currently working in Newfoundland and Labrador, I cannot guarantee your anonymity, as it is likely that other participants will be aware of your participation. As well, participation in focus groups precludes the potential for anonymity.

Confidentiality

I aim to maintain confidentiality through the optional use of pseudonyms for direct quotations originating from individual interviews or focus groups, in all written or oral material related to this research project. You will have the option of either using your own name, or selecting a pseudonym, to be used in direct quotations from your interview. A list linking your name to your study pseudonym will be stored separately from all interview and focus group data. Only myself, and my co-supervisors, will have access to the interview and focus group data. All data will be stored on a secure personal computer for a minimum of five years, as per Memorial University's policy on Integrity in Scholarly Research, and then will be destroyed. Participation in focus groups will allow other participants to hear your account of your experiences as a doula. As well, despite the use of pseudonyms, direct quotations from your interview may make it possible for others to identify you.

Potential Harms

It is possible that, despite the use of pseudonyms for direct quotations, other participants or non-participants will be able identify which quotes belong to you, based on what you have said.

Potential Benefits

There are no clear benefits to your participation in this study. However, this research may contribute to advocacy for doulas, and other forms of alternative birth attendants in this province, as this research will provide preliminary evidence of the important work currently being conducted by doulas in Newfoundland and Labrador.

Time Commitment

Individual interviews will take approximately 60-90 minutes, and focus groups will take approximately 90-120 minutes. I will make a sincere effort to schedule interviews and focus groups in locations, and at times, that are most convenient for you, and for other participants.

Recording of Data

With your permission, all individual interviews will be audio recorded. If you do not consent to being audio recorded during an individual interview, hand written notes will be used to record data from your interview. Participation in focus groups requires that you also consent to being audio recorded, since all participants in the focus group will be recorded at the same time.

Sharing of Results with Participants

Upon completion of this research project, I will present the results of my research to the Doula Collective of Newfoundland and Labrador. Also, I will provide each participant with a document summarizing the findings of this research project. All participants will have access to a copy of my Master's thesis, and any other publications and/or presentations that originate from this research.

Questions

You are welcome to ask questions at any time during your participation in this research project. If you have any questions about your participation in this research project, please contact Christina Young (Christina.m.young@mun.ca), Dr. Sonja Boon (sboon@mun.ca or (709) 864-2551), or Dr. Diana Gustafson (Diana.gustafson@med.mun.ca or (709) 777-6720).

Participant:

I have read and understood the above information []
I have had the opportunity to ask Christina Young questions about this research []
I consent to participation in a focus group at the beginning of this research project AND
to being audio recorded during this focus group []
I consent to participation in an individual interview []
I consent to being audio recorded during an individual interview []
I consent to participation in a focus group at the end of this research project AND to
being audio recorded during this focus group []
I consent to the use of my own name in any publication of this study []
I consent to the use of a pseudonym of my own choosing in any publication
of this study []

Participant Name (Print)

Participant Pseudonym (If Applicable, Print)

Participant Signature

Date

Researcher:

I have explained this study to the best of my ability. I invited questions and gave answers.
I believe that the participant fully understands what is involved in being in the study, any
potential risks of the study and that he or she has freely chosen to be in the study.

Principal Investigator Signature

Date

The proposal for this research has been reviewed by the Interdisciplinary Committee on
Ethics in Human Research and found to be in compliance with Memorial University's
ethics policy. If you have ethical concerns about the research (such as the way you have
been treated or your rights as a participant), you may contact the Chairperson of the
ICHER at icehr@mun.ca or by telephone at 709-864-2861.



