

Complicating Acts of Advocacy:

Tactics in the Birthing Room

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“Yeah, so yelling at the nurse very clearly does not make this right. She’s just a messenger. There is a way to be diplomatic about it. I like to play the dumb part a lot: ‘You know, I really don’t understand... could you clarify this for me?’ That used to work a lot better as a work-around.”

—Emily

“Sometimes it’s more talking to myself and talking to the client, like telling them what I see is going on because I guess in that case, my hope is that the provider is hearing it and even if they are not responding, that they are aware that I see what’s going on, and I’m making my client aware of what’s going on. ... I know they hear me: the provider can hear me, and the nurses can hear me.”

—Margaret

“My client is completely bewildered, she is in pain. So me in that moment, I just put my hand on the nurse’s hand that had her breast, and said, ‘could you please not do that?’ And that’s

all I said in that moment. And the nurse, she looks at me and she rolls her eyes, but she let go, which is what was important to my client. Afterwards my client said, 'thank you for that.'

—Malika

These were the stories told by three different doulas when I asked them for examples of the tactics they deployed to help their marginalized birthing clients achieve an empowering birth experience—namely, to help their clients maintain and exercise bodily autonomy and the right to make truly informed and uncoerced medical decisions in the hospital.¹ Doulas, also referred to as birthworkers, are trained, non-clinical professionals who “provide continuous physical, emotional and informational support to [the gestational parent] before, during and shortly after childbirth to help [them] achieve the healthiest, most satisfying experience possible” (DONA 2020). Numerous clinical studies have demonstrated that doulas effectively improve the health outcomes for both the birthing person and the infant (Gruber, Cupito, and Dobson 2013; Hodnett et al. 2012). Given recent attention on the US maternal mortality crisis, especially the high rate of mortality and morbidity among black women and infants, state governments, researchers, and the news media have turned to doulas as a potential solution to improve birth outcomes (Quinn 2018; Simmons 2017; Gruber, Cupito, and Dobson 2013).

While mainstream news reports and childbirth education materials often describe doulas as advocates for their clients, many of the thirty doulas I interviewed did not identify as advocates for their clients in the birthing room based on the term’s conventional definition (American Pregnancy Association 2012; Murkoff 2019). Rather, doulas, attuned to the power difference between them, their clients, and the medical institution, engage in complex performances that do not fit the conventional definition of advocacy as overt lobbying or persuasion. They deploy what I term “soft advocacy” to center the interests of their birthing clients while ensuring that the birthing room remain a calm environment for all. Doulas’ enactment of soft advocacy is transferrable to community-engaged researchers

1 Interview with Emily, Oct 1, 2018; Interview with Margaret, Aug 27, 2018; Interview with Malika, Aug 30, 2018.

who want to advocate for their participants' interests, but due to constricting factors, cannot afford to overtly challenge the status quo.

In this article, I first situate the work doulas perform for pregnant and birthing people within the context of birth and reproductive justice. I then offer an overview of the definitions and connotations of advocacy at the intersection of rhetorical studies and birthwork. To amplify the experiences and embodied knowledge of doulas, I then analyze three tactics of soft advocacy they deploy to support their clients to help protect their autonomy and agency during labor and birth: creating deliberative space, cultural and knowledge brokering, and spatial maneuvering. By doing so, I demonstrate that advocacy can be reframed as affective embodied practices that subtly shift the existing power dynamics to make room for marginalized stakeholders and interlocutors. While this article spotlights the tactics birth doulas deploy in hospitals, community-engaged researchers and activists who navigate uneven power relations and institutional terrains across stakeholders may invent new soft advocacy tactics that best suit their rhetorical situations.

BIRTH JUSTICE

Situated within the broader framework of reproductive justice, birth justice emphasizes the bodily autonomy, agency, and empowerment of pregnant and birthing people, focusing primarily on the decisions they made for themselves and their babies during pregnancy, labor, and postpartum (J. Oparah and Bonaparte 2016). Like the reproductive justice framework, birth justice calls for an attunement towards intersecting systems of oppression that lead to disempowering or traumatic birth experiences, particularly among poor women of color, queer and trans people, immigrants, and survivors of sexual violence (J. C. Oparah et al. 2018). As the research collective Black Women Birthing Justice (2019) posits:

Working for Birth Justice involves educating the community, and challenging abuses by medical personnel and overuse of medical interventions. It also involves advocating for universal access to culturally appropriate, women-centered health care. It includes the right to choose whether or not to carry a pregnancy, to choose when, where, how, and with whom to birth, including access to

traditional and indigenous birth-workers, such as midwives and doulas, and the right to breastfeeding support.

Birth justice differs from the choice framework in that it emphasizes the birthing person's bodily autonomy and their right to self-determination, rather than commodifying birth alternatives and positing them as part of consumer rights (J. C. Oparah and Bonaparte 2016).

This framework centers the lived experiences of marginalized pregnant and birthing people, taking into account the intersecting systems and histories of oppression they face. Pregnant and birthing people who do not fit the standard of the "ideal mother" (i.e. women who are not cis, straight, thin, white, in their late 20s-30s, and middle-upper class) are often diminished, demeaned, and/or coerced by medical providers into treatments and interventions that they do not want (Davis 2019; Mulherin et al. 2013; J. C. Oparah et al. 2018). When systemic biases are compounded with esoteric medical language, oppressive institutional practices, and a general culture of fear surrounding childbirth, marginalized birthing people may not be empowered enough to assert their agency and thus are more susceptible to obstetric violence (J. C. Oparah et al. 2018; Yam 2019).

Doulas are key actors in birth justice because their liminal professional and social position in the medical institution allows them to effectively observe and support pregnant and birthing people: unlike obstetricians who have attended years of formal training and are staunch members of the medical institution, doulas have not been inducted into the technocratic model of birth and medicine which prioritizes efficiency, standardization of care, and hierarchies of authority within the organization (Davis-Floyd 2018). Rather, doulas are trained to attend only to their clients' interests, agenda, and preferences (DONA 2017). For example, when her Muslim client repeatedly touched her bare head and told her she felt "too exposed" in the stirrup position the obstetrician had put her in, doula Brooke put a warm towel over her client's head, and asked the doctor if they could try a side-lying position. Soon after, her client gave birth successfully.² As trained professionals who have attended

² Interview with Brooke, Aug 24, 2018.

and seen many more births than their clients, doulas also possess the knowledge and composure to inform, support, and help their clients negotiate different scenarios throughout the labor and delivery process.

The roles doulas play to advance birth justice are particularly important when it comes to the birth experiences of marginalized people such as women of color, and queer, trans, or non-binary people. In addition to the prevalence of obstetric racism, in which pregnant and birthing people of color are treated more poorly by their medical providers on the basis of race, research in psychology and public health has also posited that the increased stress black people experience from institutional racism contributes to poor infant and maternal health outcomes (Geronimus 1992; Giscombé and Lobel 2005). Ample evidence-based research thus far has demonstrated that doula support helps marginalized birthing people and infants achieve a better health outcome (Kozhimannil et al. 2016; Thomas et al. 2017). Finally, while much research still needs to be conducted on the birth experiences and outcomes of trans people, doulas and midwives have been on the forefront of supporting the pregnancy and birth of LGBTQ* people (King-Miller 2018).

Researchers and practitioners in nursing and midwifery have identified the four pillars of support that birthworkers, including doulas, perform: physical support, emotional support, informational support, and advocacy (Anderson 2016; Goer 2012). While the first three pillars are commonly accepted by doulas as their scope of practice, advocacy remains controversial based on differing beliefs and definitions of the concept (Dekker 2017). In order to understand the complex meanings of advocacy for birth workers, I analyze how birth doulas conceptualize and enact advocacy in support of their clients.

Method

In 2018, I conducted participant-observations at two doula trainings, and thirty semi-structured interviews with birth doulas and doula trainers—each lasting about one to two hours. While the two trainings I attended allowed me insights into the cultures, ideological lineages, and professionalization of the doula profession,

the qualitative interviews reveal how doulas make sense and make use of their training in their everyday work, as filtered through their and their clients' needs and lived experiences.

The interviewees were recruited via social media advertising and snowball sampling. While doulas are primarily white, middle-upper class straight married women, motivated by the reproductive justice framework that centers the stories and perspectives of marginalized people of color, I sought to recruit participants who occupy intersecting marginalized positionalities (Morton and Clift 2014; Solinger and Ross 2017). All interview participants identified as women, and the sample included nine women of color, two deaf people, and four queer people. While most serve primarily private clients, many of them offer a sliding scale fee or work with programs that offer low-cost or free birth support to low-income communities; two of my interviewees ran their own non-profits in addition to serving marginalized pregnant and birthing people.

During the interviews, I asked participants if they identified as advocates in their capacities as birth doulas. After asking them to elaborate on their response, I invited interviewees share the tactics they deployed during particularly challenging births to support their clients. Along with the doula trainings I attended, the interviews allow me to examine how birth doulas conceptualize and enact advocacy tactics that promote their clients' interests without creating hostility.

ADVOCACY IN RHETORICAL STUDIES AND BIRTHWORK

While *advocacy* is a ubiquitous concept in rhetorical studies, its existing definition and usage in the field poses various limitations to understanding the different forms it could take outside of the dominant political contexts of law and policy. As Elizabeth Britt (2018) points out, advocacy is “a surprisingly taken-for-granted concept” with two interconnected meanings: “(1) to argue for an idea or cause and (2) to represent or speak for someone else,” with the intention to effect sociopolitical or institutional changes (7). Because advocacy in rhetorical studies is commonly situated within the context of public democratic discourse, acts of advocacy are

assumed to always be persuasive and forceful in the rhetor's attempt to overtly shift the status quo (Loehwing 2018).

The conventional definition of advocacy as overt persuasion has a significant impact on the ways in which doulas understand and perform their professional support role. Doulas I interviewed who rejected the “advocate” label outright often cited the dictionary definition of advocacy as speaking *on behalf of* another person. According to the Birth Doula Code of Ethics developed by DONA International, the first and most established doula training and certifying organization, doulas should not speak to medical staff on the clients' behalf, or make any decisions for the clients regarding their pregnancy and birth (DONA 2017). Doulas who subscribe to the conventional definition on advocacy, hence, see this stipulation from DONA as a prohibition for them to serve as advocates for their birthing clients. Yet, because the DONA training manual does not clearly define advocacy and what forms it may take within a doula's scope of practice, doulas I interviewed have devised different interpretations and performances of advocacy based on their own positionalities and the demographics of their clientele. For instance, while many white doulas reject the notion of advocacy as a problematic act of speaking for, most doulas of color I interviewed unequivocally see themselves as advocates for their clients. Sabia Wade, a queer black doula who provides voluntary birth support to incarcerated people and low-income families, posits on Instagram that “doulas who don't believe in doulas advocating for their clients aren't dealing with disparities, lack of accessibility and insecurity in the system” (@theblackdoula, Oct 6, 2019). How doulas conceptualize advocacy, hence, is tied not only to rhetorical construction of the term, but also to racial politics in obstetrics and birthwork.

The power dynamic between medical staff and doulas in the birthing room prohibits certain performances of advocacy, thus further complicating how doulas interpret and enact their roles as advocates. Because doulas are typically women who have not received formal medical training, they occupy a precarious position in the birthing room: they can be asked by the obstetrician or midwife to leave at any point. Doulas, therefore, must find ways to serve their clients without offending medical professionals who wield more power in

the institution space. As Traci, a seasoned white doula, pointed out in her interview, she always communicated tactically in the birthing room so that “the provider knows that [she was] watching, but he or she wouldn’t think that [she was] being confrontational.”³ Similar to women who perform other forms of care work professionally, doulas like Traci engage in “affect management” to emotionally appease the medical staff so that they can effectively support their clients (Hochschild 2012; Lagman 2015).

The stakes for successful affect management are even higher for doulas of color in my study, who remarked that they were often treated with immediate suspicion—and sometimes contempt—by white medical staff when they entered the birthing room. Given this power imbalance and the conventional association between advocacy and confrontation, doulas either reject the label of an advocate altogether to avoid offending the providers, or they resort to soft advocacy that allows them to effectively support their clients in having a positive birth experience.

Taking into account doulas’ desires to support their clients and their reluctance to speak on behalf of those clients, birth researcher Rebecca Dekker defines advocacy in doula work as “supporting the birthing person in their right to make decisions about their own body and baby” (2017). Since doulas provide a myriad of physical, informational, emotional, and material support for clients, Dekker’s definition requires us to not limit our objects of study to overt and discursive acts of persuasion. By moving away from defining advocacy as overt persuasions to shift public opinions, researchers can better capture the ways in which community stakeholders enact advocacy through affective management and embodied communicative acts that are contingent upon specific institutional contexts, power relations, and the conflicting demands, agendas, and cultural norms different to which stakeholders subscribe.

SOFT ADVOCACY IN THE DELIVERY ROOM

Even among those who identified as advocates, the doulas I interviewed were keenly aware of their precarious status in the hospital delivery room. Interviewees expressed that this precariousness informed how

³ Interview with Traci, Aug 31, 2018.

they enacted advocacy: instead of seeing advocacy as overt forms of confrontation and persuasion, they advocated for their clients' bodily autonomy and interests in ways that hold medical staff accountable without upsetting them. The tactics of soft advocacy I outline below may be transferrable to community-engaged researchers who must negotiate complex power relations and institutional constraints.

Creating Deliberative Space

Many interviewees—particularly white interviewees who were not immediately treated with disdain and suspicion by medical staff—stated that they deployed tactics that would help create time and space for their clients to exercise more agency and autonomy in making medical decisions their birth. Margaret, a doula who serves clients in Kentucky, noted that she was “hyper aware” of what the medical staff did in the birthing room because the birthing person and family might not notice many details. Because many of Margaret's clients were afraid to be seen as “bad patients,” Margaret enacted advocacy by making the space for her clients to ask questions and express concerns:

If I see that [the client and their family] are not gonna ask the question, then I will talk to the nurse, and say, “you know, on her birth preferences she said she doesn't want IV fluid. She just wants to be able to drink water, and I see that you are hooking her up to the IV.” And then deferring to my client—they see that I have initiated the conversation, started the conversation, so sometimes they'd be more comfortable to say, “that's right, we didn't want that.” Most of the time it's just amplifying their voices, reminding clients to ask questions [...] I am happy to open up the conversation and then they usually feel comfortable: they are not even having to have the conversation, they are just having to listen and respond.

Margaret's tactic exemplifies the kind of “affective management” common among domestic and care workers: by initiating the conversation for her clients to confirm their birth preferences, Margaret never directly challenged the power hierarchy that made her clients fearful in raising concerns. This allowed her to simultaneously

support her clients and help keep tension at bay between her, the birthing person, and the medical staff.

Similarly, while Emily had a Ph.D. in medical anthropology, she regularly, in her words, “played dumb” in front of medical providers. Instead of directly confronting medical staff when they pushed her clients to consent to non-emergency interventions against the clients’ birth preferences, Emily would pretend that she had little knowledge of the situation, and then proceeded to ask the medical staff a series of questions seeking clarification. Like Margaret who wanted to ease her clients’ concern about being seen as “bad patients,” Emily’s tactic of “playing dumb” allows her clients to listen in on the information the medical staff provides without having to risk being labeled as “difficult.”

Margaret and Emily were not alone in advocating for her birthing clients by calmly making time, as well as discursive and sometimes physical space for them and their family to make medical decisions. Several interviewees noted that, when a medical provider suggested a drastic intervention, they would first inquire if their clients were facing a medical emergency; if not, they would ask the birthing person and their family whether they would like some privacy to weigh their options before consenting to the procedure. While this tactic afforded the birthing person space to make a truly informed decision, some doulas stated that by stalling what medical staff considered to be routine procedures, this tactic could intensify the entrenched animosity some medical staff harbored towards doulas.

To minimize tension in the birthing room, doulas also drew on their keen observations as an outsider to hold medical staff accountable for their actions without triggering disgruntlement from them. Many interviewees pointed out that they would narrate what the medical staff were doing, especially if it appeared that they were preparing for an intervention that the birthing person had not consented to. Amy Gilliland, a seasoned doula trainer and researcher, clarified what this tactic entailed:

Say out loud what you see. For example, say “Oh, Nora I noticed Dr. X is picking up the episiotomy scissors. Did you have any

questions about that?” And if Dr. X continues, I can say, “Dr. X, I think Nora wants to talk about that first.” So, directly addressing the doctor is not the first thing that I would do—it is something that I would do especially if they were continuing something that I know my client would want to give specific consent for. First, trying to avoid [confrontation] and that’s a toughie because it can lead to physicians not liking you.

I call this soft advocacy tactic *play-by-play narration*: it reminds medical providers that a trained professional is observing, and hence, they should make sure that they have full consent of the birthing person before performing any interventions. Like the previously stated tactics, play-by-play narration also creates discursive space for the birthing person to actively participate in decision-making processes about their bodies and births.

While doulas deployed different tactics to create time and space for their birthing clients to make fully informed medical decisions, these tactics share several similarities and are reflective of the existing power hierarchy in birth. First, these tactics demonstrate that effective advocacy makes deliberation across power difference possible. By asking questions, verbalizing their observations, and helping their clients secure privacy and time before consenting to an intervention, doulas challenge the dominant assumption that only medical providers have the knowledge and authority to make decisions about birthing people’s bodies. Advocacy, then, should include not only confrontations and persuasions that directly challenge the status quo, but also performances that allow marginalized people to participate in deliberation and decision-making.

On the other hand, despite treating the interests and experiences of the birthing person as their first priority, doulas remain deeply concerned about potential backlash from the medical staff. Hence, they devised advocacy tactics that largely maintain the status quo at the hospital to avoid enraging providers and nurses. An anonymous doula interviewed in the podcast *Birth Allowed* (Birth Monopoly 2017) reflected on this dilemma: she was afraid to confront an obstetrician for forcibly conducting a vaginal exam on her client—what amounted to medical rape—because she felt that she and her

client would have no recourse. She lamented, “I want to yell at that person, but the most that would do, he would have booted me out of the room. She would have no one, basically” (Birth Monopoly 2017). Incidents like this highlight the limitations of advocacy tactics that work within the confines of the existing power structure. Advancing birth justice, thus, requires not only doulas advocating for their clients in the birthing room, but also systemic changes and critiques to the technocratic model of birth and medicine, as well as other forms of public advocacy that demand the medical institution respect birthing people’s bodily autonomy.

Cultural and Knowledge Brokering

Because the medical institution and the technocratic model of birth are hostile to and difficult to navigate for marginalized populations, doulas who work with non-normative birthing people—including non-native English speakers, people of color, queer people, and/or people with disabilities—often serve as cultural and knowledge brokers. Existing research on language brokering has shown that, as the mediator, the broker is able to address linguistic inequities in a way that sometimes challenges the existing power structure (Alvarez 2016). Brokering, by definition, is a form of mediation and negotiation between two cultures and/or discourse communities (Ward, House, and Hamer 2009). An effective broker, hence, needs to be knowledgeable of both communities and can transverse between them with relative ease. Based on my interviews, brokering in the context of doula work often entails 1) helping clients understand esoteric medical language and institutional practices when hospital staff fail to give clear explanations, and 2) communicating the clients’ birth preferences and desires to medical staff in a way that is more persuasive or intelligible to them. This form of brokering helps protect the clients’ autonomy by ensuring that they are in a position to give true informed consent to medical procedures.

Explaining how she made use of her knowledge and experience as a doula to support her clients in an unfamiliar hospital setting, Emily said, “sometimes as the doula I feel like it’s my job and to be the tour guide. I say, ‘Hey, okay, just I know this is what you wanted. But you know, this is what’s going on. So, let’s reinterpret the situation.’” While her work as a “tour guide” was sometimes as straightforward

as showing her client how to request more blankets, other times it required Emily to mobilize her specialized knowledge and inside-outsider status to help her clients achieve the birth they desired. Working with an undocumented immigrant who was unfamiliar with the hospital setting, Emily noticed that her client was reluctant to lay on her back—the default birthing position the obstetric had put her in. Because the birthing person did not feel empowered speaking directly to the medical staff, after talking to her client, Emily suggested the nurse to remove the stirrups so that her client could birth in a side-lying position. Emily reflected that she was successful in mediating between her client's desire and the hospital's routine practice because she had already cultivated a deep level of mutual trust with the nurses and doctors at that hospital. As a result, she was able to leverage her cultural capital to help her client fulfill her birth preference.

In addition to the relationship between doulas and medical staff, brokering as advocacy also hinges upon the bond the doula has with her client. Malika provided a concrete example of how she deployed language and cultural brokering as a form of soft advocacy. Malika's client, an African American woman, had an accidental homebirth followed by medical complications. After they were transported to the hospital by the ambulance, the client became physically unable to speak up for herself. Her husband, a French-speaking Afro-Caribbean immigrant, was confused about the information the medical staff was relaying to him about his wife's condition. Malika recounted:

We were the only three people of color in the room. All of the doctors and nurses that came into the room are white. The way it impacted my client is having someone they trusted that looks like them, that understood their values [...] in having gotten to know these people over the last few months, I had to—not translate, because I don't speak French—but I was able to speak to my client's husband in a way that for some reason he was not grasping the ways the doctors are speaking to him. I don't know though if it was a language barrier or it was a stress factor, but I was able to communicate with him in a way that he understood.

Because of the trust she had cultivated with her clients, Malika was able to communicate important and complex medical information to the husband in a way the doctors could not.

In addition to race, cultural difference, and immigration status, disability also poses a barrier for birthing people to access the information they need and to give birth according to their preferences while in a hospital setting. Ally and Brittany, two deaf doulas who serve primarily deaf clients, explained that not all hospitals provided in-person sign language interpretation—many hospitals relied on video remote interpreting (VRI) that digitally connected the birthing person with a sign language interpreter online. The issue, as Ally and Brittany identified, was that the tablets and software the hospitals used were often full of glitches and lags. In addition, they noticed that it was often difficult for birthing people to simultaneously concentrate on their labor, pay attention to a screen, and also be aware of their immediate surroundings. By being the sign language and cultural broker between their clients and the medical staff, Ally and Brittany allowed their clients to focus solely on their laboring process. While Ally and Brittany encouraged medical staff to talk directly to their clients, they signed to their clients to “put it in their language, expound as needed, make things more visual for them.”

For Ally and Brittany, the brokering occurs at the linguistic and cultural levels. When there was not an interpreter present in the room, the two of them helped mediate between their clients and the VRI technologies, ensuring that their client’s birth and ability to consent to medical procedures would not be impeded any lags by any lags with the technology. Like all other doulas whom I interviewed, Ally and Brittany emphasized that they were there for their clients, not the provider or the hospital, despite the fact that they sometimes filled the gap in accessible technologies that the hospital failed to provide. On the one hand, Ally and Brittany belong to the deaf community the way their clients did, and on the other, they were also knowledgeable of the medical institution and birth practices. As a result of this confluence, Ally and Brittany were able to broker the cultural differences between medical staff and their birthing clients. For instance, medical staff would often speak only to the interpreter or to Ally and Brittany, based on the wrong assumption

that deaf clients could not properly understand them. Ally and Brittany, therefore, saw it as their responsibility as doulas to always redirect the conversation, and remind the provider to speak directly to the birthing person. Outside of acts of brokering, the two noted that their clients appreciated having the presence of a deaf birth professional who understood their lived experiences and were there solely to support them.

Physical Touch and Spatial Maneuvers

While doulas most commonly discussed how they use language practices to advocate for their clients, several interviewees highlighted the importance of physical touch and body positioning in ensuring that their clients' body and wishes were respected by medical staff. Traci, a doula and doula trainer based in Alabama, stated that, when she encountered medical providers who were reluctant to listen to the birthing person, she often deployed what she called "the triangle of protection" to physically remind the providers and staff that her client was not alone:

I always put my physical body and between my clients and the staff if they don't know each other yet—say, it's an on-call doctor. I physically either stand beside [the client] or in between [the birthing client and the medical provider]. I just do that non-verbally until my client feels safe with them [...]. It just relieves tension, you know, to the family when they know that somebody is holding space physically.

Traci would sit back down once she saw that her client and/or her client's family felt comfortable enough to ask the providers questions about their care.

While Traci positioned her body to help the birthing person feel empowered enough to self-advocate, other doulas made use of physical touch to jolt the medical staff into seeing their clients as individuals with unique preferences and needs. For instance, Malika, a black Muslim doula who served primarily women of color, recounted that she once attended a birth in which a nurse who had just entered the birthing room forcibly pushed the newborn onto her client's breast to make the baby latch. When that happened, a different nurse

had already been pressing on the client's fundus, and the doctor was holding up the umbilical cord, attempting to detach the placenta. Malika, who had a background in social work, reflected that, while she tended to enact advocacy in the form of prenatal education rather than direct confrontation, in that moment she chose to address the nurse directly:

My client is completely bewildered, she is in pain. So, me in that moment, I just put my hand on the nurse's hand that had her breast, and said, "Could you please not do that?" And that's all I said in that moment. And the nurse, she looks at me and she rolls her eyes, but she let go, which is what was important to my client. Afterwards my client said, "thank you for that." [...] I am not speaking for my client and saying the things that I wish, you know. I am amplifying my client's voice in a moment when they are unable to do it themselves.

Malika further noted, "And in [the nurse's] mind, she is like, you know, check these boxes, "baby latched at this time," check, check, check. Sure, that was her job—she doesn't think she was doing any harm." Akin to Traci's "triangle of protection," Malika's action highlights the embodied nature of advocacy: in addition to discursively making clear her client's preferences to help her maintain bodily autonomy, by touching the nurse's hand, Malika also jolted the nurse out of her routine and reminded her to treat the birthing person in front of her as a person whose body is in pain and is disempowered.

CONCLUSION

This article examines the soft advocacy tactics deployed by doulas tasked with supporting their birthing clients while they themselves are also marginalized in a dominant medical setting. While these tactics may not directly apply to the specific rhetorical situations other reproductive justice activists and researchers encounter in their work, this study provides two key insights that could inform our praxis. First, while soft advocacy does not overtly subvert the status quo, it is a useful tool for advocates who are in a precarious situation outside of public view, and hence must mobilize affective management to ensure that they and their clients will not receive any repercussions. The soft advocacy tactics showcased in this article can

be repurposed and deployed by community-engaged researchers as they negotiate different sets of institutional expectations and power dynamics in and out of academia. For instance, researchers may mobilize soft advocacy tactics when they need to circumvent gate-keeping mechanisms in academia and other dominant institutions as they try to amplify the voices and interests of marginalized community partners and research participants.

Soft advocacy is a tool that allows marginalized people to advocate for their own interests and the interests of others while lessening the risk for institutional and personal repercussions. At its core, it is a tool for making do, and for subtly shifting the power dynamics in a given context so those who are the most marginalized can maintain autonomy. As researchers and activists committed to social justice, we will need not only soft advocacy, but also other tools and resources to build capacities that would actively challenge the status quo and shift power to communities that are currently the most marginalized.

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