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Against Gender Essentialism: Reproductive Justice Doulas and Gender Inclusivity in Pregnancy and Birth Discourse

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ABSTRACT

This article explores how reproductive justice (RJ) doulas support trans and nonbinary birthing people, while advancing more inclusive practices within the birth world. We begin by tracing historical changes in mainstream birth and pregnancy care to highlight how biological naturalism and woman-centered discourse became ingrained. Then, we analyze primary data, such as participant observations at doula trainings, interviews with RJ doulas, and training materials for birthworkers, to illuminate how RJ doulas mobilize RJ principles to provide gender-affirming advocacy and inclusive care to pregnant and birthing people of all genders. Key rhetorical strategies include (1) advocacy, (2) radical inclusion, and (3) self-reflexivity. Thus, our study extends existing feminist rhetorical scholarship on gender essentialism in popular pregnancy and childbirth discourse, expands scholarship on obstetric violence and marginalization of nonnormative birthing people, and explores rhetorical possibilities for redress.

KEYWORDS

Birthworker; doula; pregnancy and birth; reproduction; reproductive justice

> Only when our whole selves are recognized and honored in the care we receive can we come closer to obtaining birth justice—for true reproductive freedom means celebrating the needs of every person at all stages of sexual and reproductive life, not subsuming all bodies within one paradigm of reproductive care. The task of activist birth work is to uphold and further a culture of support in which all people feel they can access appropriate care for the full spectrum of their reproductive needs.
>
> —Alana Apfel

Queer families face significant challenges in reproductive and birth settings, and this is particularly true for trans and nonbinary parents. Many challenges are structural in nature, including providers' poor understandings of trans and queer fertility care and the occurrence of homophobic and/or transphobic treatment—even violence—in health care settings (Fixmer-Oraiz and Yam). Research demonstrates that medical macro- and microaggressions have detrimental effects on trans and nonbinary people, including deferral or avoidance of care (Shuster; Safer et al.). Moreover, the dominant culture of pregnancy and birth compounds these structural concerns through everyday discourses and material practices that center white, straight, cisgender women and heteronuclear

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family formation (Acosta; Fixmer-Oraiz and Wehman-Brown; Mack). Fortunately, queer, trans, and nonbinary birthworkers—such as those of the Queer Doula Network—are growing in numbers, claiming space in the world of birthwork, and offering new models of inclusive care that center the needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) and often Black, Indigenous, and people of color (BIPOC) communities. In this article, we explore the rhetorical practices of reproductive justice (RJ) doulas working with deep grit and determination to build more affirming spaces for LGBTQ families and, more specifically, for transmasculine and nonbinary birth.

Doulas provide physical and emotional support to birthing people during pregnancy, during childbirth, and in the postpartum period. We focus specifically on doulas in this article because as educators, support companions, and mediators between patients and medical providers, doulas are uniquely positioned to intervene directly in a setting that affords primacy to whiteness, wealth, and heteronuclear family formation (Yam, "Visualizing"). Previous studies have revealed how gender essentialism, white supremacy, and the technocratic model of childbirth are deeply ingrained in mainstream reproductive rhetoric (Davis-Floyd; Fixmer-Oraiz). Marika Seigel's work underscores how the intense medicalization of childbirth pairs with consumerism in ways that position the pregnant body as risky, dangerous, and in need of management. Mary Lay Schuster has written extensively on the rhetoric of midwifery—its rhetorical reliance on naturalism as an embodied alternative to the mainstream medical establishment. In addition, a growing body of scholarship in gender studies explores how RJ doulas are shifting the dominant terrain in which reproduction and childbirth unfold (Basile; Carathers; Yam, "Visualizing").

Reproductive justice is a revolutionary intersectional framework that reflects a long history of women of color–led activism. The term was coined in 1994 by U.S. Black feminists and situates reproductive rights as a cornerstone of social justice. RJ birthworkers abide by the three pillars of RJ: "the right not to have a child; the right to have a child; and the right to parent children in safe and healthy environments" (Ross and Solinger 9). Drawing on this framework, doula care has evolved significantly in the past two decades, with the rise of the "full-spectrum doula" who serve clients "during the full spectrum of pregnancy—from birth to abortion to miscarriage to adoption" (Pérez 12). Many full-spectrum doulas embrace RJ and strive to offer nonjudgmental and culturally competent care to underserved pregnant and birthing people, such as Black women, young parents, and queer and trans people (Basile). In this way, many radical doulas see their birthwork as a form of activism (Carathers).

Because they are not trained to provide medical care, doulas occupy a liminal space in the medical-industrial birth complex that often perpetuates obstetric violence, racism, fatphobia, homophobia, and transphobia. While such liminality renders doulas precarious in hospital birth settings (for example, a doula might be asked to leave by a medical provider), it also affords RJ doulas a unique position in both witnessing and disrupting hegemonic structures, discourses, and practices in birth and pregnancy (Yam, "Visualizing"). In this way, RJ doulas can create safer and more empowering reproductive experiences for marginalized birthing people. Birthworker and activist Alana Apfel notes that reproduction is political, and there is "subversive potential inherent in birthwork" (11). Radical doulas who serve marginalized people, hence, can serve

as "potentially vital political mediators within intersectional struggles for freedom and dignity" (99).

This article proceeds in three movements. We begin with a brief elaboration of method. Our study blends rhetorical analysis of curricular programs alongside qualitative interviews with doulas, many of whom identified as radical doulas of color. Next, we examine how dominant language and practice in birth and pregnancy perpetuate gender essentialism and cissexism and exclude genderqueer, nonbinary, and trans birthing people. Finally, we explore how RJ doulas engage in education, advocacy, and care work to affirm expansive transmasculine and nonbinary birthing people and families. We identify three key dimensions of RJ doulas' worldmaking efforts that spanned both their educational efforts as well as the direct services they provided to clients. These strategies include (1) advocacy, (2) radical inclusion and nonjudgmental care for all, and (3) self-reflexivity. These rhetorical practices allowed gender-affirming birthworkers to disrupt conventional exclusionary practices that do not take into account the reproductive experiences of queer and trans people. We conclude by contemplating the stakes of RJ doulas' interventions not only for individual birthing people and queer families but for their potential broader impact on queer family justice and bodily and reproductive autonomy for LGBTQ people.

Methods

We have collected primary data from different sources. The data we analyze in this article stem from fifteen semistructured interviews we conducted with RJ doulas, participant observations that Sharon conducted at two doula trainings, interviews with four queer birthworkers featured on the podcast *Evidenced-Based Birth*, seven workshops and conference panels, and educational materials on queer and trans birth that were created by queer-affirming birthworkers and educators. Our method is informed by what Michael Middleton et al. call "rhetorical field methods" (387), in which we simultaneously deploy "critical-rhetorical principles with a participatory epistemology to examine the lived experiences of individuals who are embedded within rhetorical social practices, particularly attuned to issues of power, marginalization, and resistance" (Endres et al. 514). Hence, we deploy field-based rhetorical criticism along with textual analysis of printed texts. By doing so, we can more fully contextualize the barriers marginalized birthing people and RJ doulas face; in addition, we capture the different tactics and outlets RJ doulas use to advocate and educate their peers and medical providers on providing inclusive care. By juxtaposing our analysis of field-based data with that of printed texts, conferences, and panels, we are able to illustrate how birthworkers adapt their strategies of advocacy and education when speaking to different audiences across contexts.

Sharon conducted two participant observations in 2018. The fieldnotes collected during those trainings offered us a keen understanding of how gender was discussed in mainstream birth discourse, specifically in ways that were exclusionary. Interviews with RJ doulas were conducted by Natalie and Sharon in 2020 and 2021 to examine how queer doulas promote and practice gender-inclusive reproductive care.[1] When conducting rhetorical analysis on the fieldnotes taken during participant observations and interview transcripts, we focused on moments in which the instructors, interviewees, and

authors discussed gender. While some of these discussions—especially in RJ-informed outlets—were explicit, some were not, as conventional birth discourse often assumes that only women give birth. As such, in our analysis, we paid close attention to moments of silence as well to identify unspoken assumptions about gender and reproduction. Because RJ is an intersectional framework, during our analysis we were particularly attuned to moments when research participants connected gender with other identity markers, such as race and class. We used a similar approach when analyzing training materials, conference panels, and other printed texts produced by mainstream doula training organizations and RJ doulas. To contextualize the rhetorical ecology in which RJ doulas are currently situated, we examined canonical texts and training materials that have dominated the birth industry until very recently.

Building on the foundation of RJ, we deploy what Shui-yin Sharon Yam calls "a reproductive justice model of rhetorical analysis" to amplify the rhetorical practices RJ doulas have invented to promote gender inclusivity, while paying attention to the intersecting positionalities our research participants occupy (20). To amplify the experiences of those who are most impacted by the cishet gender norms in pregnancy and birth, we were intentional about the data we analyzed for this article, focusing primarily on doulas from marginalized backgrounds and/or those who serve queer people of color. To do so, we subscribed to mailing lists, podcasts, and social media accounts created by RJ doulas and birthworkers of color. We attended educational workshops hosted by them and invited them to participate in semi-structured interviews. Because both authors have already had contacts with RJ doulas prior to this research—Sharon previously conducted qualitative research on doulas and advocacy strategies, while Natalie worked in reproductive rights organizing—we reached out to our existing networks to recruit participants as well.

Among the interviewees, four were doula trainers who designed their own curricula. Our data set includes interviewees with various racial, gender, and sexual identities. Eleven identified as cisgender, four as trans or nonbinary, and three used a range of pronouns/descriptors to indicate fluidity. Fourteen identified as queer or bisexual; three as straight. Finally, eight interviewees identified as Black, eight as white, one as biracial (Black/white), and one as Pacific Islander and Latinx. Regarding the two birth doula trainings in which Sharon participated, one was offered by the most established mainstream organization, Doulas of North America (DONA), while the other was hosted by a community-based, full-spectrum doula program that offered voluntary birth and abortion doula services.

In the analysis that follows, we first discuss how mainstream pregnancy and birth discourse has historically upheld—and continues to uphold—a ciswoman-centered approach to reproduction through analysis of field data and canonical texts in the birth industry. After establishing the dominant rhetorical ecology, we then examine the ways in which RJ doulas challenge such exclusionary discourse and practices by providing care to queer, trans, and nonbinary pregnant people and by educating the public and other doulas on a more expansive view of gender and birth.

Gender in mainstream pregnancy and birth discourse

Dominant discourse on pregnancy and birth is promulgated by guidebooks, media, and everyday language used by medical providers and birthworkers. In this section, we

contextualize the challenges RJ doulas face by analyzing mainstream doula training materials. We note two matters up front. First, the doula profession is ideologically and politically diverse, spanning a range of community enclaves from white evangelical mothers to RJ advocates. Compounded by mainstream doula trainings that center straight white women's experiences, many doulas do not subscribe to the same intersectional political commitments as their radical RJ peers. Second, we use both gender-neutral and woman-centered language in this section to reflect a complex history that accounts for the fact that although medical authorities and past studies have focused exclusively on pregnant and birthing women, trans and nonbinary people have long been giving birth. As such, we will use *women* when referring to particular contexts—specifically, historical research and advocacy efforts that have focused exclusively on cisgender women.

The gender of birthwork

The history of doula care and childbirth support in the United States has been widely studied (Morton; Davis-Floyd; Sandelowski; Michaels). While this history is beyond the scope of this article, it is important to note that pregnancy and childbirth became increasingly medicalized in the early twentieth century in a way that marginalized communal midwifery and labor support, specifically in Black and Native American communities (Theobald; Tobbell). The move toward what Davis-Floyd calls a "technocratic model of birth" (4) shifts power and control from the birthing people over to the patriarchal institution of obstetric medicine. Early obstetrics relied on disempowering and dehumanizing practices, including sensory deprivation and physical restraints, instead of promoting physical and emotional support to manage labor. At the same time, this development also erased the contribution and immense knowledge of community midwives and birth coaches of color. The hegemony of white-led medical institutions in pregnancy and birth worked in tandem with government policies that enforced binary gender and the nuclear family, targeting in particular people of color who traditionally had a more fluid understanding of gender and family formation (Theobald; Snorton).

Advocates began to successfully challenge mainstream obstetrics, beginning with the "natural childbirth" movement in the 1940s and 1950s and, later, with movements that explicitly critiqued medicalized childbirth for its dehumanization of women (Morton). Of particular significance to the recent history of birthwork, Ina May Gaskin published *Spiritual Midwifery* in 1975, a germinal text that champions unmedicated vaginal home births. Drawing on her midwifery practice on The Farm in Tennessee, Gaskin argues that as the "maternal" body undergoes "good pain" from unmedicated vaginal birth, the birthing woman will experience a euphoric and orgasmic experience (147, 137). As Ashley Mack points out, Gaskin and other unmedicated home birth advocates like her often deploy gender essentialist language on womanhood, tethering "moralistic and naturalistic" ideals to motherhood (62).

This emphasis on motherhood, and related essentialist claims of women's innate biological power and intuition, was widely embraced to challenge the patriarchal authority of obstetrics, which has long wielded sexist assumptions in its treatment of pregnancy and

traditional forms of reproductive expertise. While essentialist claims may have proven politically expedient in particular contexts, reifying sex and gender binaries has its costs—not only for LGBTQ-identified people but for cisgender women who refuse motherhood altogether or who parent outside of heteronuclear, white, middle-class expectations. Gender essentialism as a vehicle for justifying reproductive autonomy retains an indelible imprint on contemporary birth culture. Like Gaskin's *Spiritual Midwifery*, most mainstream guidebooks on pregnancy and birth assume that pregnant and birthing people are exclusively cisgender women and, by and large, straight. For instance, while Penny Simkin's *The Birth Partner* does not assume that all doulas and birth partners will be of a particular gender, the book refers to all birthing people as either "women" or "mothers." These texts also are mostly written by middle-class cis white women for other cis white women. They bolster hegemonic familialism and fail to reflect the reproductive experiences of nonnormative birthing subjects, including queer, trans, and nonbinary people.

One specific example is worthy of mention, both for how it reflects these struggles in general and for its durable impact on contemporary birthworker communities. In 2014, the Midwives Alliance of North America (MANA) revised its core competencies, which "establish the essential knowledge, clinical skills and critical thinking necessary for entry-level midwifery practice" (para. 1). The goal of this revision was twofold: first, to align with the core competencies of the International Confederation of Midwives and the World Health Organization; and second, to revise the language so that it would be "inclusive and welcoming to all who seek midwifery care" ("Overview of the MANA Core Competencies Revisions" para. 4). The revisions provided a more intersectional framework for midwifery care by underscoring matters such as environmental risks, food insecurity, and the human rights concerns specific to LGBTQ communities and communities of color. Of particular note for many within the midwifery community, the MANA revisions also affirmed gender diversity in the context of pregnancy and childbirth, using terms such as *pregnant person*, *birthing person*, or *parents* in lieu of *pregnant woman* or *mothers*.

MANA's shift to gender-inclusive language ignited a firestorm. Under the banner of Woman-Centered Midwifery, a large group of birthworkers that included leaders of national repute cosigned an open letter denouncing MANA's decision. The open letter insisted on language that recognized women's primary role in reproduction as biological fact: "There is life-giving power in female biology. As midwives we protect the lives of the life-givers: women, mothers, females, and their offsping [*sic*]. We must not become blinded to the biological material reality that connects us. If midwives lose sight of women's biological power, women as a class lose recognition of and connection to this power. We urge MANA to reconsider the erasure of women from the language of birth" (para. 9). This emphasis on shared biology among women lies at the heart of Women-Centered Midwifery as an organization, described on their website as

> a group of gender-critical midwives, mothers, and birthworkers deeply troubled by the present cultural trend of enforcing socially-constructed sex-role stereotypes as the primary definitions of female and male. While we believe all people's dignity, civil rights and safety should be supported regardless of their gender identity or manner of self-expression, we understand humans as a sexually dimorphic species that conceive and give birth through the biological functions of males and females, not through gender identity. We understand that a "woman" is a mature human female and that only females are capable of conceiving,

> gestating, and birthing children. Because we stand in support of females, fully acknowledging their unique experiences, capacities and vulnerabilities, we stand in resistance to the cultural, legal, and medical erasure of biological females and their lived reality. ("About" para. 1)

MANA released a public statement in response to the "Open Letter," titled simply "Position Statement on Gender Inclusive Language." The statement defended the use of gender-inclusive language in birthwork to better serve and affirm a range of families. It also insisted that a refined understanding of sex and gender matters for all families, as the rich diversity of sex and gender that one might encounter in birth is not limited to serving LGBTQ-identified parents but also includes, for example, the provision of compassionate and competent care to intersex infants.

MANA's response to Women-Centered Midwifery was not the only one. Numerous midwives and doulas, organized under the group name Birth for Every Body, released an open letter of their own in response to Woman-Centered Midwifery's "Open Letter to MANA." Noting the harm and confusion resulting from the original "Open Letter," Birth for Every Body's response was written "to explain why and how the Open Letter is harmful to transgender, genderqueer and intersex people, why midwifery documents should be gender inclusive, and why people of all genders should be welcomed into midwifery care" (para. 1). The response offers various points of critique, provides educational resources related to sex/gender/sexuality, and encourages birthworkers to educate themselves and initiate conversations with others about supporting trans, intersex, and nonbinary people in pregnancy and birth.

This debate reflects the history of birthwork in general and that of doula care specifically. Mainstream doula practice and discourse in the United States has been heavily influenced by canonical texts and historical developments in midwifery. In 1992, the Doula Organization of North America (DONA) was founded by five maternal health experts, including Simkin, to provide doula training and certification. As the leading professional organization, DONA's language use and approach to childbirth support is extremely influential. DONA's doula workshops usually span two to three days (at least sixteen hours of instruction) in which students learn different techniques of labor support through guidebooks, lectures, and videos; students also practice communication and hands-on skills for physical comfort with one another. As Morton notes in her research from 2014, the typical practicing doula in the United States is "female, white, married, with children. She is likely to have a college degree or attended some college … . She is passionate about how birth can be an empowering, positive experience for women. She may or may not be a self-declared feminist" (114). In the three mainstream birth doula trainings Morton attended as part of her research, she observed that in training materials, pregnant and birthing people are referred to either as "moms" or "the generic woman" whose bodies "naturally know how to birth" (119). The trainers also encouraged students to make use of "women's natural intuitive knowledge" to provide care (119). In addition to reinforcing the assumption that doulas and birthing people are by default women, this discourse also relies on gender essentialism and naturalism that treat pregnancy and birth as exclusively women's domain.

Reproductive justice critiques of mainstream doula trainings

In this section, we draw on our interviews with RJ doulas and Sharon's participant observation to elaborate how mainstream doula trainings fuel gender exclusion. RJ doulas—some of them queer identified—regularly witness and confront cishet normativity in mainstream birthworker training and discourse. Their experience and critiques illustrate the need for more inclusive alternatives that would better equip birthworkers to serve queer and/or gender-nonconforming birthing people.

Sharon's participant observation at a DONA birth doula training in 2018 echoed Morton's findings with regard to demographics. In the workshop, all but one of the other students in class were cishet married and educated white women who had given birth before; most students expressed that they intended to serve clients who were from similar social backgrounds. At the beginning of the workshop, the instructor—a cishet white woman who was a seasoned childbirth educator and doula trainer—explained that she would be using a variety of terms to refer to the client base. The terms she used included the gender-neutral *birthing people*. She further noted that she used the word *family* to refer to various kinship arrangements and structures. Despite the instructor's initial mindfulness on using inclusive language, during the workshop she frequently reverted to heteronormative language that assumed that the birthing person was a woman. In addition, course materials, such as assigned textbooks, workshop manual, and videos, did not discuss the specific needs of queer, trans, and nonbinary birthing people; nor did they include any images of queer families. As queer and polyamorous full-spectrum doula Vicki remarked in her interview, going to a childbirth education class that refers to parents as "mommies" and "daddies" can be "very dysphoric" for gender-nonconforming and genderqueer parents who do not always feel comfortable bringing it up with their instructors.

Other interviewees who received DONA training also remarked on the lack of discussions surrounding trans and queer birth and parenting. Beverly, a queer RJ birth doula, was initially skeptical of DONA's approach to queer and trans inclusivity: "I've heard from people that [DONA] might not be accepting, say, lesbian couples, or surrogates, or transgender birthing people … . Their stuff all uses the feminine pronouns, so I was hesitant but also wanted to get the training done quickly, and knew that I am capable of making those adjustments myself, even if they don't come at this training from the same intersectional perspective that I do, I can bring that to it with my academic training." While Beverly found the workshop to be a good learning experience overall, she witnessed fellow participants—most of them white working mothers hoping to start careers as doulas—expressing exclusionary views toward nonnormative and marginalized birthing people, such as Black women, queer and trans people, poor people, and people with substance use disorders: Many announced that they could not work with clients from those populations.

The two trainers at Beverly's workshop responded to these exclusionary views differently. The one who was, as Beverly described, more social justice oriented, called out the participants' biases explicitly and encouraged critical reflection. The other trainer merely advised the participants not to take on clients from social backgrounds that made them uncomfortable. Tara Brooke, a DONA-trained doula who later founded a more inclusive and radical doula organization, remarked that DONA was not

progressive and the organization and workshops they offered mostly treated advocacy for birthing clients as taboo. In the DONA workshop manual, directly communicating the client's preferences to their health care providers was listed as an unacceptable action. Instead, trainees are instructed to encourage their clients to ask their own questions and express their preferences and concerns to their providers. This protocol severely limits the doula's ability to support clients who are systematically disempowered in medical birth settings as medical staff are not always receptive to their needs (Davis; Bixby Center for Global Reproductive Health). By discouraging doulas from speaking directly to medical providers, doulas could not leverage their knowledge and social capital to help advocate for their marginalized clients.

Other RJ doulas expressed in interviews that they did not receive sufficient education on serving marginalized birthing people from their DONA training. Some of them subsequently enrolled in more radical doula training workshops that were built on intersectional RJ principles. Stevie Merino, a queer Boricua and Chamorro doula and the cofounder of Doula of Color Training, noted that many of her trainees had previously received mainstream training from DONA, but had experienced alienation due to their positionality as queer people of color. Merino herself attended a BIPOC-centered doula training that was taught by a queer instructor. Similar to Sharon's DONA trainer, Merino's instructor used gender-inclusive language but "sort of switched on and off, [and] not really talking specifically or intentionally about serving this population or even being birthworkers who maybe identify as queer or trans." Merino's experience highlights the lack of intersectional birthworker training that refuses a piecemeal approach to people's identities and reproductive experiences.

In response to these deficits, RJ doulas have been promoting a more intersectional and inclusive framework that takes into account the reproductive experiences of pregnant and birthing people who claim a range of identities and experiences. In the next section, we analyze how RJ doulas are actively working to transform the birth world and affirm queer families through birthworker education and direct service.

Reproductive justice doulas and queer care

RJ doulas enact change in two arenas: direct care and educational efforts. In what follows, we highlight rhetorical strategies that span both the development of inclusive birthworker curricula and ongoing education, as well as direct care for birthing people. This dual emphasis reflects the reality of work as an RJ doula; many found that, as they worked to transform doula care for queer, transmasculine, and nonbinary clients, they were increasingly called upon to do educational work so that other birthworkers might adopt better practices for supporting LGBTQ+ families. Within these two arenas, we elaborate on three themes that characterize RJ doulas' rhetorical efforts to dismantle exclusionary heteronormative language and practices in birth and pregnancy: (1) advocacy, (2) radical inclusion and nonjudgmental care, and (3) self-reflexivity. Given their liminal status in medical birth settings, RJ doulas perform advocacy for marginalized people through different tactics based on the specific contexts: while some would directly intervene in a situation when their clients did not feel comfortable speaking up, others deployed what Yam calls "soft advocacy" ("Complicating" 199) to promote more

gender-inclusive practices. Radical inclusion and nonjudgmental care was expressed in myriad ways, for example, in the creative use of language to center queer and BIPOC family formation. Meanwhile, in this context, self-reflexivity was embodied as a capacity to deeply listen to experiences from marginalized positionalities and to consider how identity, social location, and life experiences have shaped individuals' attitudes, beliefs, and behaviors.

Challenging dominant culture and discourse through birthworker education

To promote inclusive care, RJ activists and birthworkers began establishing doula organizations that disrupt gender essentialist discourse in birthwork services and training. We interviewed the cofounders and educators of four such organizations: Doula Training International (DTI), Cornerstone Doula Trainings (hereafter, Cornerstone), Doula of Color Training, and Birthing Advocacy Doula Trainings (BADT). All developed curricula that prompt students to consider the politics of birthwork and reproduction in an intersectional manner. These trainings tended to attract queer, nonbinary, and trans students who might otherwise feel alienated in more mainstream workshops.

First, radical doulas recognize the inherent political nature of birthwork and embrace advocacy as an essential dimension of doula care. Tara Brooke, cofounder of DTI with Gina Giordano, is a white woman first trained by DONA. After working as a birth doula for several years, she became disillusioned by DONA's insistence that a doula be "a fly on the wall" in the birthing room, rather than an advocate. Brooke realized that in many circumstances, doulas could advocate for their clients in ways that could prevent obstetric violence and emotional trauma, which is especially important for marginalized birthing people who are subjected to systemic violence and discrimination in medical institutions. Brooke was not alone in feeling frustrated about mainstream approaches to doula work, specifically the restrictions on advocacy. Sabia Wade, a Black queer birthworker who founded BADT, echoed her frustration. Wade mentioned that given her firsthand experience with medical racism, she understood the importance for community doulas to advocate alongside their marginalized clients. Advocacy, for Wade, was an essential component of birthing support.

This belief in advocacy as fundamental is embraced by DTI, BADT, Cornerstone, and Doula of Color Training. Founded in 2011, DTI's doula training curriculum departs from mainstream curricula in its use of the RJ framework and its focus on the politics of reproduction and birthwork in ways that underscore the necessity of advocacy in particular settings. In addition, DTI offers scholarships to people of color and started a Trans Health Initiative in 2015 that provides free in-person training and a nine-month mentorship to trans doulas. Brooke noted that DTI leadership frequently revisited and revised their curricula to be more inclusive and reflective of the wide range of reproductive experiences and bodies that birthworkers may encounter. The organization made the shift from woman-centered to gender-neutral language in all their materials. They also removed Gaskin's canonical work from the reading list and added Trevor MacDonald's *Where's the Mother: Stories from a Transgender Dad* to the list for all certifying doulas. By changing the texts that were assigned to student doulas, DTI and

other doula educators who also choose to do so are rewriting the canon of birthworker education.

BADT has also been challenging exclusions in mainstream birth discourse and practices through advocacy. For Wade, birthwork, activism, and social justice are interconnected. The mission statement of BADT reflects her commitment to educate birthworkers about such connections: "We not only train our students to serve their clients using the best practices available, we also provide them with a wide perspective of disparities, inequalities, policies and rights, and prepare them to be active partners in the movement to change birth and reproductive health culture locally, nationally and globally" (Wade). In addition to full-spectrum doula and childbirth educator trainings, BADT also offers courses and workshops on queer and trans reproductive support, racism and privilege in birthwork, and birth and disability. Workshops such as these help doulas in training to develop a critical intersectional understanding of reproduction and birth—a necessary foundation for RJ birthwork and being an effective advocate for marginalized birthing people.

Doula of Color Training underscores similar commitments in describing its curriculum and goal: "There will be knowledge shares from POC midwives, doulas, herbalists, healers, abortion companions, etc. We will discuss birthwork as activism, trauma informed care, birth disparities, how to support pregnant people through all pregnancy outcomes, inclusive language, and so much more" (Merino para. 2). Merino noted that when promoting the training on social media, the training would "uplift queer and trans voices, and use inclusive language." In addition to attracting queer and trans people to the training, Merino also wanted to train cishet birthworkers to better serve queer people and people of color: "[It is a] very revolutionary, intentional act that we don't want to just attract queer and trans people. We want cisgender heterosexual people to also be forced to be uncomfortable and to sit in this space of them needing to get right. And [it's revolutionary] because you cannot say that you serve and uplift families and birthing people of color, if you're not also talking about the queer and trans experience." The doula training Merino helped design and facilitate encouraged students to consider the politics of birth through an intersectional lens that critically considers the needs and experiences of queer and trans birthing people of color, including when intervention in medicalized birth settings might be necessary.

Cornerstone similarly recognizes the political power of birthwork. This organization is committed to examining the connotations and histories of language in birth discourse and, more recently, decided to move away from the term *doula* because of its gendered connotation. Like DTI, Cornerstone also offers scholarships to people of color and LGBTQ students to help diversify the demographics of birthworkers in the United States. These scholarship and mentorship programs are important, because marginalized birthworkers often do not see themselves reflected or valued in mainstream training.

All four of these organizations also collaborate with Black, disabled, and/or queer activists and birthworkers to offer workshops and panels on topics supporting queer and trans birthing people, people with substance use disorders, and survivors of sexual violence. In her interview with us, Merino mentioned a guest lecturer on abortion support that centered trans and queer narratives and did not address cisgender people much at all. By highlighting abortion experiences of trans and queer people, the talk

challenged the widely held assumptions that only women need access to abortion care and provided insight into the specific needs of trans and queer communities in terms of abortion care. In sum, RJ doulas are reimagining the scope of birthwork and birthworker education to include advocacy and political awareness as central to care for pregnant and birthing people.

Second, RJ doulas insist on radical inclusion and nonjudgmental care. This commitment is manifest in their transformation of educational curricula to center open, collaborative, and culturally competent care that is sensitive, in particular, to gendered language and the needs of gender-nonconforming clients. For example, in Miriam Zoila Pérez's landmark text, *Radical Doula Guide*, the author sees gender essentialist discourse—such as women's unique ability to tap into "feminine wisdom and instincts" (30) during birth—as a historical response to sexism in obstetrics. In other words, by promulgating woman-centered gender essentialist arguments, midwives—who are commonly women—were working to challenge the patriarchal authority of obstetricians. Pérez argues, however, that "fighting gender essentialism with more gender essentialism" is "dangerous and damaging," as it has been used to dismiss women and exclude men and genderqueer people in doula work (31). Pérez urges their readers not to "rely on ideas that imply biologically based gender differences" (31). Pérez's argument is a deft critique of the subsequent pushback against it by midwives, including Ina May Gaskin, who identify as "woman centered," as it articulates why perpetuating gender essentialism does not only exclude queer, trans, and nonbinary people but also further entrenches women in misogynist and sexist ideologies.

Other birthworkers are building on Pérez's commitment to radical inclusion, shifting curricula and using language in creative and expansive ways. In 2017, Brooke and Giordano started Born into This, an annual conference for birthworkers, doulas, and health care professionals. The conference featured panels and talks on RJ and birthwork, birthworkers as activists, and gender biases and essentialism in mainstream birth culture. In 2019, the conference featured a panel titled "They/Them/Theirs," facilitated by Emma Robinson, a Black cisgender RJ activist, and in conversation with three birthworkers/educators on the transmasculine spectrum: Pérez, Trystan Reese, and Mac Brydum. The panelists discussed criticism mounted by woman-centered reproductive advocates on gender-neutral language. Noting his own desire to get pregnant in the near future, Brydum elaborated on his use of gender-neutral language: "I'm not here to take away from the amazing, powerful things that women's bodies can do that my body also happens to be able to do … the point is that there's more room for all of us. That inclusion is the goal." Robinson expanded on this note, positing that gender inclusivity was never a zero-sum game between women and queer and trans people: "We have to figure out a way to make sure that everybody is seen, because there are enough seats at this table. Like if we are all sitting at this table, no one's going to be invisible. Women don't instantly become invisible because we say *parents*." For the RJ activists and birthworkers, it is both possible and necessary to recognize the shared struggles and oppression women, trans, and nonbinary birthing people face.

This insistence on shifting language and curricula is echoed in other places. In 2020, Brooke and Giordano published a short book called *Born into This: A Creative Guide through Reproductive Health* that covers the full spectrum of reproductive experiences.

The target audience of the text is wide: "a young adult looking for more education and information around reproductive health, a birth professional, a reproductive justice advocate or someone who is pregnant for the first (or third) time looking to learn more about a birthing person's body" (6). *Born into This* differs significantly from canonical guidebooks on pregnancy and health. In addition to assuming that pregnant and birthing people are always women, as Marika Seigel points out, mainstream pregnancy and birth manuals also frequently perpetuate the technological system of childbirth in which the birthing body is seen as always on the brink of malfunction. Especially when a pregnant person miscarries or has a difficult birth, their body is often framed as the source of the problem. More expansive in scope, in addition to several chapters on pregnancy and labor, *Born into This* also contains chapters on miscarriage, loss, abortion, fertility, postpartum, and menopause. The two beginning chapters and the conclusion introduce the readers to concepts of reproductive health, reproductive rights, and RJ, while offering an introductory primer on gender, sex, and sexuality. Moreover, this sensibility is woven throughout the book. For example, when discussing infant feeding, Brooke and Giordano are mindful in explaining why and how they use *chestfeeding*, *bodyfeeding*, and *breastfeeding* to reflect different people's relationship to their body parts and their preferred language. The text, in other words, consistently demonstrates an attunement toward queer and trans experiences and needs.

Radical inclusion and nonjudgmental care are evidenced also in a willingness to challenge the dominant assumption that doulas are always women. Educators from RJ doula organizations normalized the use of preferred pronouns and encouraged students to examine their language use and biases. For instance, Merino expected students in her training to mirror the gender-inclusive language she and other teachers used. This framework not only made the space more inclusive for queer, trans, and nonbinary trainees, but as Simone—a seasoned DTI trainer—pointed out, it also provided an opportunity for others to identify their biases and examine their gendered assumptions about doula work: "Because if a person identifies as perhaps as a 'he' instead of a 'she,' and you're used to being in a room full of women because we're doulas and birthworkers, you have to be mindful of your language from the very beginning as being respectful of the way the person identifies." Echoing Merino, Brooke remarked that DTI's curriculum was meant to be somewhat uncomfortable for students as the course challenges dominant gendered and racist assumptions about pregnancy and birth.

While most students who sought training at RJ-oriented doula organizations tended to identify with the organization's intersectional RJ approach, they were not always comfortable with gender inclusivity in birth. Brooke observed that in more socially conservative regions of the United States, DTI trainers encountered resistance from attendees on trans pregnancy and birth. Similarly, Tilsner pointed out that while she had not experienced much pushback from students on supporting genderqueer, trans, and nonbinary birthing people, students sometimes had a difficult time "wrapping their minds around like birth not being a woman thing."

This willingness to sit with and engage discomfort highlights the third significant rhetorical strategy that emerged within our data: self-reflexivity. For instance, Simone mentioned that in training workshops predominantly composed of white students, students often perpetuated white savior discourse when speaking about serving racialized

communities. Hence, RJ doulas often find ways to prompt others to consider their own positionality, beliefs, and biases. For example, Brooke and Giordano's *Born into This* situates sex, gender, and sexuality as existing on a spectrum and subsequently invites readers to think of these categories, and their accompanying language, as fluid and changing. Before and after that chapter, the reader is encouraged to free-write to the following prompts: "How has your gender influenced your life experiences? Has your gender presentation changed during your life? What are some ways in your life you already use gender neutral terms? Where could you start using more?" (8, 14). This journaling exercise is intended to cultivate greater awareness and sensitivity to the diversity of gendered experiences in the world and to empower doulas to better meet the needs of trans, nonbinary, and queer families in particular.

RJ birthwork educators also used their position in the context of doula training to facilitate meaningful exploration of cultural beliefs and bias. Mainstream doula training programs often avoid these conversations, recommending instead that trainees refrain from working with populations that make them feel uncomfortable. RJ educators, however, take a different approach—one which emphasizes self-reflexivity, awareness, and the possibility of growth or change. DTI trainer Simone stated that when a trainee expressed discomfort about serving a particular population, she would ask the trainee to consider where their hesitation was coming from and to examine their biases. As Simone recounted, some trainees experienced moments of revelation as they confronted their feelings on nonnormative birthing people. Prior to the workshop, these trainees were not aware of the biases they harbored. In her Doula of Color Training, Merino also invites her students to engage with deep questions as to why and how they might wish to serve particular birthing people and/or communities. This critical reflection includes whether one is best positioned to serve particular communities:

> I do a lot of lactation trainings and discussions with other lactation professionals. And a lot of people will ask, "Well, I want to serve queer and trans families in lactation. What should I do as an ally?" And my number-one controversial response is, "You should refer them to someone who actually knows how to work with queer and trans people." And a lot of allies, of course, get in their feelings and center themselves … but there are people who are in these populations who are battle tested and able to support in a good way, right?

For Merino, critical self-reflection is crucial and entails knowing the limits of an individual's capacity to serve clients at a particular moment in time.

The full-spectrum doula training that Sharon attended included similar value-clarification activities that were meant to prompt self-reflexivity. Participants were given a worksheet to evaluate on a scale of 1 to 5 their comfort level supporting different pregnant people during an abortion. The list included thirty-six marginalized subject positions, such as fat people; trans and gender-nonconforming people who want their doula to use their preferred pronouns; people who have mental health issues; disabled people; sex workers; undocumented immigrants; and people who are from a different racial, cultural, or religious background. Similar to Merino's teaching, the instructors at this training suggested participants avoid taking on clients whom they rated as 1 on the scale, which was described on the worksheet as "I will never, ever, ever be comfortable/confident in a situation like this. It is not for me, and it never will be. I will avoid situations like this; this is a limit." For the instructors and the developers of the worksheet,

not serving specific populations because of one's personal biases was a demonstration of accountability to oneself and others. The instructors then asked participants to review items they had rated 2 ("It would take considerable growth to be comfortable with this situation, but it's not out of the question. I would be considerably challenged by a situation like this"). They encouraged participants to review resources mentioned in the training manual and seek additional education. They also taught participants to build and learn from a network of doulas who were already equipped to serve those clients.

Distinct from canonical pregnancy guidebooks and DONA's training manual, the resource binder provided by the community full-spectrum doula training included extensive examples and scenarios from trans, queer, and nonbinary people. In a worksheet developed by the Bay Area Doula Project, participants were asked to address different challenging scenarios as doulas. The scenarios include a genderqueer 18-year-old who wanted a medication abortion despite their partner's desire to continue the pregnancy; a 32-year-old transman who felt nervous about seeking an aspiration abortion in a clinic because he did not feel comfortable with medical providers; and a cisgender woman who was polyamorous and was supported by her female partner. By inviting participants to consider the abortion experiences of queer, trans, and nonbinary people who disrupt heteronormativity, this activity reminded full-spectrum doula trainees of the radical political potential of birthwork, while encouraging them to examine any feelings they might have had while going through these scenarios.

Similar prompts to encourage self-reflexivity are embedded in workshops that RJ birthworkers and educators offer to birth professionals, including medical professionals in a range of settings. Several of these also discuss privilege in an intersectional framework, encouraging participants to take stock of how they benefit and how they might leverage social capital to support marginalized people. For example, in one workshop led by a Black queer nonbinary birthworker, cis white trainees were asked how they could mobilize their social privilege in medical settings to support queer clients of color whose experiences and preferences were often dismissed by the institution. Given the typical demographics of doulas in the United States (middle-class, cisgender, straight white women), these conversations within educational settings were significant in promoting more self-reflexivity among aspiring birthworkers who may not have much knowledge or experience serving trans and queer clients.

Inclusive practices in doula work

In this section, we examine how RJ birthworkers deploy the rhetorical strategies of advocacy, radical inclusion, and self-reflexivity in doula work itself. Many RJ doulas view all aspects of their work—whether visible, overt, subtle, or behind the scenes—as a form of advocacy and activism, as providing nonjudgmental and inclusive care to those who regularly encounter violence at the hands of medical providers, the state, and culture writ large is a political act. For example, in medical settings, birth doula and midwife Gwen expressed that she practiced "feminist charting" when writing notes about patients in her midwifery practice: "When I'm writing notes about people, I like to include a lot of things about their life, how they're feeling emotionally, their decision-making process, because I feel like it really humanizes them." Gwen observed that quite

frequently obstetricianswould focus solely on queer and trans patients' anatomy. By including more emotional information about her clients, Gwen hoped that her notes would help promote more holistic care that does not reduce queer and trans people to their body parts. This insistence functions as a more subtle form of advocacy that prioritizes the interests of queer and trans patients over institutional norms.

RJ birthworkers' advocacy sometimes took a more direct route. Miranda, a white, queer, full-spectrum doula and midwife, stated that she would prepare her queer and trans clients for microaggressions that might occur in hospital birth settings so that they would have time to ready themselves. Miranda's experience demonstrates that in addition to supporting clients before their medical appointments, queer RJ doulas often also engaged in advocacy and mediation between their clients and medical staff during labor in hospital settings. For example, Miranda described how, in serving a lesbian couple, a nurse stopped both partners from entering the birthing tub. The nurse informed the couple that while the birthing person could enter the tub naked, the supportive partner must wear a swimsuit. Miranda noted that this particular policy on modesty was implemented out of the assumption that the partner of a birthing person would be someone with a penis. When Miranda noticed the couple beginning to shut down because neither brought a swimsuit to the hospital, she diffused the situation by asking the nurse: "We are all women here. Why could [the birthing person] be naked, and her partner have to put on a swimsuit?" The nurse and nonbirthing parent both then felt more comfortable about the situation, and she was able to accompany her wife in the tub. By inviting the nurse to consider the inapplicability of the hospital policy, Miranda simultaneously advocated for her client and disrupted mainstream gender assumptions about birth and family.

Sometimes advocacy took the form of visibly aligning with a client's marginalized identity or experience in mainstream medical settings. For example, Miranda shared that she would occasionally and strategically out herself as queer to medical staff as a form of solidarity that would often deflect unwanted attention from her clients:

> I'm like, "Oh, well, my wife and I, you know, when we have babies, we're both going to call each other *Mom*. And you know, we actually read this study that said that, you know, children actually know based on who is saying and how they're saying it who you're referring to when you say *Mom*, even if they have two moms. And so we'll just both call each other *Mom*, and then when our kids differentiate, they differentiate however they want." I might throw that out there, and [the clients] were like, "Yeah, yeah, we do that too."

In addition to educating the medical staff and placing herself in the conversation to, as Miranda put it, "take the heat off the family," she also modeled preferred language and framing to medical staff. For instance, she would consistently use correct pronouns for her queer clients and refer to their family as such, even when they did not resemble a normative heteronuclear family. In situations where medical staff consistently misgendered her clients or ignored her queer clients as equal parents, Miranda would remain in the birthing room the entire time to provide support.

This more subtle advocacy strategy was echoed across our interviews. Merino, who frequently serves masculine-of-center birthing people, noted that misgendering and deadnaming were common occurrences at medical settings, even when the client "had a full-on beard, and their partner [was] calling their name." In these instances, Merino

saw her advocacy role as crucial in supporting the trans client. For Merino, advocacy did not need to be "guns blazing," but rather be "sustainable" in a way that would allow her "clients to be protected in their oxytocin bubble." This would include "gentle reminders" to health care workers about pronouns or queer family configurations, as well as open and ongoing conversations with clients to help them navigate their circumstances with her.

Second, RJ birthworkers emphasized radical inclusion as central to the provision of care—a commitment that included nonjudgmental care as well as a deep sensitivity to language. While nonjudgment should be a cornerstone of all reproductive care, our interviewees noted that this was especially true for clients who are systematically marginalized because of age, drug use, body shape, disability, race, class, gender, and sexuality.

Monica, a birth doula, midwife, and childbirth educator, noted that she adopted a nonjudgmental approach in the childbirth classes she provided to pregnant people: "My classes are really based on radical acceptance. And like radical nonjudgment of people and their birth choices. I really strive to just give people information that is extremely nonjudgmental … however you choose to do this is, like, it's completely up to you. You should have the right to make those choices, and you should have the right to not be pressured into birthing a certain way from any angle." For Monica and all of our other interviewees, providing nonjudgmental care involves centering the client's desires and preferences and providing them with sound, accessible information from reliable sources so that they can make their own decisions. Nonjudgmental birthwork enacts the RJ principle that honors individuals' autonomy to their own bodies and reproductive experiences.

Because gendered assumptions about birth and pregnancy are prevalent in mainstream discourse and medical infrastructure, birthworkers who want to provide trans-, nonbinary-, and queer-inclusive services often have to reexamine the language and documents they use in their birth practice. Wade recommended birthworkers include visual representations of queer and trans birthing people and families in their education materials and websites. Monica, Wade, and Danie Crofoot, a queer doula who serves primarily LGBTQ people, use gender-neutral language in their client intake forms, and include questions about pronouns and gender identity. Beyond pronouns, RJ doulas were attuned to the different language that queer, trans, and nonbinary people might use to describe their bodies. For example, *chestfeeding* might be a preferable description for feeding one's baby; *pelvic delivery* might reduce the dysphoria that can accompany descriptions of birth that reference female anatomy. Echoing the chapter on bodyfeeding in *Born into This*, queer birthworkers and educators encouraged their peers to ask and pay attention to how their clients referred to their bodies.

All interviewees remarked on the importance of using language that was gender affirming to their clients. Gwen and Chaney, a Black queer full-spectrum doula and midwifery student, chose to use gender-neutral language in all settings, unless their clients preferred gender-specific wordings. Similarly, Pérez used both gender-neutral and specific language to accommodate her clients' diverse identities: "For some people, their identity as a woman or man is really, really important, and that's beautiful and valid. And some of those people are trans too, and they want that language. I think for me,

it's like, how do we use both types of language in the way we talk about people that are getting birth so that, um, people feel seen across the identity spectrum." For Pérez, using gender neutral language—such as *birthing people*—as a default did not erase the reproductive experiences of women. At the same time, they also believed that birthworkers should feel comfortable using *women* to refer to clients who identified as such (Pérez et al.). Like Gwen, Monica, and Chaney, Pérez recommended that birth professionals never assume clients' identities and preferred language but rather to ask and listen openly: "We just listen to people about who they are, and then we mirror that back to them. And that's, for me, such a part of what it means to be a doula" (Pérez et al.).

The emphasis on listening underscores the third key theme we identified across this work: self-reflexivity. RJ doulas embodied this commitment to reflecting on their own assumptions by leading, first and foremost, with questions, centering the clients' understanding of their own needs, and resisting the impulse to make too many assumptions. For example, on her intake form, Monica would ask clients to share, at their own discretion, any affirming and/or nonaffirming experiences they had experienced with medical providers and would initiate open conversation about how she could best support them given their identities. Many of our interviewees noted that this kind of reflexivity on behalf of birthworkers was unfortunately rare. Assumptions in reproductive health care settings are commonplace; RJ doulas worked actively to avoid, for example, assumptions about someone's gender identity or pronouns or anatomy, assumptions about relationship status, or that their client's relationship was monogamous. RJ doulas underscored the importance of asking questions only on a need-to-know basis and leading with open-ended questions. Birth doula and midwife Gwen described a wellness visit with a young cisgender woman who described a particular physical ailment that worsened after sex. Gwen followed up by saying: "Tell me a little bit more about the kinds of people you have sex with and their genders and anatomy." This open-ended, unassuming question was a catalyst, as Gwen noted: "It came out that she had three partners and one of them was a cis man, one was a trans woman, and one was a cis woman. And she ended up having chlamydia and we ended up treating all of her partners … [which] could have easily been missed if someone hadn't taken the time to ask those questions." This example is a clear illustration of how cishet cultural norms and expectations undergird reproductive health care and how accessible comprehensive health care pivots on a provider's self-reflexivity—in short, on their willingness or capacity to think broadly about gender, sexuality, and intimacy.

Self-reflexivity is also informed by deep listening to the needs and comfort of a client. Vicki recounted a time when she supported a nonbinary client: "I work with a nongendered [birth parent] who had chosen not to get into [their gender identity] with the staff, because they thought it would compromise their care. So [when] I'm in the room, just us in the room, I'm using *they* pronouns for them. And then when the nurse comes, I switch over to using *she* pronouns. And when the nurse leaves the room, I go back to using *they* pronouns. So being comfortable to do that respects the choice that individual is making." Vicki's support demonstrates cultural competency and fluency regarding queer and trans care, which must be tailored to a client's needs and preferences, and particularly within hospital settings. RJ doulas who advocated for their clients often emphasized the need to adapt their tactics to ensure a calm atmosphere in the

space to avoid further distressing the birthing client (Yam, "Complicating"). Beyond birth settings, RJ doulas are aware of the potential postpartum challenges that might be amplified for LGBTQ-identified people. Miranda noted that queer and trans parents had a much higher risk of developing postpartum anxiety and mood disorders; birth support, hence, should continue in the postpartum period. Trans- and nonbinary-inclusive full-spectrum and postpartum doulas have an integral role to play in supporting the formation of queer families. Their capacity for self-reflexivity and critical awareness is foundational to providing this support.

Conclusion

The history of reproduction and childbirth in white, Western contexts has long reflected binary understandings of sex and gender; it also reflects the legacies of cissexism, misogyny, racism, and the cultural primacy assigned to nuclear family formation. Contributing to the small but burgeoning scholarship that examines doulas as social justice agents (Basile; Carathers; Yam, "Visualizing"), our study examines how RJ birthworkers—many of them queer and/or people of color—engage in practices that disrupt gender essentialism through multifaceted rhetorical strategies of advocacy, radical inclusion, and self-reflexivity. Moreover, in embracing a nonjudgmental approach to the full spectrum of reproductive experiences—from fertility, pregnancy, and birth to abortion and miscarriage—RJ doulas challenge not only exclusionary practices of birth but also the normative ideals of family. RJ doulas are actively crafting spaces for queer families to grow and thrive. As such, this study also contributes to current conversations and research on trans health and queer family creation (e.g., Shuster; Acosta; Smietana et al.).

Moreover, RJ doulas' efforts are potentially resonant and meaningful beyond the immediate health care needs of those who identify as trans, nonbinary, and queer. For instance, an increased amount of scholarship in medical anthropology and gender studies has drawn attention to the ways in which Black women experience obstetric racism and misogynoir when navigating prenatal and birth care (e.g., Davis; Nash). As noted by some of our interviewees, these experiences of racism and marginalization in health care settings motivated them to become doulas at the first place. A birth care practice that insists on advocacy, inclusion, and self-reflexivity, hence, is one that benefits a range of people in the context of reproduction and childbirth—a process fundamentally marked by profound vulnerability and which necessitates deep care in kind. Adjacent to, but not of, formalized reproductive care systems, doulas are uniquely positioned to provide support informed by RJ principles. In doing so, they are also prompting other providers to consider how they, too, might participate in creating more just spaces to birth—not only for people of varying genders and familial configurations but also for others who struggle to be recognized and affirmed outside of white, wealthy, heteronuclear norms.

We believe this study also prompts us to consider the promise and possibility of rhetorical worldmaking beyond individual experiences with reproduction and childbirth. By challenging cishet norms in mainstream birth and pregnancy practices, RJ doulas are prompting medical institutions and the society writ large to expand the definition of

family. Family justice is intimately connected with RJ, as reproductive freedom necessarily entails creating families that go beyond the heterosexual biological nuclear norm (Gamson). By advocating for the freedom for queer, trans, and nonbinary people to birth on their own terms, RJ doulas are creating the space for familial self-determination. In addition to family justice, the rhetorical acts of RJ doulas also intervene in existing debates that threaten the rights of trans people, especially youth. Repeatedly, RJ doulas affirm the right for trans people to live autonomously, free from coercion and stigma.

As our interviewees were quick to note, pronoun clarifications and neutral language are good and necessary places to begin this work, but this alone will not create cultures of inclusion and affirmation. Turning to the creative rhetorical practices of RJ doulas not only clarifies how the world of birthwork must and will be transformed; it also offers us a template from which to think broadly about the complexity of gender identity across various contemporary cultural contexts. How might we imagine these strategies—those of advocacy, radical inclusion, and self-reflexivity—being deployed in other settings? How might we use these stories as inspiration and perhaps even blueprints to create more just worlds?

Note

1. Before we began the interview, we asked each research participant whether they would like to use a pseudonym or their real name. Those who chose to use their real name and organization affiliation were often doulas and educators who were well-known as reproductive justice advocates. We honor their decision both during the research and coding process and in writing this article.

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