TOOLKIT FOR DOULAS

UNDERSTANDING THE IMPACT OF GENDER-BASED VIOLENCE

This project was led by Carrie Low, an accomplished and acclaimed advocate for survivor's rights in the criminal justice system in Nova Scotia, with support from Grisha Cowal, Clare Heggie, and Dr. Martha Paynter.

The project was made possible through funding from the Canadian Women's Foundation and the Chebucto West Community Health Board with support from the Chebucto Family Centre.

Illustrations by Julia Hutt, Wellness Within Artist in Residence.

Graphic design by Pinwheel Communication Design in Halifax, Nova Scotia.

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

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

wellnesswithinns.org

TABLE OF CONTENTS

GENDER-BASED VIOLENCE

Gender-based violence (GBV) is a term used to acknowledge that violence occurs within the context of gendered power dynamics in our patriarchally dominated society. Gender-based violence can manifest in a variety of ways and is not exclusive to intimate partners. Gender-based violence is interconnected with other forms of oppression and disproportionately affects youth, people who are LGBTQ2S+, experience a disability, and racism. It is imperative that as a doula you are aware of the signs that a client may be experiencing violence, how to discuss violence with your client respectfully, and how to provide trauma-informed care.

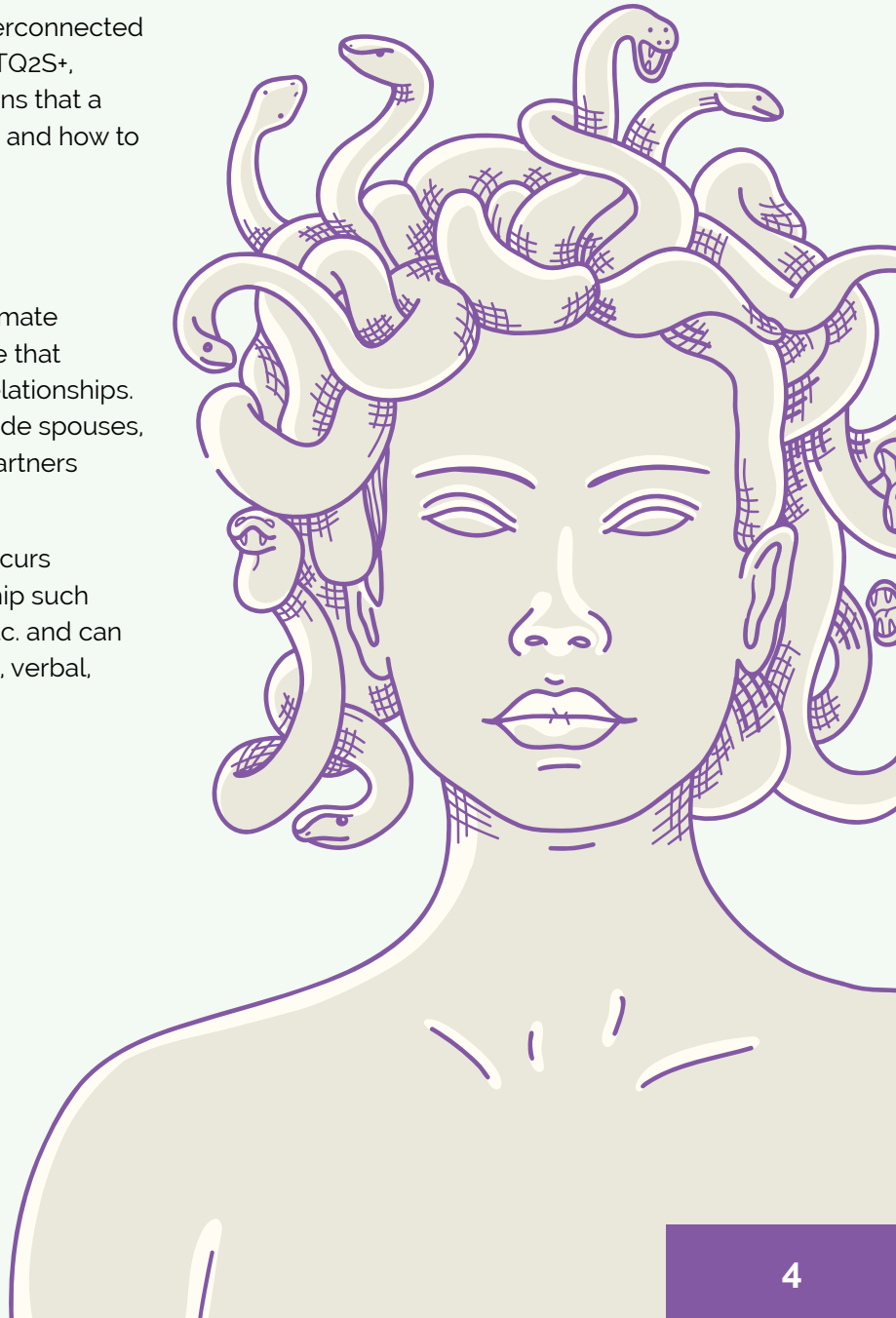
DEFINITIONS

Gender-based violence (GBV): Gender-based violence is violence directed at a person as a result of their gender identity and or gender expression. GBV can occur in personal relationships such as between friends, family or intimate partners as well as in society between acquaintances and strangers. GBV is rooted in gender inequity and patriarchal dominance in our society, therefore women, trans and nonbinary people are more impacted by gender-based violence compared to cisgender men.

Domestic violence: The term domestic violence can be used as an umbrella term to refer to more specific types of violence that fit within its scope, such as intimate partner violence or family violence. Domestic violence occurs within relationships such as family, romantic, parent-child, etc. and can include but is not limited to physical, verbal, sexual and emotional abuse.

Intimate partner violence (IPV): Intimate partner violence is violence or abuse that occurs specifically within intimate relationships. Examples of intamate partners include spouses, dating partners or ongoing sexual partners (Drexler et al., 2022).

Family Violence: Family violence occurs specifically within a family relationship such as parent-child, spouses, siblings, etc. and can include but is not limited to physical, verbal, sexual and emotional abuse.



GENDER-BASED VIOLENCE STATISTICS

Although GBV can impact anyone, women, trans and nonbinary people, Indigenous women, women living in Northern rural and remote communities, women with disabilities and people who are part of the LGBTQ2S+ community are most at risk of experiencing GBV (Government of Canada, 2021). 2018 data show that 44% of Canadian women experienced intimate partner violence at some point in their life (Government of Canada, 2021).

44% of Canadian women **experienced intimate partner violence** at some point in their life

Youth

- Women age 15-24 were the highest age group to report experiencing intimate partner violence, at a rate of three in ten (29%) women, more than double the amount reported by women between the ages of 25 to 34 or 35 to 44, and about six times higher than women age 65 years or older (Government of Canada, 2021).

LGBTQ2S+

- One in two (50%) LGBTQ2S+ women and one in four (26%) LGBTQ2S+ men in Canada were sexually assaulted since age 15, compared to 30% of heterosexual women and 8% of heterosexual men
- One in two (45%) LGBTQ2S+ women and 47% LGBTQ2S+ men were physically assaulted since age 15, compared to 26% of heterosexual women and 33% of heterosexual men
- Four in ten (40%) LGBTQ2S+ women and three in ten (32%) LGBTQ2S+ men experienced online harassment in the 12 months prior to the survey, more than double the amount reported by heterosexual women (18%) and heterosexual men (13%).
- 49% of LGBTQ2S+ women and 35% LGBTQ2S+ men experienced unwanted sexual behaviours in the workplace, compared to 28% of heterosexual women and 16% of heterosexual men.
- In the 12 months prior to the survey, trans and nonbinary people in Canada (58%) were more than twice as likely as cisgender people (23%) to have experienced unwanted sexual behaviours in public places.
- Trans and nonbinary people (69%) were more likely than cisgender people (23%) to have experienced unwanted sexual behaviours in the workplace.
- Trans and nonbinary people (42%) were more likely than cisgender people (16%) to have experienced online harassment in the 12 months prior to the survey (Government of Canada, 2021).

Indigenous Women

- Indigenous women are more likely to experience intimate partner violence in their lifetime compared with non-Indigenous women (61% vs. 44%).
- Indigenous people who are part of the LGBTQ2S+ community were significantly more likely than non-Indigenous LGTBQ2S+ people to have ever experienced a physical assault (73% versus 45%) or a sexual assault (65% versus 37%) since the age of 15.
- In the 12 months prior to the survey, one in six (17%) Indigenous women experienced intimate partner violence, compared to 12% of non-Indigenous women.
- In Canada, Indigenous women (43%) are more likely than non-Indigenous women (30%) to have been sexually assaulted at least once since age 15 (Government of Canada, 2021).

Disability

- About seven in ten (71%) LGBTQ2S+ women with disabilities have experienced IPV.
- In Canada, women living with a disability are more likely than women without a disability to have experienced sexual assault since the age of 15 (39% versus 24%).
- In the 12 months prior to the survey, women living with a disability more likely than women without a disability to have experienced unwanted sexual behaviours in a public place, both in the provinces (39% versus 27%) and in the territories (45% versus 28%) (Government of Canada, 2021).

TRAUMA-INFORMED CARE

WHAT IS TRAUMA-INFORMED CARE

Trauma-informed care promotes understanding of the extent and influence that trauma has on individuals and groups as well as promotes recovery from trauma through services that are often rooted in strength-based approaches (King, 2017). Trauma-informed care assumes that each individual has some degree of trauma that can impact multiple aspects of their life in a complex interaction. A trauma-informed approach to care focuses on what is known as the 4 R's when responding and interacting with those impacted by trauma.

1. Realization and acknowledgement of the extensive impacts of trauma on every aspect of a person's life.
2. Recognition of symptoms and signs of trauma in both individuals and groups.
3. Responses that completely integrate knowledge and understanding of trauma into practices and policies.
4. Resisting re-traumatization of individuals and groups. (Champine et al., 2019)

Trauma-informed approaches to care are guided by 6 key principles.

1. Physical and psychological safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues.

When applying a trauma-informed lens to doula care, understanding and utilizing the 4 R's and 6 key principles support the provision of appropriate support to meet client needs. A doula can:

1. Protect their clients physical and psychological safety
2. Build trustworthiness, transparency and confidence with the client
3. Provide peer support
4. Collaborate and build mutuality between themself, the client and the healthcare system through relationship building and eliminating power differences
5. Promote their clients' resilience, empowerment, voice and choice, and
6. Be responsive and respectful to cultural, social, and historical considerations such as racial, gender, and sexuality differences (Mosley, 2020).

When conceptualizing trauma, caregivers examine the 3 E's.

1. **Event**: The occurrence of one or more traumatic events or circumstances.
2. **Experience**: Physically or emotionally harmful or life threatening feelings that arise from the event.
3. **Effects**: The adverse impact that the event and experience has on the individuals functioning and wellbeing.

Examining the 3 E's helps to connect the event(s) with how the individual experienced it and how this affects the individual (Sperlich et al., 2017).

When applying a trauma-informed approach, be sure to understand that your client is the one to determine whether you are applying a trauma-informed approach or not. It's not as simple as taking a 3-hour Trauma-Informed Care course and labeling oneself as "Trauma-Informed" with a certificate. Trauma-Informed care is an on-going practice and can be very different with each client. Be sure to check in with your client consistently to ensure they are receiving trauma-informed care that is effectively working for them.

WHAT TRAUMA CAN LOOK LIKE

Trauma presents differently in every individual. Factors such as a person's genetics, the type of traumatic event(s) and their duration, the person's age when the event(s) occurred and more all contribute to how a person responds to trauma.

Post Traumatic Stress Disorder (PTSD) is a mental health condition that results from witnessing or experiencing a traumatic event. Symptoms may not present right away and can vary in their extent.

Complex Post Traumatic Stress Disorder (C-PTSD) has similarities to PTSD however it is the result of experiencing trauma over an extended period of time. C-PTSD can arise from physical abuse, sexual abuse, emotional abuse and other traumatic events that happen over a prolonged duration.

Below are some examples of PTSD and C-PTSD symptoms. Keep in mind that these are only some of the ways that trauma can present. Your client may experience none of these or several signs at once.

COMMON C-PTSD SYMPTOMS

- Emotional flashback - Intense flashbacks that bring on the worst emotions felt during the traumatic event(s). These feelings are overwhelming and can leave an individual feeling helpless. Oftentimes C-PTSD emotional flashbacks are not accompanied by visuals of specific memories which can be confusing for those experiencing them as it becomes hard to identify why they are feeling such extreme emotions.
- Toxic shame - An overwhelming sense of self-disdain.
- Self abandonment.
- Social anxiety.
- Extreme feelings of loneliness and abandonment.
- Fragile self esteem.
- Attachment disorder.
- Developmental arrests.
- Relationship difficulties.
- Dissociation.
- Over sensitivity to stressful situations.
- Suicidal ideation (Walker, 2013).

4F TYPES

A person's 4F type refers to their instinctive response to a perceived threat that has been shaped by their experiences of trauma. These survival strategies and defense styles are influenced by a person's abuse/neglect pattern, birth order and genetics, resulting in an individual gravitating towards a specific 4F response (Walker, 2013). While the most commonly known 4F types are fight and flight, freeze and fawn are also responses that many people have. A person's 4F type will have a large influence on how they respond to stress and perceived danger. Many trauma survivors are 4F hybrids, with both a dominant 4F response and a backup response (Walker, 2013).

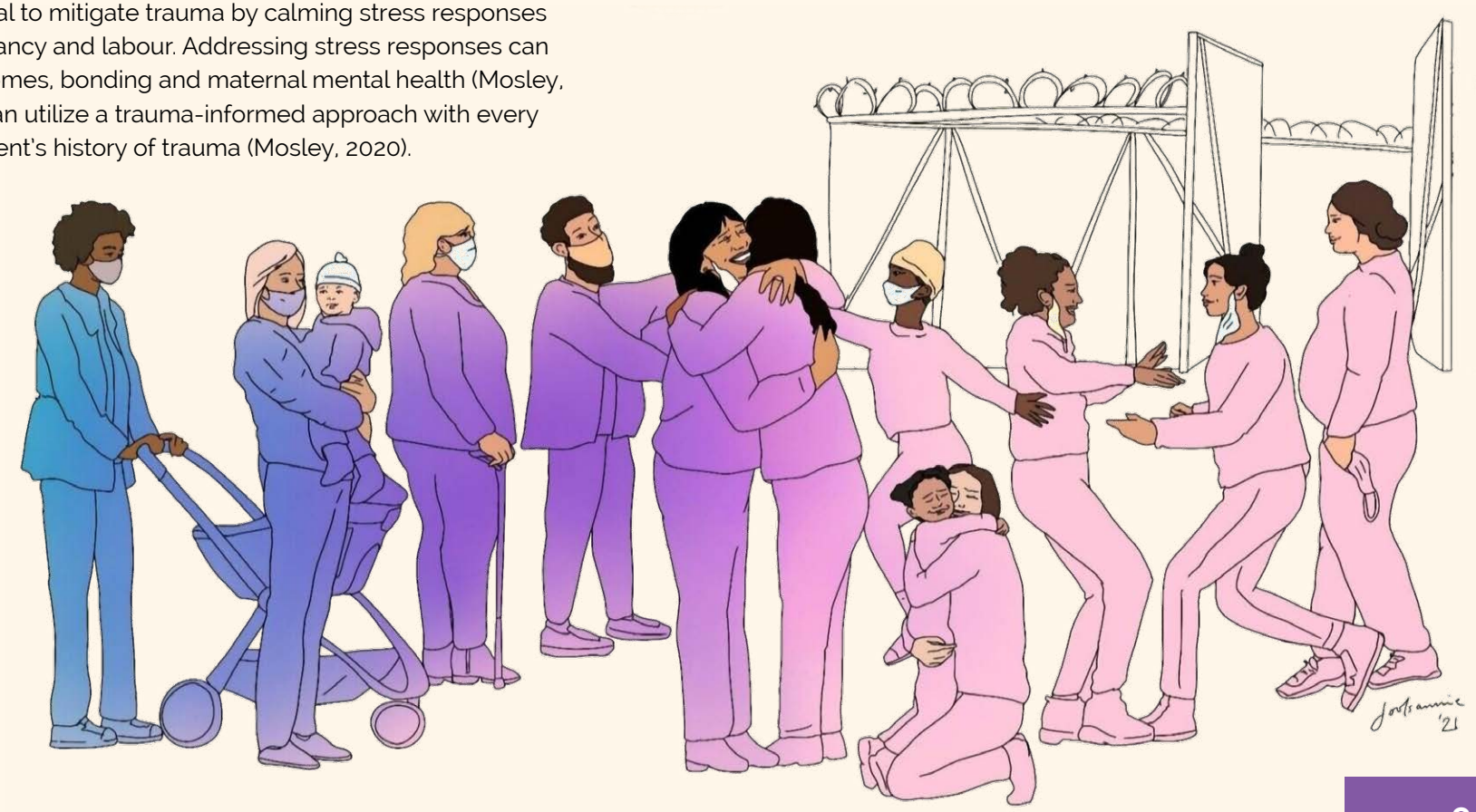
HOW TO SUPPORT YOUR CLIENT THROUGH TRAUMA

Doulas play an important role in supporting clients who have a history of trauma throughout their pregnancy and birthing process. As a doula, you can serve as the in-between person for the client and healthcare system. Interacting with the healthcare system can cause a person to feel vulnerable and powerless. By being an avid support person both during and outside of healthcare interactions you will ultimately learn how your clients' trauma presents and what works best for them, which will provide ease and a greater sense of autonomy in your clients interactions with the healthcare system. As described by Mosley (2020), "Doulas can improve birth, parent, and child outcomes by providing informational, emotional, and instrumental support in the forms of prenatal birth planning, continuous labour support, and postnatal visits".

Doulas have the potential to mitigate trauma by calming stress responses that occur during pregnancy and labour. Addressing stress responses can also improve birth outcomes, bonding and maternal mental health (Mosley, 2020). As a doula, you can utilize a trauma-informed approach with every client regardless of a client's history of trauma (Mosley, 2020).

TRAUMA INFORMED CARE DURING CLINICAL APPOINTMENTS AND PROCEDURES

Receiving healthcare places the patient in a position of vulnerability which is especially intimidating for survivors of trauma. Both the structural power dynamics of healthcare as well as the physical aspects such as examinations and procedures can be triggering for clients with a history of trauma. Developing trust with the patient/client is an imperative step in trauma informed care and to building a meaningful relationship while creating a comfortable atmosphere. Trauma survivors have identified that they value caregivers that are nonjudgmental, compassionate, and confidential, as opposed to caregivers that are critical or encourage them to leave their situation (Drexler et al., 2022). It is important to check in with your client before, during and after appointments and procedures to understand how they are feeling and how you can support them.



TRAUMA, DEPRESSION AND PREGNANCY

During pregnancy, the risk of a person experiencing re-traumatization is high due to intrusive physical contact, vulnerability and dependence on a caregiver during labour (Sperlich et al., 2017). It is estimated that 9% of childbearing people have PTSD, with the rates increasing as more is uncovered about trauma (Mosley, 2020). Domestic violence is the most frequently reported trauma in pregnancies and is associated with infection, anemia, still birth, pelvic fracture, placental abruption, fetal injury and low birth weight (Huls & Detlefs, 2018). Both PTSD and depression are shown to increase the risk of experiencing negative physical health outcomes as well as negative birth outcomes such as increased nausea and risk of preterm birth (Nillni et al., 2018). The perinatal period is an especially vulnerable time that can have serious health consequences for both the parent and child if trauma and depressive symptoms go untreated. Depression poses the most frequent risk of complications during pregnancy and childbirth and can have adverse mental and physical health affects on both the parent and child (Dekel et al., 2019). Despite depression being the most common mental health concern during pregnancy many women go undiagnosed, especially if they are only screened once throughout pregnancy or have fewer checkups (Míguez & Vázquez, 2021). Depression has negative impacts on both foetal and neonatal outcomes as the birthing parents' psychological state during pregnancy influences the neurodevelopment of the fetus (Míguez & Vázquez, 2021). It can have prolonged consequences for the parent and child such as:

- Delayed infant development,
- Perinatal obstetric complications,
- Challenges with breastfeeding
- Strained social supports and family dynamics (Rafferty et al., 2019).
- Disruption of early parent-infant attachment and bonding
- Poor physical, emotional, cognitive and social development in the child (Rafferty et al., 2019).

There are preventative measures that care providers and doulas can take to deter or mitigate the risks of depression during and after pregnancy. Recognizing and screening for risk factors throughout the pregnancy is important. Certain sociodemographic (age, education level, socioeconomic status, intimate partner relationship, social environment), obstetric (pregnancy planning, obstetric history, physical symptoms), and psychological (history of mental health issues, perception of social support, anxiety and stress) factors can influence depression during and after pregnancy (Míguez & Vázquez, 2021).

THE "WINDOW OF TOLERANCE"

The Window of Tolerance is a term that was coined by Dr. Dan Siegel (1999). This concept is used to describe the ideal zone of "arousal" for a person to function in everyday life. In this window, you can handle emotions efficiently and make informed decisions with rational thinking.

When clients have experienced trauma, it can be difficult for them to manage their emotions, and the zone of arousal where they can function effectively is quite limited. The stress of a traumatic memory or trigger may cause them to be pushed out of their window of tolerance which can cause a client to become hyperarousal or hypoarousal.

HOW TO HELP CLIENTS MANAGE THEIR WINDOW OF TOLERANCE?

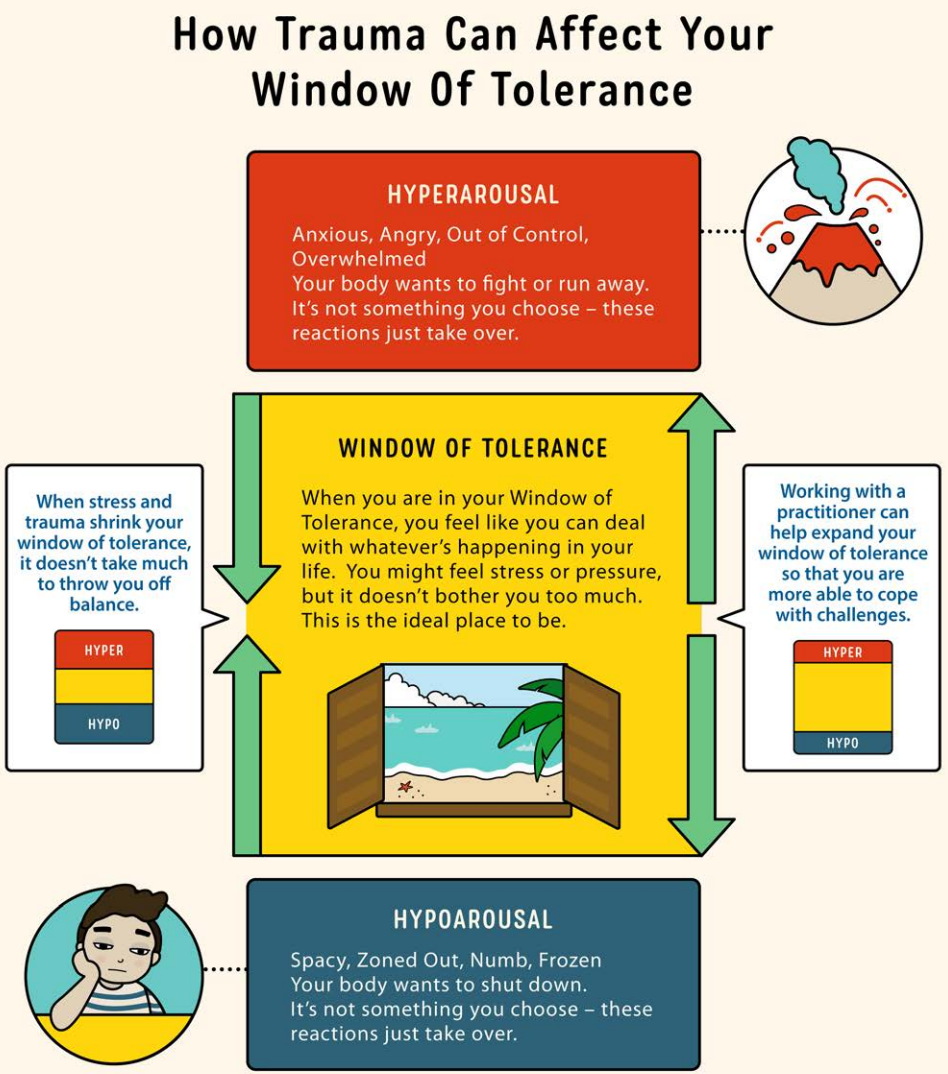
To begin, clients must recognize when they are experiencing emotions outside their tolerable range and then gauge how they feel and how it affects their bodies.

Clients can begin to manage their window of tolerance by:

1. Recognizing their window of tolerance and increasing their awareness of symptoms
2. Widening their window of tolerable emotions
3. Learn techniques for re-regulating when experiencing hypoarousal or hyperarousal

Body-based strategies and exposure-based can be effective in helping clients cope with intense emotions.

It can also be effective in helping clients reduce any shame they might feel from being easily dysregulated. Compassion-focused strategies can help build resiliency, self-compassion, and self-acceptance.



TOOLS TO HELP YOUR CLIENT STAY IN THEIR WINDOW OF TOLERANCE?

- **Breathwork** – Using the mindful experience of breathing as an anchor to the body and the present.
- **Guided Imagery** – To start, in place of breathwork, a client might imagine themselves on a swing, paying attention to the internal feelings of the movement. The rocking motion of the swing actually brings the breath online differently, helping circumvent certain triggers.
- **Positive Containment Imagery** – An example of positive containment imagery might be to have a client imagine a chest, or whatever their choice of container might be. Then, they can imagine arranging the intrusive thoughts or images in that chest or container, and locking it securely until they're ready to process them more fully.
- **Safe Place or Sacred Space Imagery** – Finally, there is safe place or sacred space imagery. They can base this place on any real, fictional, or imaginary location where they feel calm or content, and can design it at will. By giving the client an image where they have complete control, it can reduce a sense of helplessness or uncertainty in life.

EXPANDING THE WINDOW OF TOLERANCE

The suggested tools above to help clients who have experienced trauma and are coping in a smaller window of tolerance are a temporary fix in the moment. In order to expand one's window of tolerance, it is suggested they consider focused work.

- **Therapy**. A professional counselor or psychologist can help clients process and deal with the impact of trauma on their everyday life.
- **EMDR**. Eye Movement Desensitization and Reprocessing (EMDR) helps process and reorganize the traumatic memories in your brain such that they aren't creating such strong emotional reactions. Through the use of this technique, the negative narratives and emotions linked to those memories are replaced with a more grounded and centered perspective, as well as positive, affirming words.
- **Regular mediation practice**. As mentioned above, a short version of meditation and breathing can help. Regular mediation practice and breath work can help significantly over time creating a habit that develops into a reflex to react to stress.

BE AN ACTIVE BYSTANDER

We can all be bystanders. Every day events unfold around us. At some point, we will register someone in danger. When this happens, we will decide to do or say something (and become an active bystander), or to simply let it go (and remain a passive bystander).

When we intervene, we signal to the perpetrator that their behaviour is unacceptable. If such messages are constantly reinforced within our community, we can shift the boundaries of what is considered acceptable and problem behaviour can be stopped.

Learning to recognize when someone is in danger and how you can intervene safely is an essential skill. Safely intervening could mean anything from a disapproving look, interrupting or distracting someone, not laughing at a sexist or violent joke, or talking to a friend about their behaviour in a non-confrontational way to caring for a friend who's experienced problematic behaviour. Other times, it means asking friends, staff, or the police for help.

HOW TO BE AN ACTIVE BYSTANDER

Sometimes, a situation just does not feel right. It might be comments made by a friend that you feel are inappropriate or you spot someone being harassed at a party or club.

Being an active bystander means being aware of when someone's behaviour is inappropriate or threatening and choosing to challenge it. If you feel uncomfortable doing this directly, get someone to help you, such as a friend or someone in authority.

Research shows that bystander intervention can effectively stop sexual assault before it happens, as bystanders play a key role in preventing, discouraging, and/or intervening when an act of violence has the potential to occur.

BEFORE STEPPING IN, TRY THE ABC APPROACH.

- **A**ssess for safety: If you see someone in trouble, ask yourself if you can help safely in any way. Remember, your personal safety is a priority – never put yourself at risk.
- **B**e in a group: It's safer to call out behaviour or intervene in a group. If this is not an option, report it to others who can act.
- **C**are for the victim. Talk to the person who you think may need help. Ask them if they are OK.

HOW YOU CAN INTERVENE SAFELY

When it comes to intervening safely, remember the five Ds – direct, distract, delegate, delay, and document.

Direct action - Call out negative behaviour, tell the person to stop or ask the victim if they are OK. Do this as a group if you can. Be polite. Don't aggravate the situation - remain calm and state why something has offended you. Stick to exactly what has happened, don't exaggerate.

Distract - Interrupt, start a conversation with the perpetrator to allow their potential target to move away or have friends intervene. Or come up with an idea to get the victim out of the situation – tell them they need to take a call, or you need to speak to them; any excuse to get them away to safety. Alternatively, try distracting, or redirecting the situation.

Delegate - If you are too embarrassed or shy to speak out or don't feel safe to do so, get someone else to step in.

Delay - If the situation is too dangerous to challenge then and there (such as there is the threat of violence or you are outnumbered) just walk away. Wait for the situation to pass then ask the victim later if they are OK. Or report it when it's safe to do so – it's never too late to act.

Document - Document refers to taking notes about a situation or recording incidences of sexual violence or harassment. Some tips for documentation: note the date, time, and place of the occurrence. Document as much as possible the situation as the purpose of documenting the situation is to support those who have been harmed

INCREASED RISK OF VIOLENCE DURING PREGNANCY

People that are pregnant are at an increased risk of facing intimate partner violence. Drexler et al., (2022) discusses some of the potential implications that violence during pregnancy can result in and shares the following statistics

- The risk of experiencing intimate partner violence is estimated to increase by approximately 20% during pregnancy
- An estimated 5% of pregnant people worldwide experience intimate partner violence and 50% of those encounter intimate partner violence for the first time during their pregnancy.
- pregnant people who experience intimate partner violence during pregnancy were found to be three times more likely to experience perinatal death.
- Intimate partner violence during the perinatal period is associated with increased risk of complications during pregnancy such as miscarriage, placental abruption, preterm labour or birth, and low birth weight.

RECOGNIZING AND RESPONDING TO VIOLENCE

It is important to keep in mind that each individual client will have different experiences, coping mechanisms, trauma responses and desired ways of handling their situation. Below are some things to consider.

- Meet clients where they are at. Each client will be at a different point in their experience. Be respectful of how your client views their situation and how they would like to handle it. Be a person that they can lean on without judgment throughout their journey. When discussing your client's situation with them you can share your concerns and suggestions (if it feels appropriate) while respecting their feelings and making it known that they are in control and that their desired way of handling the situation is valid. By sharing your concerns and suggestions respectfully while validating your client's feelings, you may become a safe person that your client can feel comfortable disclosing information to.
- Be aware of general signs of trauma and abuse and check in with your client.
- Respect your client's boundaries and autonomy. Set aside some time at the beginning of your journey together to discuss both your client's boundaries and your own. Boundaries can change throughout your time together and that is okay as long as there is open communication between you and your client to ensure that everyone is on the same page.
- Always ensure that there is ongoing consent. In physical situations this means asking your client before you make contact with them and letting them know what you are doing (e.g.: Is it okay if I hold your arm to help you up?). This can also look like checking in with your client to make sure that a conversation you are having with them is okay to continue (e.g.: Is it still okay to discuss this? Would you like to take a break or end the conversation?).
- Do not put yourself in danger. If you suspect that your client is in immediate danger do not go to their residence to check on them alone. You will have to use your best judgment to determine if a wellness check is necessary. Although your client may not want to get other people involved it may be necessary if their safety is at immediate risk. Be mindful that police conduct wellness checks in Nova Scotia which could further escalate the situation. Consider A) your reasoning/evidence to believe your client is in immediate danger (e.g.: you heard them being attacked on a phone call), B) Who is involved, are there any minors in danger?, C) Your client's safety plan or previously discussed approach. If you feel it is necessary to call in a wellness check, keep your clients' confidentiality in mind. You do not have to disclose all of their personal details, especially if it has no relevance to helping ensure their immediate safety.

DUTY TO REPORT

Each province in Canada has guidelines and requirements for an individual's duty to report child abuse. Generally, each person is legally required to report any knowledge or suspicion of abuse of a person under the age of 19. For more information check your province's official government website. In Canada, Child Protection Services disproportionately removes Black and Indigneous children from their families.

CONSENT

DEFINITIONS

Doula support is based on ongoing, informed consent.

Ongoing consent: Ongoing consent refers to maintaining your client's consent for various things throughout your time together. Part of ongoing consent involves checking in with your client to ensure that what was okay a week ago is still okay today, whether physical touch or certain conversations. Ongoing consent involves allowing your client the space to change their mind and retract their consent, and respecting this boundary.

***Example**: Is it still okay for me to put my hand on your back in breathing exercises?*

Informed consent: Informed consent refers to providing all the details necessary for a client to understand the potential risks, benefits, and outcomes of a situation.

***Example**: Can I help you stand up? You may hurt your back if I pull you up too hard, we can move slowly.*

IMPORTANT THINGS TO REMEMBER WITH CONSENT

- Always ask before you touch a client, no matter how minor it may seem.
- Check in with your client, especially when they appear to be in distress. Ask them if the conversation/physical touch is still okay.
- Ask for your clients consent before they take any medications (pain or other) that could alter their ability to provide consent. It is still important to ask for ongoing consent even if your client is medicated, however asking beforehand is important so that they can make an informed decision.
- Let your client know of any risks, benefits, possible outcomes, side effects, etc. when asking for their consent.
- Inform your client that they can always change their mind and retract their consent, and create a safe space where your client feels comfortable doing this.
- Doulas do NOT provide clinical care. It is not appropriate for a doula to work outside of scope, even if a client consents.

SAFETY PLANNING

Each client you work with will have different experiences with violence resulting in varying risk factors to their safety. Some clients may have experienced violence in the past while others may be in the midst of experiencing violence or are fearful that a perpetrator may return. It is important that you and your client discuss where they are at in their experience of violence to determine if a safety plan is necessary. Each safety plan will look different based on your client's unique situation, experiences, desires, boundaries and more.

WHAT IS SAFETY PLANNING?

Safety planning is a process of working with your client to identify potential risks to their safety as well as identifying resources and options that can help mitigate these risks (Shim, n.d.). A safety plan clearly identifies possible risks that may endanger your client or their baby alongside a plan for what to do if these risks occur. When safety planning, you and your client should discuss the likelihood of each risk occurring, the potential severity of harm that could result from each risk, how to prevent risks from occurring and what to do/ who to contact if a risk does occur or your client feels like one is about to occur.

WHAT TO INCLUDE IN A SAFETY PLAN

Every safety plan will look different based on your client's unique situation and experiences. It is important to have a plan in place so that your client is prepared for the worst. Even if your plan feels complicated or rough it is better to have something in place rather than nothing at all.

The following charts have been adapted from Shim (n.d.) components of a safety plan:

Risk Assessment Chart

POSSIBLE RISK OR HARM THAT MAY OCCUR IN THE FUTURE	WHO IS THE CAUSE OF THE HARM AND WHAT IS/WAS YOUR RELATIONSHIP TO THEM	WHO IS THE TARGET OF THE HARM/RISK (YOU, YOUR BABY, FAMILY, ETC.)	WHAT IS A POSSIBLE SAFETY SOLUTION?	WHO WILL SUPPORT THIS SAFETY SOLUTION AND HOW?

PLANS FOR INTERVENTIONS OR ESCAPING CHART

Ask your client:

- Where are safer spaces they can go to?
- How will they get to these spaces?
- Who can help them execute this plan and how will they contact them?

IMMEDIATE	SECONDARY	LONG TERM

PLANS FOR HEALING CHART

Ask your client:

- Are they doing anything to feel supported? (e.g.: meditating, journaling, etc).
- Who can help them to feel supported and what can this person do?
- What resources can help them to feel supported?
- Who can they reach out to when they are struggling?

IMMEDIATE	SECONDARY	LONG TERM

IDENTIFYING SAFE PEOPLE

Oftentimes survivors choose not to disclose their experiences of abuse and violence for a variety of reasons such as a fear of being blamed, ridiculed or not believed. Along with the fear of the social stigma that may occur when disclosing their experiences, clients may also fear being subjected to additional violence. Being pushy or forceful will only further isolate your client and likely cause them to retreat into themself. You can have a strong approach without being coercive or overbearing. Part of keeping this balance is being able to identify the appropriate time to make suggestions or bring up the topic, using non stigmatizing language that emphasizes autonomy and choice, and maintaining calm and open paraverbal (tone,volume, rhythm of speech) and nonverbal (body language, personal space) communication.

Identifying Safe people

Shim (n.d.) provides the following list that can help you and your client identify safe people:

- Who is usually a source of support in a crisis? Would they be helpful in this situation?
- Is there someone who could be influential with and helpful to the person abusing? Could they help support this person to stop using violence?
- Who is connected to the situation and could help out in some way?
- Who is disconnected from the situation but could still help out in some way?
- Who might seem good at first glance, but could actually pose some problems or challenges?
- Who might be great if they had the right information and got some support?
- Who is good at thinking through complex situations without jumping to conclusions or leaping to take action on their own?
- Who is a great communicator?
- Who can stay calm in stressful situations?
- Who has resources they could share—a car, a living room, a safe place to sleep, a temporary cell phone, etc.?
- Would these people be good allies to help support and safety plan? Why? Why not? If not, is there anything that can be done to help make them more supportive? What kind of role could they play? (p. 27)

It is important to understand that due to the nature of GBV or intimate partner violence a survivor may not have any relationships with people that they feel could be a support. Perpetrators of violence often rely on isolating the person that they are enacting violence or abuse onto in order to gain control and restrict options for that person to leave. According to Shim (n.d.):

Disconnection, loneliness, and isolation are expected outcomes in a society that is anchored in individualism, racism, economic inequality, gender violence, ableism, and the deeply rooted colonial practices of extraction, dispossession, and violent repression. Many are forced to seek care, support, and community in unfamiliar, intimidating, or outright hostile places because they simply do not have anywhere else to go. (p. 28)

IMPORTANT CONSIDERATIONS WHEN SAFETY PLANNING

Shim (n.d.) provides additional things to consider when preparing a safety plan.

Documentation: Can your client document the abuse/violence and the timeline? Can you or a safe person help document conversations with your client about incidents or events? How can your client keep this documentation safe? Can a safe person hold onto it for them? We understand that documenting the abuse/violence can be upsetting and may not be the right choice for everyone, however it is important for your client to know that if law enforcement or social services ever get involved in their situation that this can potentially help reduce the risk of them being wrongfully criminalized. "Though retroactive, documentation is critical for a survivor's self-defense case (if they become criminalized), child custody, or immigration relief." (Shim, n.d., p. 30).

Finances: Does your client have access to their own money or is it shared or controlled by the perpetrator? How can your client access their finances safely and quickly? Where can they store them? Are there safe people or services that can help provide funds in an emergency?

Emergencies: Where can your client go in an emergency? Is there a safe public space such as a coffee shop or library open 24/7? Does your client have a safe person they can stay with? Are there any services such as shelters or centres nearby that can provide support?

Children: If your client has children can anyone help take care of them in an emergency? How can you ensure the children's physical and emotional safety?

Pets: If your client has pets can anyone help feed or watch them in an emergency? Can any safe people or services support your client in getting their pet an emotional support animal certification to protect them under housing laws?

Legal Issues: Who can your client call if they get arrested during a violent situation or for doing something to ensure their survival (e.g. shoplifiting)? Can this safe person or service help them with bail or connect them to affordable legal representation?

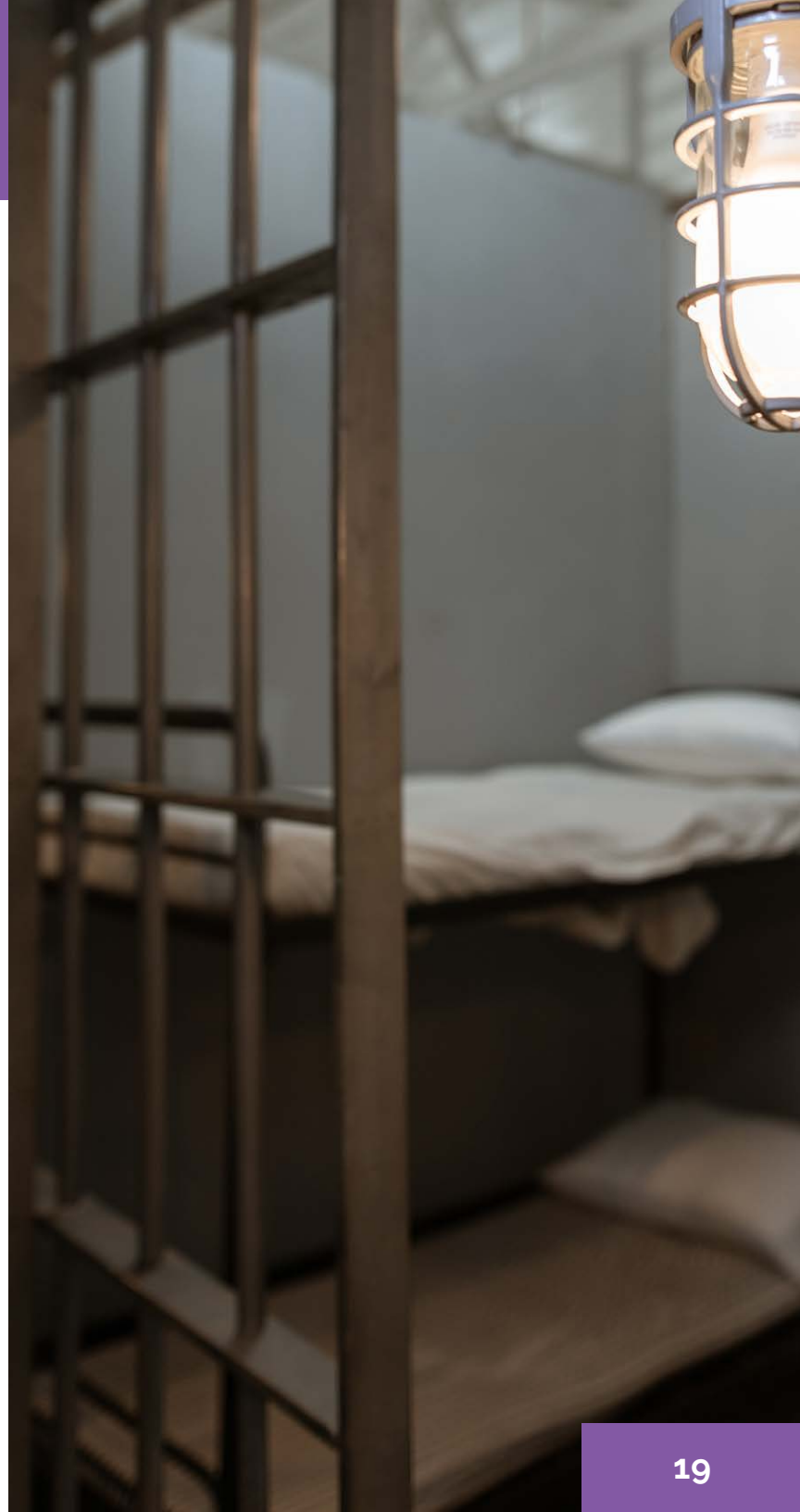
Important Documents: Can your client gather all of their important documents (ID, birth certificate, passport, etc.) and keep them somewhere safe without the perpetrator knowing? Can they keep them with a safe person? If they can not gather their documentaion can they make copies and store it somewhere safe? If your client does not have important documents can a safe person or service help them get new ones?

Healthcare: If your client relies on the perpetrator for healthcare benefits or caregiver support who can help them find other accessible options?

THE CRIMINALIZATION OF GENDER-BASED VIOLENCE

CARCERAL FEMINISM

Carceral feminism refers to feminists and feminist organizations that rely heavily on police and the legal system as a dominant intervention strategy to GBV. Carceral feminism works under the assumption that increased surveillance, policing and incarceration will resolve GBV while failing to acknowledge the ways in which the state perpetrates violence through prisons, immigration laws and raids, detention centres, and the over policing of BIPOC communities (Whalley & Hackett, 2017). The common misconception that GBV can be mitigated by increased reliance on the carceral state can be traced back to the anti-violence movement which consisted of several more specific movements that were prominent throughout the 1970's in the United States and Canada. During this time, neoliberal ideologies of privatization, decreased government expenditure and increased individual responsibility were on the rise, thus the anti-violence movement merged its values to fit a neoliberal agenda. Rather than shifting efforts to increase social supports such as housing or income assistance as this would both reduce factors that lead to GBV as well as benefit those most vulnerable, social services were gutted while investments went into the legal system. The push for increased criminal intervention resulted in GBV being perceived as a legal issue fueled by criminal tendencies rather than a social issue with roots in broader forms of societal inequity (Kim, 2018). It is no surprise that the voices of BIPOC women and gender diverse people within the anti-violence movement were dismissed by white women who would not suffer the consequences of mitigating GBV with state violence to the extent that BIPOC would. Dominating forms of white feminism disregard the ways that heterowhiteness is embedded into laws, and white feminist's reliance on carceral action as a response to gender violence reflects neoliberal practices that govern racialized and impoverished people through crime (Whalley & Hackett, 2017).



INTERSECTIONALITY AND CRIMINALIZATION

Gender-based violence intersects with other aspects of an individuals identity such as their race, class and sexuality to create a unique and complex experience of discrimination, oppression and trauma. Intersectionality refers to the ways in which discrimination and disadvantage are conceptualized in society on a single-axis framework that erases the experiences of Black women and those who are "multiply-burdened", as focus is either solely put on either race or gender and never how oppression is experienced from multiple aspects of a person's identity occurring simultaneously (Crenshaw, 1991, as cited in Rice et al., 2019). Gender and racial oppression are interconnected and social conditions such as poverty and unemployment have been shown to increase GBV (Gill, 2018) putting marginalized communities at greater risk. Systems of power and inequity within the broader context of our society have an influence on personal manifestations of violence, therefore require us to examine the unique ways that gender overlaps with other forms of oppression. Gill (2018) discusses the historical connections of racism to GBV in the present, stating:

> *From early history of colonization, slavery and unethical medical experimentation on Black bodies, to the criminalization of sex work, which allows for racialized and gendered police profiling and abuse of transgender and cisgender women of color, the roots of personal and state violence against marginalized bodies are well-formed. Further, the unintended consequences of past domestic violence and sexual assault laws and policy have often disproportionately impacted women and girls of color, leading to increased policing in communities of color, mandatory arrests, escalation of violence and excessive force by police officers and other first responders to domestic violence calls. (Para. 5).*

As a result of multiple social inequities Black women, trans and nonbinary people are at an increased risk of experiencing death from intimate partner violence, yet they can not rely on the police to keep them safe as they also face a high risk of experiencing violence enacted by the state. Barriers created by these social inequities such as fear of the legal system and social services, lack of financial security, fear of deportation, lack of child care and lack of affordable housing are common barriers that Black women, trans and nonbinary people face when seeking help (Gill, 2018). An intersectional feminist approach is critical inaddressing GBV as it emphasizes the ways in which social categories influence experiences of violence and how mainstream services often fail to meet the unique needs of people experiencing multiple forms of oppression. (Kulkarni, 2019).

POLICE AND GENDER-BASED VIOLENCE

Despite the mass funding that police departments are granted, there is little to no oversight in regards to how law enforcement handle situations of domestic and GBV violence (Jones et al., 2022). The lack of oversight and accountability of law enforcement creates an environment where police are able to act on their own personal biases, abuse their power and contribute to gender based violence with little to no consequences. "Data on police domestic violence is not only notoriously difficult to gather but also skewed by a culture of silence and intimidation, it suggests that police officers in the United States perpetrate acts of domestic violence at roughly 15 times the rate of the general population." (Burmon, 2022, para 3).

ABORTION

As doulas, it is important to support clients in all outcomes of a pregnancy, and therefore to understand how abortion services can be accessed and what they involve. Abortion in Canada is completely decriminalized, it is health care. It is publicly funded. Access depends on where you live and who is trained to provide care in your area. Abortion is normal, common and safe. For help finding care near you, you can contact **Action Canada for Sexual and Reproductive Health and Rights** access line: 1-888-642-2725.

MEDICATION ABORTION
(MIFEPRISTONE & MISOPROSTOL)

Medication abortion includes two medications: 1 mifepristone pill and 4 misoprostol pills, taken 24 hours apart. It can take a few days to work, and involves heavy bleeding, cramping and expelling the tissue at home. In Canada, primary care providers (GP, NP) are authorized to prescribe Mifepristone. The medication is publicly funded for people who have a health card.

Due to COVID-19, many providers started using telemedicine to provide what is called 'no touch' or 'low touch' abortion- meaning you don't have a physical appointment, just a phone call and you can receive medication at your pharmacy after.

ASPIRATION (SURGICAL) ABORTION

Aspiration abortion in the first trimester is a short procedure: first, the cervix is frozen with regional anesthetic, then dilators are used to open the cervix, and then a small tube is inserted through the cervix into the uterus, and suction is used to remove the tissue. Pain relief is provided. It can be performed by family physicians or obstetrician-gynecologists in either a clinic or a hospital. In the second trimester and beyond, the procedure takes longer.

NOVA SCOTIA

In Nova Scotia, abortion is accessed through self-referral. Call **1-833-352-0719**. A nurse will do an intake, help the client decide between medication and aspiration abortion, and make arrangements for care as close to home as possible. The nurses will arrange any bloodwork or ultrasound if needed, and provide info about birth control options. There are several surgical/aspiration abortion sites in NS, but most care is provided at the abortion clinic in the Dickson building of the VG in downtown Halifax. There are dozens of medication (pill) abortion prescribers across the province, from Sydney to Yarmouth. Medication abortion is available to 9 weeks gestational age. If you are under 9 weeks, whether you choose medication or aspiration abortion depends on your personal preferences and circumstances. Aspiration abortion is available to 16 weeks. If you are beyond 16 weeks, the nurses will help you get care out of province. You can also speak to a counsellor.

Image by Julia Hutt

INCLUSIVE BIRTHING TERMS

Not everyone who is pregnant or has a baby is a mom! The following chart gives a few alternative options you can use for common terms around birthing and labour. This chart of terms is not exhaustive or authoritative. Always talk with your doula client about how they talk about their body, birth process and experience and ask how they would like you to talk about it. Please note: These terms will not be accurate for every situation. It is important to know the terms and language your client uses to ensure you provide safe, compassionate support. The type of language you use in relation to your clients experiences with violence is important as this can have an impact on how your client sees themself, their experience, and their current situation. Be mindful that you are not using terms/phrases that promote victim blaming, a lack of autonomy or an overall toxic message.

Images by Julia Hutt

COMMON LANGUAGE	INCLUSIVE ALTERNATIVES
Breast feeding	**Chest feeding, nursing.**
Breasts	**Chest**
Breast pump	**Nursing device, nursing pump.**
Women in labour	**Labouring person, person in labour, birthing person, person giving birth.**
Woman, Women	**Person with a uterus, egg producing person.**
Man, men	**Person with sperm, sperm producing person.**
Women abuse, violence against women	**Gender-based violence**
Victim	**Survivor**

BREAST/CHEST HEALTH AND BREAST/CHEST FEEDING

TERMINOLOGY

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

CHEST BINDING

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

INDUCING LACTATION

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

ADVOCACY/ASSERTING YOURSELF WITH HEALTHCARE PROFESSIONALS

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

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

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

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

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

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

Image by Julia Hutt

STRICT PRIVACY

A client may choose to be classified as "strict privacy" while they are admitted to hospital. Under this protocol, hospital staff will not provide any information about a patient to anyone inquiring, such as if they are in the hospital or their room number in the hospital. This approach is frequently taken by survivors of violence to prevent contact.

COPING AND SUPPORT STRATEGIES

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

1. Have a list of "pull cord" phrases for when you encounter inappropriate questions and attitudes from health care professionals, birth care workers, and hospital staff:
    - I do not see how that is relevant to this appointment."
    - "I am not comfortable answering that question."
    - "I have come to talk about _____ not _____."
    - "Can you tell me if what you are commenting on is related to why I am here?
2. If there are specific interactions you are worried about, ask your doula to role-play while you practice setting boundaries and communicating the kind of care you expect.
3. Assemble your team! Keep them looped in on your appointment days and times and let them know what you are concerned about or know you will encounter. They can then know to send words of care and affirmation when you are about to head to an appointment and / or to check in after.
4. If it feels safe and comfortable, ask your doula or the organization your doula practices with to approach the professional(s) or their office to directly or indirectly address any incidents that you felt to be harmful, innapropriate or upsetting. This can include the offer of training, supports and resources on gender based violence and trauma-informed care.

STRATEGIES FOR WORKING THROUGH ANXIETY AND TRIGGERS

HELPS ME FEEL SAFE

List some things that make you feel safe. This can be objects, people, places, sounds, smells, etc.

HELPS ME COPE

How do you cope with pain and fear?

There are many aspects of labour and childbirth which may cause individuals who have experienced gender-based violence to feel anxiety. Review the following chart of possible anxiety triggers. Make note of which evoke anxiety reactions for you. Describe what is fearful and triggering and work to develop a coping strategy that works for you.

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

PAIN RELATED TRIGGERS

MY TRIGGERS	MY FEARS	MY STRATEGIES
Change in physical appearance		
Nakedness/exposure of body		
Internal/pelvic exams		
Secretions and bodily fluids (blood, discharge)		
Blood draws/intravenous fluids		
Attachments to machines		
Restriction to bed		
AROM (Artificial Rupture of Membranes "breaking the water")		
Episiotomy/tearing		
Forceps or vacuum extraction		

PAIN RELATED TRIGGERS

MY TRIGGERS	MY FEARS	MY STRATEGIES
Cesarean section		
Holding baby		
Chestfeeding/nursing		
Postpartum (examinations of birth canal, stitches, fundal massage)		
Pain with labour contractions		
Pain related behavior (panic, loss of control)		
Pain medication side effects • Narcotics: groggy, sleepy,less pain, more relaxation, less alertness, loss of control • Epidural: numbness, less mobility, possible inadequate pain relief, less pain, more relaxation		
Post birth pain experiences (stitches, nursing, fundal massage)		
Bruises, scars or other visible marks caused by the pregnancy or care		

INTERPERSONAL/STRUCTURAL TRIGGERS

HEALTHCARE/MEDICAL SYSTEM	MY FEARS	MY STRATEGIES
Relationship with healthcare provider (gender, familiarity, trust, gender based violence knowledge)		
Strangers (unfamiliar caregivers, healthcare workers, students at hospital)		
Behavior of caregiving staff (respect, control, individual treatment, consent to touch, competent care)		
Issues regarding partner(s), doula, family, friends (disapproval, distrust, abandonment, physical violence, emotional abuse, verbal threats or threatening actions, control		
Certain smells, sounds, objects or phrases		
Certain subjects (the assumption/ mention of another parent being involved, questions/ comments about scars or other bodily marks that are not relevant to your care)		
The presence of police or social workers in the hospital		
Hospital security		
Vulnerability (potentially having to rely on healthcare providers, family, friends or partner(s) to assist with daily activities while you recover such as bathing, walking, using the restroom)		
Judgment from hospital staff		
The presence of male presenting people		

COMFORT POSITIONS FOR BIRTHING

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

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

COMFORT POSITIONS FOR BIRTHING

Considerations for Selecting Positions

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

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

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

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

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

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

Standing Positions

Lunge Standing

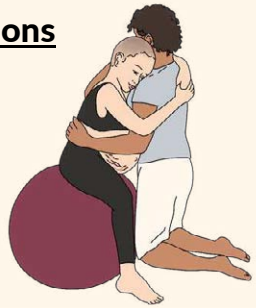
Standing Supported

Leaning Forward

Slow Dancing

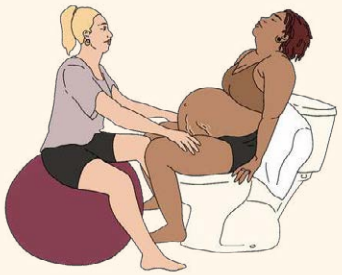
Seated Positions

Sitting Upright



Sitting Leaning Forward

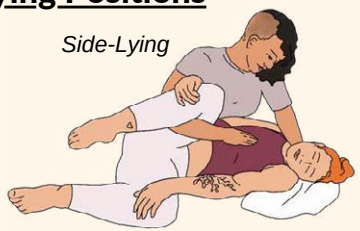
Sitting on Commode



Semi-Sitting

Kneeling / Lying Positions

Kneeling Over Birth Ball



Side-Lying

Kneeling Lunge

Kneeling Using Chair

Knees to Chest

Hands and Knees

Squatting Positions

Supported Squat

Lap Squat

The Dangle

Tips for supporting people's weight:

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

Never bend at the waist to lift.

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

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

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

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

Artwork created by: Audrey Chan and Julia Hutt

LABOUR ANALGESIA

DEFINITIONS

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

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

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

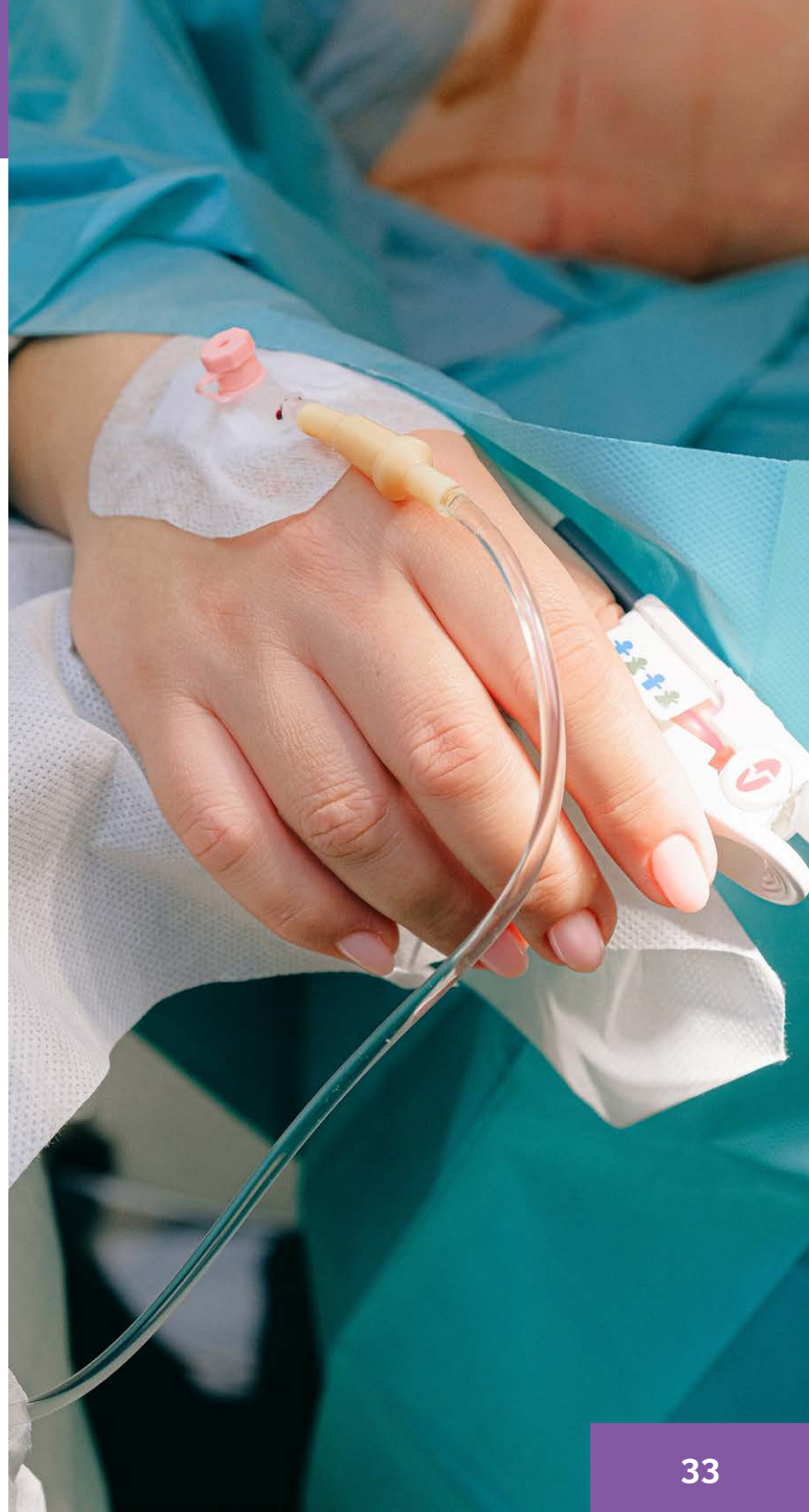
Inhaled nitrous oxide (N_2O): "laughing gas"

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

Patient controlled analgesia (PCA): "pain pump"

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

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



COMPARING PAIN CONTROL METHODS

INHALED N20

Benefits

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

Potential Side Effects

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

Disadvantages

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

PATIENT CONTROLLED ANALGESIA

Benefits

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

Potential Side Effects

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

Disadvantages

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

Rare Risk

- Respiratory depression in the birthing person or the baby

EPIDURAL

Benefits

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

Potential Side Effects

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

Disadvantages

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

Very Rare

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

POSITIONING FOR EPIDURALS

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

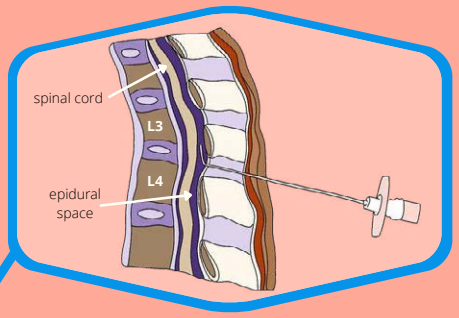
POSITIONS FOR EPIDURAL INSERTION

Preferred Position

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

Alternate Position

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



What NOT to do:

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

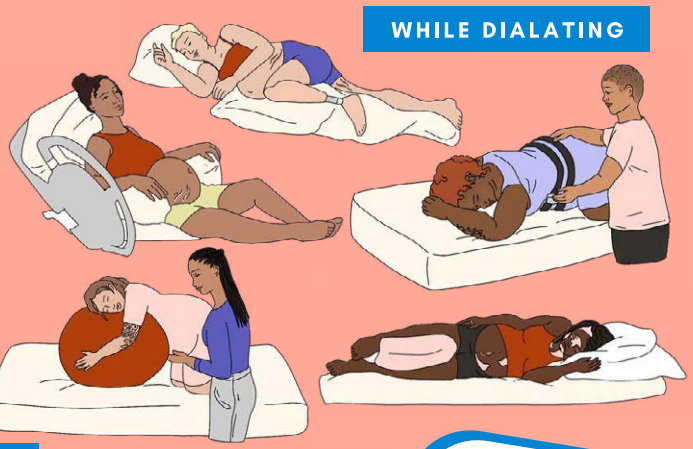
EPIDURAL RESTING POSITIONS

Here are some suggested comfort positions.

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

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

WHILE DIALATING



FULLY DIALATED

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

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

EPIDURALS: DESTIGMATIZING COMMON MYTHS

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

FACT: EPIDURALS DO NOT AFFECT RISK OF CESAREAN DELIVERY

Myth: "They make labour longer!"

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

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

FACT: EPIDURALS ARE SAFE FOR BOTH BIRTHING PEOPLE AND BABIES

Myth:
"But epidurals cause chronic back pain"

FACT: THEY ARE NOT ASSOCIATED WITH CHRONIC BACK PAIN

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

FACT: IT DOES NOT ENTER THE SPINAL CORD

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

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

Myth:
Epidurals cause autism

FACT: THEY DO NOT CAUSE AUTISM

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

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

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

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

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

UNDERSTANDING THE C-SECTION

WITH ANESTHESIOLOGIST DR HILARY MACCORMICK

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

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

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

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

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

Types of Neuraxial Anesthesia

Epidural

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

Spinal

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

CSE

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

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

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

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

BIRTH PLAN

Due date:

I will give birth at:

My primary caregiver(s) and their pronouns are:

My support people and their pronouns are:

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

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

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

BIRTH PLAN FOR LABOUR PREFERENCES

Stage 1

Pain Control:

Medical Interventions:

Stage 2

Positioning:

Pushing Efforts:

Medical/Surgical Interventions:

Other important information regarding labour and birth

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

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

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

BIRTH PLAN FOR POSTPARTUM

Plans for feeding
(Chestfeeding/nursing, formula, co-nursing, a combination):

How I feel about visitors
(who is welcome, who is not welcome, times I do not want to be disturbed):

Pain control:

Follow up after discharge:

Additional questions, concerns, needs:

Educational needs:

HOSPITAL BAG PACKLISTS

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

PACKLIST FOR THE PERSON GIVING BIRTH

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

PACKLIST FOR YOUR BABY

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

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

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

PACKLIST FOR THE DOULA

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

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

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

PACKLIST FOR OTHER SUPPORT PEOPLE

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

NEWBORN CARE PLAN

NAME:

BABY'S CARE PROVIDER:

MY SUPPORT PEOPLE ONCE I'M HOME WITH BABY

INFANT FEEDING PLAN:

CHESTFEEDING, NURSING, FORMULA, A COMBINATION OF BOTH

How can your doula support your feeding plan?

I have the following experience with newborns:

Newborn care issues, fears, or concerns:

Newborn exam and procedures, including immediate immunizations:

Unexpected problems with the newborn:

Educational needs (baby care / feeding):

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

PREGNANCY LOSS RESOURCES

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

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

Reproductive losses: challenges to LGBTQ family-making, by Christa Craven. 2019.
Book is available in Novanet and can be borrowed with any Nova Scotia public library card. Contact your local university library to borrow or follow the instructions here: https://www.novanet.ca/about/mission-core-activities/community-borrowers/

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

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

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

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

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

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

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

GENDER-BASED VIOLENCE RESOURCES IN NOVA SCOTIA

SHELTERS AND HOUSING SERVICES

Bryony House
Dartmouth
902-429-9002

Adsum House
Halifax
902-423-4443

Barry House
Halifax
902-422-8324

Alice House
Halifax
902-466-8459

Tearmann House
Antigonish
902-752-0132

Harbour House
Bridgewater
902-543-3665

Chrysalis House
Kentville
902-679-1922

PROGRAMS AND SERVICES FOR PEOPLE WHO HAVE EXPERIENCED GBV

Every Woman's Centre
Sydney
902-567-1212

Antigonish Women's Centre and Sexual Assault Services
Antigonish
902-863-6221

Avalon Sexual Assault Centre
Halifax
902-422-4240

Colchester Sexual Assault Centre
Truro
902-897-4366

LEGAL SUPPORTS

Dalhousie Legal Aid
Halifax
902-423-8105

Coverdale Courtwork Society
Halifax
902-422-6417

Elizabeth Fry Society of Mainland Nova Scotia
Dartmouth
902-454-5041

Nova Scotia Legal Aid
Multiple locations across Nova Scotia
Visit **nslegalaid.ca/legal-aid-offices/** for specific locations and phone numbers.

REFERENCES

Attridge, D. (2018) *Be an active bystander, Breaking the silence - preventing harassment and sexual misconduct*. Available at: **https://www.breakingthesilence.cam.ac.uk/prevention-support/be-active-bystander**

Buczynski, R. (2022) *How to help your clients understand their window of tolerance*, NICABM. Available at: **https://www.nicabm.com/trauma-how-to-help-your-clients-understand-their-window-of-tolerance** Burmon, A. (2022, July 6). Police violence at home: What the numbers say. Fatherly. **https://www.fatherly.com/life/police-brutality-and-domestic-violence#:~:text=Though%20data%20on%20police%20domestic%20violence%20is%20not,15%20times%20the%20rate%20of%20the%20general%20population**.

Champine, R. B., Lang, J. M., Nelson, A. M., Hanson, R. F., & Tebes, J. K. (2019). Systems measures of a traumainformed approach: A systematic review. *American Journal of Community Psychology*, 64(3–4), 418–437. **https://doi.org/10.1002/ajcp.12388**

Dekel, S., Ein-Dor, T., Ruohomäki, A., Lampi, J., Voutilainen, S., Tuomainen, T.-P., Heinonen, S., Kumpulainen, K., Pekkanen, J., Keski-Nisula, L., Pasanen, M., & Lehto, S. M. (2019). The dynamic course of peripartum depression across pregnancy and childbirth. *Journal of Psychiatric Research*, 113, 72–78. **https://doi.org/10.1016/j.jpsychires.2019.03.016**

Drexler, K. A., Quist-Nelson, J., & Weil, A. B. (2022). Intimate partner violence and trauma-informed care in pregnancy. *American Journal of Obstetrics & Gynecology MFM, 4*(2), 100542. **https://doi.org/10.1016/j.ajogmf.2021.100542**

Fournier, A. (2021). Language and gender based violence. *Black Voice*. **https://www.blackvoice.ca/articles/gender-based-violence/language-and-gender-based-violence/**

Gill, A. (2018). Survivor-centered research: Towards an intersectional gender-based violence movement. *Journal of Family Violence, 33*(8), 559–562. **https://doi.org/10.1007/s10896-018-9993-0**

Government of Canada. (2021). *What is gender-based violence?* **https://women-gender-equality.canada.ca/en/gender-based-violence-knowledge-centre/about-gender-based-violence.html**

Jones, E., Ajadi, T., Bonn, M., Bowden, A., Carvery, J., Dryden, O., Farahbakhsh, C., Gordon, S., Low, C., Mcclintock, C., Powley, J., Richardson, G., Swaine, R., Lead, P., Critchley, H., Rodgers, J., Bruno, F., Crudo, M., Curtis, S., & Guscott, N. (2022). *Defunding the Police: Defining the Way Forward for HRM*. **https://www.halifax.ca/sites/default/files/documents/city-hall/boards-committees-commissions/220117bopc1021.pdf**

Kim, M. E. (2018). From carceral feminism to transformative justice: Women-of-color feminism and alternatives to incarceration. *Journal of Ethnic & Cultural Diversity in Social Work*, 27(3), 219–233. **https://doi.org/10.1080/15313204.2018.1474827**

King, E. A. (2017). Outcomes of trauma-informed interventions for incarcerated women: A review. International Journal of Offender Therapy and Comparative Criminology, 61(6), 667–688. **https://doi.org/10.1177/0306624X15603082**

Kulkarni, S. (2019). Intersectional trauma-informed intimate partner violence (ipv) services: Narrowing the gap between ipv service delivery and survivor needs. *Journal of Family Violence, 34*(1), 55–64. **https://doi.org/10.1007/s10896-018-0001-5**

Marcoux, N., Roberts, J., Chan, A., Hutt, J., MacIntosh, C. (2021). *Queer doula toolkit*. Nova Scotia Interest Group. **https://www.nspirg.ca/wp-content/uploads/2021/06/Queer-Doula-Toolkit-2.pdf**

Mayo Clinic. (n.d.) *Post-traumatic stress disorder (Ptsd)—Symptoms and causes*. **https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967**

Miguez, M. C., & Vázquez, M. B. (2021). Risk factors for antenatal depression: A review. *World Journal of Psychiatry, 11*(7), 325–336. **https://doi.org/10.5498/wjp.v11.i7.325**

Mosley, E. A., & Lanning, R. K. (2020). Evidence and guidelines for trauma-informed doula care. *Midwifery, 83*, 102643. **https://doi.org/10.1016/j.midw.2020.102643**

Muzik, M., Ads, M., Bonham, C., Rosenblum, L., K., Broderick, A., Kirk, R. (2013). Perspectives on trauma-informed care from mothers with a history of childhood maltreatment: A qualitative study. *Child Abuse & Neglect, 37*(12), 1215–1224. **https://doi.org/10.1016/j.chiabu.2013.07.014**

Rafferty, J., Mattson, G., Earls, F. M., Michael W. Yogman, W. M. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics 143* (1) **https://publications.aap.org/pediatrics/article/143/1/e20183260/37306/Incorporating-Recognition-and-Management-of**

Rice, C., Harrison, E., & Friedman, M. (2019). Doing justice to intersectionality in research. *Cultural Studies Critical Methodologies, 19*(6), 409–420. **https://doi.org/10.1177/1532708619829779**

Shim, H. (n.d.). ***Safety planning and intimate partner violence***. Community Justice Exchange.

Siegel, D. (1999). *The Developing Mind*.

Sperlich, M., Seng, J. S., Li, Y., Taylor, J., & Bradbury-Jones, C. (2017). Integrating trauma-informed care into maternity care practice: Conceptual and practical issues. *Journal of Midwifery & Women's Health, 62*(6), 661–672. **https://doi.org/10.1111/jmwh.12674**

Walker, P. (2013). *Complex ptsd: From surviving to thriving: a guide and map for recovering from childhood trauma*.

Whalley, E., & Hackett, C. (2017). Carceral feminisms: The abolitionist project and undoing dominant feminisms. *Contemporary Justice Review, 20*(4), 456–473. **https://doi.org/10.1080/10282580.2017.1383762**

WELLNESS WITHIN

An Organization for Health & Justice

wellnesswithinns.org