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International

35 Years of Birth Work

Where Are We Now & Where Do We Go From Here?

Because it's ancient

CONTENTS

Letter From the President

Cathy Daub
PT, CCE (BWI), CD (BWI)

Thirty-five years ago was 1980, the year that my son was born—a VBAC (vaginal birth after cesarean) birth. I was a novelty amongst my friends because VBAC back then was rather unusual. His birth was a pivotal point in my life because now I knew that in a climate of "once a cesarean, always a cesarean," a VBAC was safer than a planned repeat cesarean in most cases. I gave birth to him without any medical procedures or drugs, in what today is called a physiologic birth. I didn't know anything about optimal pelvic positioning then, so I was extremely sore for days afterwards from pushing so hard. If only I'd known the importance of keeping my pelvis forward rather than lying on my back in the hospital bed!

It was his birth that spurred me on a mission of helping other women in New Jersey to know that a VBAC was safer in most instances than a repeat cesarean. Soon, the goal became that of preventing unnecessary cesareans, especially repeat cesareans (for no other reason then the previous cesarean)—not just in New Jersey, but anywhere.

Since the 1980s, there has been a shift in cultural belief systems that has led to an increased cesarean rate. Many women today believe that a cesarean is a safe way to give birth, and that it will prevent damage to their pelvic floor musculature. In addition, on both the medical and the consumer sides, there are incentives to use more technology and drugs enabling women to give birth with less pain.

Furthermore, over the last 35 years medical liability issues have soared. A cesarean is the ultimate intervention that comes with a multitude of other interventions—continuous electronic fetal monitoring, Pitocin, epidurals or spinal anesthesia, IVs, and lying supine on the back—all of which have become acceptable ways of giving birth, and which have risks of their own.

Through it all, too many women have lost the "peak" experience that birth has to offer. Hormones have both physical and behavioral characteristics that contribute to this peak experience of love, euphoria, bonding, and attachment at birth. Today, we know that secretions of hormones such as oxytocin and endorphins are decreased with epidurals and cesareans. Further research is needed to determine how much this affects mother/baby bonding and attachment and more work in the field of primal health will tell us the long-term effects on our health as adults. The question Michel Odent, MD raises is, "What will a generation of children be like who were birthed under the influence of an epidural?"

In the 1980s, the birth climate was, "once a cesarean, always a cesarean," and the VBAC rate was low. Then in the 1990s, the VBAC rate rose slightly with publicity in favor of VBACs. In the 2000's until now, the cesarean rate has increased again reaching an all-time high of 33.7% of all births. Where a cesarean used to be performed only in the case of an emergency, it is now becoming routine, and what becomes routine is often perceived as safe.

Yet there are women today who are questioning what is happening. Just a week ago, my niece caught her first baby while laboring in the shower at a hospital in Ohio with her midwife present. My nephew's wife just gave birth a couple days ago to her sixth baby in a water birth. As I teach childbirth educator and doula workshops around the country, I hear more and more women talking about taking back birth and feeling its power. As dismal as the birth picture appears today, I believe the pendulum has reached its low point and is beginning to swing back again. I hope so—for the sake of women and their babies, everywhere.

BirthWorks believes...

Birth is instinctive...We believe that the knowledge about how to give birth is born within every woman. We help women to have more trust and faith in their own body knowledge that already knows how to give birth.

35 Years of Birth Work:

Where Are We Now & Where Do We Go from Here?

Henci Goer, BA, ACCE

Where We Were

To understand where we are now, we must first jump into our Wayback Machine and see where we were in 1980. The shift to high-tech labor management was in full swing. The cesarean surgery rate had reached the shocking high of 15%—high enough that the National Institutes of Health convened a consensus conference on how to bring it down. Vaginal Birth After Cesarean (VBAC) was rare, making repeat cesarean one of the soaring rate's main drivers. Epidural anesthesia for labor was burgeoning, and as hospitals began installing dedicated obstetric anesthesia services, the need to recoup their costs soon became pressure to have one. Likewise, routine continuous electronic fetal monitoring (cardiotocography) was rapidly becoming the norm. Episiotomy was routine, but progressive practitioners were questioning it, and the first randomized controlled trials would begin appearing mid-decade. Klaus and Kennell's landmark bonding research hadn't had much impact, and babies were typically removed to the nursery shortly after delivery. Few nurses knew much about breastfeeding, and babies of breastfeeding moms were commonly given bottles of sugar water or formula, and pacifiers. Rooming in was rare.

Some hospitals were opening "Family Birth Rooms" (FBRs) or "Alternative Birth Centers" (ABCs). Theoretically, they were supposed to provide a more natural childbirth experience in a home-like environment for low-risk women who desired it. Their main advantage was that women could labor, give birth, and recover with their babies without being moved from place-to-place. In actuality few women got to use them, many who did risked out during labor, and care mostly amounted to Polly Perez's analogy to designer jeans: "Fancy new label, same old jeans".

Some petunias had sprouted in this increasingly medicalized potato patch. The appearance of freestanding birth centers was one. Another was the increasing use of nurse-midwives, mostly as employees of private obstetricians or hospitals serving low-income women. Independent practice was difficult as they were often denied hospital privileges. The concept of having an experienced woman to provide continuous 1:1 labor support had also poked its head above ground. I use "experienced" rather than "trained" because there were as yet no wide-spread, formal training programs or agreement on scope of practice or even on what such a person should be called. Eventually, consensus settled on "doula" with a job description restricted to providing emotional and physical supportive care and advocacy. Doulas worked mostly in stealth mode. Hospital staff generally had no idea they weren't simply a family member or friend.

Childbirth education stood at a crossroads. It arose in the 1960s on the principles that laboring women had the right to labor with a loved one by their side to comfort and assist them and to be awake and aware if they wished to be. This was an easy sell. By the early 1980s, most middle- to high-income white, married women and their husbands took "Lamaze" classes, which had become the generic term for childbirth preparation classes. Classes lasted a couple of hours or more on a once-a-week basis over six to eight weeks. Now childbirth educators had to contend with a new message: OBs and the media were promising women that Electronic Fetal Monitoring (EFM) and liberal use of cesareans averted fetal death and brain damage and that epidurals were a free pass out from unendurable pain. The doctor will almost always win a face-off with a mere childbirth educator saying those promises were false—and that's assuming the woman even hears the other side of the debate. More and more couples were taking classes at the hospital, many of which simply prepared them to be good patients.

Still, not every woman in this category bought in. Aided by such books as the *Immaculate Deception, Spiritual Midwifery,* and *Silent Knife*, women wanting what we now term "physiologic birth" sought out Bradley classes, hired doulas, and chose home or birth center birth attended by mostly direct-entry midwives in the former case and mostly nurse-midwives in the latter. Unlike nurse-midwifery, direct-entry midwifery was not organized, had no agreed-upon training standards, and its practice was either explicitly illegal or in a legally gray area in almost all states.

Other women had learned to their sorrow that they

had been sold a bill of goods. They banded together to form grassroots maternity-care reform organizations. While the broader reform movement was toward less interventive care, access to VBAC was a specific focus. The Cesarean Prevention Movement (CPM), founded in that era, survives to this day as the International Cesarean Awareness Network (ICAN). BirthWorks itself began under the auspices of CPM to train childbirth educators to teach women how to avoid the first cesarean. Agitation had some effect. It led, among other things, to the opening of the FBRs and ABCs mentioned above and to a rise in the number of VBACs. Even so, as noted, hospital birthing rooms were mostly window dressing, and the vast majority of women continued to have automatic repeat cesareans.

As for my special interest, the research, what little there was of it, supported physiologic care. Not that it mattered. The concept of evidence-based medicine was still in its infancy, and collective opinion still ruled, especially in obstetrics, so the research didn't cut much ice.

Where Are We Now? "It Is the Best of Times; It Is the Worst of Times."

Now that you have the back story, we can turn to where we are now. This can be summed up in a series of good news/bad news or, if you prefer, clouds/silver linings statements:

The cesarean rate rode the rollercoaster up to 25%, back down to 20%, mostly thanks to the increasing VBAC rate, and then, after the American Congress of Obstetricians and Gynecologists (ACOG) did a 180 on VBAC, it sailed past its former high to 32%, where it has topped out for the past few years. Rates have risen as well for first cesareans, hitting first-time mothers especially hard. As of 2013, the rate for low-risk first-time mothers was 27%. The silver lining in this cloud is that even ACOG now acknowledges that the cesarean rate is too high. It has issued a joint report with the fetal medicine doctors recommending ways to reduce first cesareans. ACOG has also issued revised VBAC guidelines that are more supportive of VBAC, although its effect on the VBAC rate remains to be seen.

For several decades now, hospital labor management in most hospitals has been organized around the assumptions that a large percentage of women will be induced, most of the rest will have labor augmented, all will be tethered to their beds by monitoring equipment tracked from a central nursing station, and all but a few hold-outs will have an epidural. As a result, many doctors and nurses may never have seen a labor and birth free of medical intervention and have no idea that what they see isn't normal. Some changes for the better have happened, at least with some providers in some hospitals. These include the push to delay elective inductions and cesareans until 39 completed weeks (yeah, I know it's not much, but it's something); the steep decline in episiotomy; the growing awareness that it's a bad idea to clamp the umbilical cord immediately (see article on page 10); more early contact with the baby, at least for women birthing vaginally; more rooming in with the baby; and better breastfeeding support.

The FBRs and ABCs of yesteryear have been reincarnated as Labor & Delivery Rooms. They make no pretense at being anything other than business as usual; still, they are a more pleasant and comfortable environment than the old style labor rooms, and thanks to specialized beds that convert to delivery tables, women delivering vaginally don't have to be moved in the throes of giving birth.

Doulas are now on the radar screen, although this isn't always a good thing. They may be regarded with suspicion, if not outright hostility, because of their perceived potential to influence women to want something other than what the institution provides. This isn't always the case, of course, and for those who can afford them, they can act as a buffer against what all too often can be a lonely and frightening experience.

Nurse-midwives enjoy increased acceptance, but this silver lining comes with a cloud. Nurses who view midwifery as nothing more than an advanced practice option rather than a commitment to a model of care and midwives who are constrained by hospital policies or doctor supervision may be reduced to "med-wives" with little or nothing to distinguish their care.

The mandate to practice evidence-based care has led to what Phil Hall, an obstetrician as witty as he was wise, termed "decision-based evidence making." Deeply flawed studies and reviews that claim to provide support for such things as elective induction, routine cesarean for breech, the dangers of home birth, even equivalency between elective first cesarean and planned vaginal birth now pepper the research literature and are cited in support of medical-model management. Back in the '80s and '90s, the argument was between opinion and research. Now it's between my analysis and interpretation versus theirs, a much more difficult case to make to the public—which isn't to say it can't be done.

The fight for the hearts and minds of pregnant women has grown increasingly difficult. Women of childbearing age today have grown up in an era of high cesarean rates and highly interventive labor management. This was the experience of their mothers, their friends,

and what they see on birth reality programs. It seems quite normal to them. They believe right along with their doctors that safety lies in high-tech management and satisfaction depends on having an epidural. Mainstream childbirth preparation has been reduced to a few weekend hours spent learning a bit about the labor process and some things to do until they can get their epidural. Still, legacy methods have evolved with the times, as Lamaze's campaign promoting healthy birth attests, and newer methods, such as hypnosis for birth, have sprung up alongside.

The internet is the wild card in the deck. It allows misinformation to travel further faster, and the public has no metric to separate the good from the bad because misinformation often comes from credible sources. On the other hand, the internet allows unprecedented access to both the public and the media to vast amounts of information that makes the case for our side. It also enables maternity care reform organizations and individuals to get out their message, and it brings together like-minded people at little or no cost.

Looking at the big picture, a number of forces converge to maintain the current system. Fear of liability is most frequently cited in this regard, but it isn't the only factor. Perverse economic incentives reward labor induction, epidurals, and cesarean surgery, especially planned cesareans. Beliefs about the inherent dangers of labor and the need for routine intervention reinforce each other. In a vicious circle, intervention begets harms, which beget the need for further intervention, and all will be attributed to the propensity for the process to go wrong rather than the rightful cause. No silver linings here other than, perhaps, that pressures to reduce health care costs could alter the economic incentives.

Furthermore, these forces have another, even darker consequence. They lead to a belief that medical staff have the right, even the obligation, to obtain compliance. In furtherance of that goal, staff may give incomplete, no, or misinformation; perform procedures or give medication without seeking consent; threaten and bully women; or proceed despite the woman's express refusal. Many hospitals operate within a culture of impunity. No adverse consequences follow for violating patient rights either within or from outside the institution. The legal system offers no redress, and may, in fact, be called in on the side of the perpetrators. The silver lining here is that this has ignited a new wave of grass roots reformers, and unlike the women of the previous waves, this generation is better armed because women bring their professional skills into the battle.

Saving the best news for last, we now have an infrastructure for providers of physiologic care. The intervening decades have seen the founding of certifying and accrediting bodies for direct-entry midwives, schools that train direct-entry midwives, and freestanding birth centers as well as doulas and lactation consultants, all of which enhances quality of care and credibility. All, too, have membership organizations, which enables speaking with a unified voice and collaborating on joint projects. Perhaps the most exciting of these is a coalition of nurse- and direct-entry midwifery organizations, factions that have not always played well together in the past, and another that has brought together all the stakeholders to find common ground around home birth.

Finally, nurse- and direct-entry midwives have gotten political. Their organizations now lobby at state and national levels. As a result, direct-entry midwives are now legal in many states with more hopefully coming online.

Where Do We Go from Here?

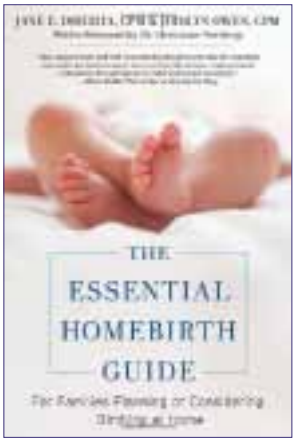
The ship has traveled a long distance in the wrong direction, and its engines continue to drive it on its course. Turning it around will take time and a Herculean, many-pronged effort. This doesn't mean that we shouldn't try, but expecting too much too quickly is a recipe for burnout. My advice? Choose your own adventure. Figure out what best suits your passion and interests and fits with your other needs and obligations. In the words of one of the great rabbinic sages: "You are not obliged to complete the task. Neither may you cease from it". (Pirke Avot 2:21).

Henci Goer, long-time member of BirthWork's Advisory Board, is an award-winning medical writer and internationally-known speaker. An acknowledged expert on evidence-based maternity care, her first book, *Obstetric Myths Versus Research Realities,* was a valued resource for childbirth professionals. Its successor, *Optimal Care in Childbirth: The Case for a Physiologic Approach,* has won the American College of Nurse-Midwives "Best Book-of-the-Year" award. Goer has also written *The Thinking Woman's Guide to a Better Birth,* which gives pregnant women access to the research evidence, as well as consumer education pamphlets and articles for trade, consumer, and academic periodicals. Currently under development, Goer's latest project is Childbirth U (CBU), a website selling narrated slide presentations at modest cost that will help pregnant women make informed decisions about care. You can find out more about CBU and sign up for CBU's e-newsletter on CBU's facebook page at https://www.facebook.com/ChildbirthU.

BOOK REVIEW

The Essential Homebirth Guide

Jane E. Drichta, CPM and Jodilyn Owen, CPM, (New York: Gallery Books, 2013)
379 pp. $12.68 Amazon Paperback / $10.38 Kindle



The Essential Homebirth Guide is my new favorite book. It is wondrous, wise, and woman-centered. It is really the only book like it on the market for families planning or considering birthing at home. It's also a great resource for homebirth midwives and childbirth educators looking to provide a valuable educational resource for expectant parents.

The information in the book is well-structured. With a foreword by Dr. Christiane Northrup, the book features twelve chapters with appendices on questions to ask during an interview, further reading for the homebirth family, resources for childbirth education and support, and resources for higher-risk mamas with homebirth hearts. Chapters begin with a brief overview of the contents followed by a quotation from a mom that conveys her perspective. Every chapter is full of questions that families might ask followed by answers and explanations. Interspersed throughout each chapter are stories from mothers, black and white photographs, and occasionally an offset box that begins "the midwife says …" or contains some useful, related information. The question-and-answer format and the cheerful, down-to-earth tone makes this book easy to understand and enjoy.

Chapter 1 tells the story of homebirth, giving a brief history that mentions early American midwives like Bridget Lee Fuller who caught babies on the Mayflower and Martha Ballard who practiced during the Revolutionary War era. It discusses the rebirth of natural childbirth and homebirth midwifery in the 1970s, referring to Ina May Gaskin, as well as some of the reasons that motivate families to seek homebirth today: many women are seeking it because they feel that birth is not a medical event nor should it be treated as one (p8); for others, it is more affordable care (p9); and some choose it because of deep religious convictions (p10). A growing number of women who have experienced birth trauma in the hospital are seeking a different kind of birth experience at home.

Chapter 2 focuses on early pregnancy, finding a care provider, and the importance of prenatal nutrition. The authors outline the distinctions amongst midwives: direct-entry midwife, certified professional midwife, licensed midwife, certified nurse-midwife, and physicians, including reference to the MDs, DOs, and obstetricians who attend homebirths in some communities.

Chapter 3 focuses on what prenatal care with a homebirth midwife is like. Since midwives focus on holistic care, prenatal visits are 30-60 minutes long (compared to the average obstetrician visit, which is only 7-15 minutes long), giving the opportunity for conversations that build trust and develop relationship. Visits naturally include good, standard care: checking maternal blood pressure, pulse, weight, and urine as well as fetal heart tones and position. But mothers are involved in this process, reporting their own weight and learning how to read their own urine analysis strips. This is all part of encouraging home birthing families to take responsibility for their own self-care.

Chapter 4 discusses relationships in the mother's life with her partner, her parents, coworkers, and even strangers, and how these relationships might be affected by her desire or decision to birth at home. It gives wise advice for coping with diverse reactions to this choice.

Chapter 5 is likewise about communication, specifically the importance of informed consent, crafting a birth plan for homebirth and the possibility of hospital transport, and involving family members in the plan with the understanding that it's important not only to be informed, but flexible (since things rarely go exactly as we plan them!).

The authors give BRAINS as a great acronym for **B**enefits, **R**isks, **A**lternatives, **I**nstincts/Intuition, **N**ow/Never/Nothing, and **S**afety/Satisfaction (pp76-77). These six evaluative measures can be helpful when applied to any decision being made during the childbearing year.

Chapter 6 focuses on the birth team and different types of childbirth education. The authors note the benefits of having a birth doula for physical and emotional support. They mention four doula training organizations: ALACE, Birth Arts International, CAPPA, and DONA. In the next edition of the book, I hope they mention TOLABOR: The Organization of Labor and Birth Options and Resources (http://www.tolabor.com) and BirthWorks doulas. With childbirth education, they give a brief survey of Lamaze, the

Bradley Method, HypnoBabies and HypnoBirthing, Birthing from Within, and The Pink Kit. Again, I hope they'll also mention BirthWorks childbirth education classes in the next edition, as these classes are excellent preparation for vaginal birth after cesarean (VBAC), homebirth after cesarean (HBAC), and homebirth in general.

This chapter also mentions a variety of other professionals and services that pregnant and birthing moms can benefit from, including postpartum doulas, massage therapists, and chiropractors as well as Mayan abdominal massage, yoga, and acupuncture.

Chapter 7 is all about special circumstances that might impact a family's decision to have a homebirth. The authors address risk and fear and also discuss twins and breech babies. They acknowledge that some, but not all, homebirth midwives attend twin or breech births. They explain state regulations that may restrict a midwife's ability to attend as well as the risks that make hospital-based resources useful in some of these cases.

They also take time to acknowledge the emotional impact a personal history of abuse can have on a childbearing woman. I hope the authors will expand this section in the next edition because this is such a critical issue facing a third of childbearing women today. On a related note, they discuss the pressures facing teen moms and what a great option homebirth can be for them. The story they include from the perspective of Nikki, a teen mom, is one of the most encouraging, inspiring, and witty in the whole book.

Chapter 8 focuses on HBAC. It's a splendid chapter exactly in line with the BirthWorks philosophy and the principles of International Cesarean Awareness Network (ICAN) (http://www.ican-online.org). It reassures mothers that home birth is possible after cesarean and informs them of options and resources.

Chapter 9 considers the "big ten" pregnancy-related issues: the emotional experience, anemia, vitamin D deficiency, Rh-negative blood, GBS, gestational diabetes, thyroid problems, the common cold, hypertensive disorders, and miscarriage. The information provided is concise and comprehensible with an emphasis on prevention. As the authors say, "What is the take-home message?" 1) Make sure that the calories you ingest are nutrient dense. 2) exercise regularly (p209). Good nutrition does prevent many (though, of course, not all) pregnancy-related complications.

Chapter 10 focuses on labor and birth at home. The authors discuss in some detail the importance of cleaning the house before the birth, and what to do with pets and siblings as well as the necessity for a homebirth kit. In this chapter, they also advise what to pack in a bag in case of hospital transport and options for what to do when a pregnancy is postdate, including out-of-hospital methods of induction. Also discussed is the experience of early labor, some pain relief measures for active labor (with an emphasis on water birth), and pushing out and catching the baby.

The authors also mention some of the top reasons for transport to the hospital: fatigue, pain management, maternal fever or high blood pressure, significant blood loss prior to the birth, baby's heart rate too low or too high, meconium in the amniotic fluid, uncontrolled postpartum hemorrhage, retained placenta, newborns who cannot maintain their temperature, and other newborn anomalies that require pediatric care (p266). This provides a good overview for parents and helps to foster realistic expectations.

Chapter 11 focuses on the postpartum period, including immediate postpartum care, skin-to-skin mother-baby contact, breast-feeding, and newborn medications (eye ointment and Vitamin K) and screenings (initial heel-stick and others). The authors discuss postpartum depression and how to get help for it. Happily, they note postpartum depression (PPD) is rare in homebirthing mothers, but it does occur, so it's important to be on the lookout for it. They are careful to distinguish between normal "baby blues" and PPD. In this chapter, they mention placental medicine, including encapsulation, as one option that families may use to combat PPD.

Chapter 12, the final chapter, includes in the tradition of Ina May Gaskin's *Spiritual Midwifery and Guide to Childbirth,* eight birth stories from mothers with different homebirth experiences. There is a note of realism and a diversity of experience represented in the stories. The mothers express themselves honestly, often with a great sense of joy and triumph, but they don't over-idealize their experience. Only one says she had a pain-free birth, and none mention an experience of orgasmic birth. Perhaps these are the sorts of stories that connect to most American women's experiences of childbirth, even at home, today.

I recommend this book wholeheartedly to expectant parents, childbirth educators, and midwives. Doulas looking to add to their resources for families should pick this book up immediately. In my opinion, it is the best book available today for American families on midwifery care and preparing to birth at home.

Reviewed by Jane Beal
PhD, CD (DONA), CCE (BWI), CLS

The Brain and Birth: The Mothers' Day Birth of Lex

Maria Pyanov, CCE (BWI)

As a first-time mom, I took the eight-week BirthWorks class my midwife recommended and I absolutely loved it. My first birth experience was rather relaxed and very positive. I delivered at a free-standing birth center, labored in the tub (amazing!) and then welcomed my son with just my husband and two midwives. In the following years, I had two more sons with very precipitous deliveries, both out of the hospital. They were not bad experiences, but they were rather intense and rushed. When baby number four was about to come, we were all prepared for another fast birth, however, things went a little slower that time.

During my fourth pregnancy, I did not even feel pregnant—I just felt ill. Not thinking much about my own labor, I taught five BirthWorks classes during those nine months. I spent my whole pregnancy discussing the birth process, the role of the brain, the role of hormones, and the importance of a proper environment and a birth team that respected it. The importance of not disturbing a mom in labor and keeping her from having to use her "thinking" brain was also explored. I knew the importance of an undisturbed labor, yet I did not think much about my own delivery. My last two labors had been so fast, I assumed the same would happen again.

As with my other three deliveries, the birth began with a rupture of membranes and the absence of active labor. My water ruptured at 4:45am on Mothers' Day. All at my house were still sound asleep and I allowed everyone to rest. Around 7:15am, my husband, Ed, awoke shocked that I did not wake him. He rushed the boys to grandma's house, assuming we were in for another precipitous birth. I still had no contraction pattern and only had random contractions that felt more like Braxton Hicks than true labor. We remained at home simply relaxing until around 5pm. I knew I was not in active labor, but Ed feared he would be catching another baby (he caught our second), and we decided to head to the center and arrived at 6pm.

I was having some intense contractions in the car, still 5 minutes apart, but as soon as we arrived they seemed to fizzle out. Our doula (a good friend), a new midwife not yet attending births solo, our experienced midwife, and a birth assistant were at the center. Our seasoned midwife gave the new midwife charge and remained close in case she was needed. I was only 4cms and about 70% upon arrival. My doula and I went for a walk while Ed ran to grab my pump—we were going to try and get things going. Part of the delay was because I was not ready to handle the intensity that I knew was coming. In my last two births, transition and delivery were less than an hour, so it was extremely intense and a bit frightening. I did not verbalize my fear and handled the contractions I was having very well, so the new midwife was unable to tell I was contracting.

I preferred laboring in privacy but did not realize how much privacy I needed. In my previous births, I retreated to the bathroom alone. With things happening so quickly, I was not making very conscious decisions—I was simply just doing what was comfortable. The new midwife was very sweet but did not realize my need for privacy, and I failed to communicate that to her. While some women need company, reassurance, physical comfort measures, etc., and her presence may have been very helpful for them, I am one who dislikes most communication, touch, and any feeling of being watched. My husband knew this and my doula picked up on it, so they both hung out in the next room; they checked in often, brought me a drink, and just held space. I needed to know they were there without them being too close. During thirty minutes of pumping, my doula offered reassurance, asked about my contractions, and was very present; this prevented me from really letting go and telling her how intense it would become. I was not giving my body permission to really get into labor.

About two hours after we started trying to move things along, I was only 5cms with no contraction pattern. The experienced midwife checked in and was surprised we had no baby yet, given my history. She observed I was pumping for a second time, and she suggested my husband and doula leave the room. After they left, I immediately started having more intense contractions with the pumping. The midwife came in again and did a check, stretch, and sweep; I was at 7cms and the baby was low. While I generally am not fond of touch or chatter, I recall her gently touching me and saying not to worry because I would be having my baby soon. I found that incredibly reassuring. She was present for my other deliveries and her presence helped my body feel safe.

The midwife then decided I needed to be left alone to rest. As I heard the door latch, I felt my first real intense (can't speak or move through it) contraction. It was like my body just knew it could let go and progress. It was about 10pm. I had a few more really intense contractions, and although they were getting harder to cope with, I did not want anyone in the room.watching. As with my previous precipitous births, I went from no contraction pattern to a handful of intense contractions to involuntary pushing in a very short time frame. I felt the involuntary pushing with three contractions before I realized it was not in my head; he was in fact coming out. Until this point, I was quiet but I finally just yelled, "He's coming out!" and everyone rushed into the room to find him crowning.

I lost my cool at this point, but there was no time to cope; I yelled a lot. Not being in a great position (another thing I discussed for nine months during classes) and physically unable to move, it hurt as he fully descended but lasted only a few minutes. I still had my hoodie and T-shirt on when my baby was handed to me. After nine months of horrific sickness, I was so very thankful to finally be done. It was a moment of such relief and joy.

My labor experience as a whole reinforced all that I teach through BirthWorks. Birth is instinctive, our environment matters, our brain and hormones drive the experience, and we need to feel safe to naturally progress. Even if we logically know we are safe, our instincts and our body need to feel it.

Difficult Birth Journey: A Much-Needed Support Group

Tiffany Tice, CD (BWI) CCE (BWI)

Mothers meet monthly at the Village Learning Centre (a classroom and meeting space operated by Healing Passages Birth & Wellness Center in Des Moines, IA) to receive and offer support as they grieve a difficult pregnancy, birth, or postpartum period.

I have heard from clients and students who have attended the group that it has been incredibly helpful for their grieving process. This is the type of support many women need, but are not receiving. I encourage doulas, educators, and other birth professionals to consider bringing this type of group to your own community!

I recently sat down with the facilitator, Emily Alberhasky, CD (BWI), to learn more about this group.

Please tell me what this group is and what kinds of women attend. Difficult Birth Journey is for any mother who considers any part of her pregnancy, labor, delivery, or postpartum period difficult or disappointing. Almost all the women that participate have planned a natural pregnancy and delivery, whether at home, in the hospital, or birth center setting. I also encourage women who have experienced healing from their own experiences to come and offer moral support.

Why is this group important for the community?

I had a difficult experience with my first baby and found that no one ever once asked me how I felt about my birth or if I was emotionally doing ok. Everyone who heard my story said, “Well at least you have a healthy baby!” And, while I was so incredibly grateful for my healthy baby, I was devastated by my experience. And I hear this over and over by every woman who comes into our group. Having a safe place to talk about how painful and disappointing our experiences have been is so crucial to our healing!

What have you learned by facilitating the group?

I have learned so much by listening to women share their stories. Personally, I am learning what it means to hold the space for a grieving mother—that it is ok that I can only offer her a safe and gentle place for her to share. She needs to feel that her story and feelings are valid, and she is not alone.

I have also learned that women who feel that they prepared as much as they could, and surrounded themselves with a supportive and loving birth team, have a much greater chance of making peace with their experience.

What advice would you give to others that may want to start a similar group in their communities?

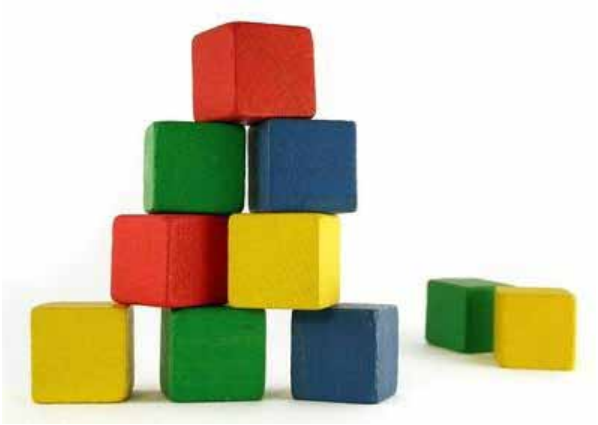
I would encourage anyone starting a group like this to allow it to function as organically as possible. Small groups work better for this type of setting. Women come wanting to share their stories. And, women innately love listening to each other’s stories. I’d advise others who want to facilitate a group to get comfortable in the sadness and pain—not offering opinions or advice often. I have to remind myself that this is their time to share their story. They’re not asking for my opinion or thoughts. This is about processing. It’s almost always best to remain quiet and just listen. You might be surprised at how much you’ll learn just from listening!

HEALTHWISE

Protein: The Building Blocks of the Body's Cells

Horatio Daub, MD and

Cathy Daub, PT, CCE (BWI), CD (BWI)



Proteins are the building blocks of the body's cells and many people worry they are not getting enough protein in their foods. Our culture is obsessed with the idea that protein is the holy grail of good nutrition probably because both fats and carbohydrates have been vilified as causing many of our health problems, particularly obesity. However, no nutritional researcher has ever identified a diet that provides enough calories for growth in children and caloric balance in adults so that a stable weight is achieved, as protein deficient as long as the diet is based on whole foods rather than processed foods.

Therefore, whether you are an omnivore, vegetarian, or vegan, pregnant or non-pregnant, you will get enough protein as long as you eat a variety of whole foods that are consumed close to their state in nature and try to avoid processed foods that have mostly empty calories or lots of added fats/oils.

Labor is active work and pregnant women who eat in a healthful way can be assured that they will have the strength they need for pregnancy, labor, and birth without worrying about protein intake. The best way to build strength and muscle mass, or slow muscle loss that often occurs with aging, is not by increasing protein intake in your diet, but by doing regular strength-training exercise and eating a healthy diet with a variety of whole (unprocessed) foods. These foods must provide enough calories for growth whether you are a child or pregnant woman, or to maintain a healthy weight if you are an active adult.

Here are some important things to know about protein in pregnancy:

1. The vast majority of women in the U.S. regularly eat enough protein every day, so pregnant women in our country don't need to worry about protein intake if they are eating a healthy diet with a variety of whole foods that provide enough calories for themselves and their babies to grow.

2. Both animal and plant foods can be good sources of protein. Plant protein, however, has an advantage because the plant foods have much less fat and overall are less calorie dense than animal foods.

3. When the baby is small in the first trimester, it makes sense that a pregnant woman won't need much more food than she normally eats. As the baby grows, the mother's appetite will increase, and along with it the protein and calories that she needs for herself and her baby to grow.

4. It is important to pay attention to the quality of foods you are eating rather than the quantity or specific nutrients in the foods. If you are eating whole foods that are minimally processed or cooked, your body will naturally get the calories and nutrition you and your baby need.

5. Good sources of plant protein are beans (hummus), soy (including tempeh and tofu), seeds, nuts, and whole grains (quinoa-although technically it is a seed). Good sources of animal protein are lean meat, poultry, fish and shellfish, eggs, milk, cheese, and yogurt, but again, remember that animal protein comes usually with a large amount of fat, mostly saturated, which is detrimental to cardiovascular and overall health.

"Unfortunately, the worry about getting enough protein has led to an over-emphasis on high-protein foods that are also high in fat and cholesterol. Americans consume more than twice the amount of protein they need. A high-protein intake is detrimental to bone strength and overworks the kidneys."

—Neil Barnard, MD
Physicians Committe for Responsible Medicine
www.pcrm.org

RECIPE

Chocolate Ganache

A holiday rich chocolate favorite.
No sugar or added sweeteners!

¾ cup dried dates soaked in water for 1 hour and drained
¾ cup unsweetened dark cocoa powder
½ cup raw almond butter
½ Tablespoon pure vanilla extract
¾ cup water

1. Cut dates in half and dig out pits. Even if you buy pitted dates, cut them in half and check to make sure there are no pits. Transfer the pitted softened dates to a high-speed blender (Vita Mix)
2. Add ¾ cup water and blend until smooth.
3. Add the remaining ingredients.
4. Cover and whirl on high speed until smooth and creamy.
5. If you are coating fruit, you might want to add a little more water for a slightly thinner consistency.

RESEARCH UPDATE

Unattended Home Labor Until Complete Cervical Dilatation Ending with Hospital Delivery

Cathy Daub, PT, CCE (BWI), CD (BWI)

With attention and research, we are now gaining a better understanding of the role of hormones in labor. It is well-known that a woman needs to have plenty of oxytocin, the hormone of love, to establish labor. In order to secrete oxytocin to help labor progress, a woman in labor needs to feel safe. This is the reason that many women are advised to stay at home until labor is more established. At home she is familiar with her environment and can relax better. The sounds, smells, and sights are all familiar as well.

In the hospital, the sounds, smells, and sights are very different from her home. She is also not sure what to expect, how her labor will go, and what will be suggested during labor that she may or may not agree with. This often causes anxiety and the production of stress hormones, such as adrenalin, which are a brake for labor. Therefore, staying home until labor is well established helps to keep her anxiety level lower and encourage more production of oxytocin to help labor progress. In fact, women who arrive at the hospital in very early labor are often sent home until their labor becomes more active.

The 2013 study by Eryilmaz et al looked at how women and babies fared when they stayed at home until reaching complete cervical dilatation, followed by planned hospital delivery. In their study, they retrospectively compared 238 pregnancies having home labor plus hospital delivery (study group) with 476 pregnancies that had spent the whole labor in the hospital setting, considering various maternal and neonatal outcomes. They recognized that fear of hospitals and avoidance of routine hospital obstetrical interventions led some women with low-risk pregnancies to spend most of their active first stage of labor at home without a health provider before going to the hospital to give birth.

Their results showed that cesarean and episiotomy rates were lower (($P < 0.0001$ and $P < 0.001$, resp), however neonatal intensive care unit admissions of the infants were more prevalent in the study group. Other maternal and neonatal outcomes, including neonatal mortality, were comparable. They concluded that although their preliminary data generally does support the safety of home active labor plus hospital delivery for low-risk pregnancies, the clinical implications of current data warrant further prospective trials.

Gun Eryilmaz O[1], Dogan NU, Gulerman C, Mollamahmutoglu L, Cicek N, Deveer R.
"Unattended Home Labor until Complete Cervical Dilatation Ending with Hospital Delivery: Analysis of 238 Pregnancies" *Obstet Gynecol Int.* 2013;2013:196709. doi: 10.1155/2013/196709. Epub 2013 Feb 26.

Delayed Cord Clamping: A Look at the Evidence

Brittany Sharpe McCollum, CCE (BWI), CD (DONA)

Let's start this with: I have a new favorite blog. I might not love every post and definitely haven't read every post from the archives, but when it comes to a research-based look at obstetrical procedures, I'm finding this blog far more favorable than not—The Academic OB/GYN, blogger Dr. Nicholas Fogelson. His articles are intended for obstetricians, not for the average person delving into the world of obstetrics for such minor things as having a baby (Now I hope you all caught the complete sarcasm there), but his posts are actually research-based and not always in line with American Congress of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) (which is something I've come to admire as I've learned more about the constraints of the system). Tonight's post is inspired by and largely based on his Grand Rounds discussion from January 2011, at the University of South Carolina School of Medicine (but I promise it will read much more easily than that sounds).

More times than I can count, I've had couples in classes ask "What about delayed cord clamping?" Such a valuable question. What about it?

Delayed cord clamping refers to waiting, an undetermined amount of time, to clamp and cut the baby's umbilical cord after birth. Dr. Fogelson has compared the modern procedure of immediate cord clamping and cutting to the antiquated practice of blood-letting, "It's interesting to talk about blood-letting and then talk about immediate cord clamping because I think that you'll see a bit of a parallel."

Perhaps one of his most poignant and beautiful points is made in watching the role that cord clamping takes on in births outside of the human realm. The clips Fogelson shows in his Grand Rounds presentation from 2011 of the births of a cat, a horse, an orangutan, and a dolphin show nothing being done to the cord.

That is, the cord is actually simply ignored by the mother for a long while after the birth. The cat and orangutan take their time licking their little ones while the foal figures out its way onto its feet. The dolphin in Fogelson's video starts moving its tail and swims up and with its mother. It is only in human culture that we've initiated this obsession with cord management.

Cultures around the world have varying traditions surrounding the umbilical cord. In some cultures, a lotus birth is the tradition, where the placenta is left attached to the baby until the cord naturally falls off on its own (usually a few days shorter than when a "cord stump" dries up and falls off). In other cultures, the midwife calls in another woman from the community to cut the cord. In the islands of Micronesia, the cord is referred to as "the house of the soul" and is preserved in a small box or burred with the placenta near the family's home (Kitzinger, 145). One thing that remains constant, though, is that the need to 'care for' the cord seems to be a distinctly human trait.

The umbilical cord is composed of three vessels. Two vessels (arteries) bring waste products away from the baby back to the placenta and one vessel (vein) brings blood and nourishment to the baby. Until the placenta begins to detach from the mother's uterus, the cord has the potential to continue bringing blood and nourishment to the baby. This means that human umbilical cords will often pulsate for at least ten minutes after birth. In addition, as the cord is exposed to the air, it begins to contract but the first vessels that are closed off are those that bring waste products away from the baby, meaning the vessel bringing blood to the baby continues to pulsate and closes off last. It's theorized that this allows the baby a certain measure of circumstantial control over its use of this extra blood volume (Buckley). Interestingly, a placenta drained of blood tends to shear away from the lining of the uterus more easily than a placenta swollen with blood (Kitzinger, 145).

I have had several clients whose OB told them that the baby must be held below the mother after birth for gravity to allow the benefits of cord pulsation. Some research does show that holding the baby at or below the level of the uterus until cord pulsation ceases maximizes the blood transfer. In considering this, I remind mommas that birth and the immediate postpartum is a complexity of physiological and emotional responses to the baby's entrance into the world. Having the baby on one's chest while the cord pulsates may not lead to maximum blood

transfer from the placenta but will provide the baby with a portion of it's own blood while also providing the benefits of immediate skin-to-skin contact with mom. According to the World Health Organization, "Trials in which newborns were placed on the mother's abdomen, or on the bed where she lay, and the cord was clamped only when it stopped pulsating, showed that these babies had blood volumes 32% higher than babies whose cords were clamped immediately after birth" ("Review of Evidence"). Thirty two percent higher blood volume paired with skin-to-skin benefits such as lower cortisol levels; assistance in regulating breathing, heart rate, and temperature; elevated blood sugar levels; and colonization of the mother's bacteria ("The Importance of Skin-to-Skin"), to name a few, is a far better deal for most babies than 50% greater blood volume from being held below the level of the mother's uterus and being denied skin-to-skin with mom.

The clinical indication for keeping the baby at uterus level while the cord is intact really comes into play in the case of a cesarean. After a cesarean, babies are often held at a level several inches higher than the uterus. In this case, gravity can force the blood to remain in the placenta. According to Sarah Buckley, MD, this may cause an increased incidence of respiratory distress in babies born via c-section; several studies have shown respiratory distress can be eliminated in many circumstances by allowing a full transfusion of blood from the placenta.

By delaying the clamping of the umbilical cord, babies gain up to 40% of their own blood volume (Fogelson) and increase their oxygen level (Buckley). This cord and placental blood provides a back-up of blood for use in the rapidly changing pulmonary and organ systems (such as the lungs). When the cord is clamped immediately, other organs sacrifice their blood to the pulmonary system since it requires blood immediately for necessary lung function when the blood-oxygen supply from the placenta is cut off (Morley). Studies have found delaying the clamping of the cord helps raise iron levels (reducing the risk of anemia), in addition to favoring early contact between mom and baby (WHO, "Delayed Clamping"). A frequent question I hear is about the potential for greater jaundice levels due to the increased blood volume. Research does show that jaundice levels can be higher when the cord is clamped later versus earlier with no adverse effects (Morley) and actual antioxidant benefits from the bilirubin (MIreles).

The research that our technology and advances in science and medicine allow us is crucial in aiding our understanding of physiological processes. As professionals, though, information that challenges the accepted norm can be difficult to recognize. As Fogelson noted in his Grand Rounds discussion, it may be comforting for those who have trouble incorporating new technique into their practice to realize that delayed cord clamping has, in fact, a fairly strong history. Even Erasmus Darwin, grandfather of Charles Darwin, in 1801 recognized the importance of blood flow to the baby: "Another thing very injurious to the child is the tying and cutting of the navel string too soon; which should always be left till the child has not only repeatedly breathed but till all pulsation in the cord ceases. As otherwise, the child is much weaker than it ought to be, a part of the blood being left in the placenta which ought to have been in the child." As a childbirth educator, encouraging clients to ask questions of their care providers and seek out evidence-based practice is incredibly important in creating the systemic change to truly providing care that is safest for mom and baby.

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Birthing a baby requires integration of the mind, body, and spirit.

I Am a Doula

Loralee Pendergast, CCE (BWI), CD (DONA)

I am a doula. I have been to about thirty births and the following birth is one that stands out among the others.

It is 1:00am and I get a phone call. It is the husband of one of my clients. His wife, a healthy mom, is at the hospital and is 8cms dilated. This is their first baby. I can hear her in the background moaning, but not the kind of moan that tells me, as a doula, that she is comfortable. It's more of a painful moan that tells me she is not in a good situation. He tells me she is in heavy labor and "they" are trying to stick her with needles for a routine blood draw, only they are not having success in getting any blood. I hear her moan again, in that same painful tone. I tell the husband I will be right there.

I quickly get dressed and into my car. I am hoping I can get there before she gets too stressed. I know if she gets too stressed, it could possibly slow down her labor and the progress she may have already made. In my mind, all I can picture is medical staff gathered around her with needles and blood everywhere from the unsuccessful needle pokes. It is my job as a doula to be there by her side, to comfort her, to "protect" her, to tell her she does not need to be afraid, and to let her know she can take a time out. I want "them" to leave her alone and give her the privacy a birthing mom needs. As my mind races, I can't get to the hospital fast enough!

I finally arrive and walk into her room. I notice a nurse; her eyes are fixated on a computer screen, and I hear the clicking of keys on a keyboard. "They" have obviously left the room and the chaos is over. The room is dimly lit except for a bright fluorescent light off in the corner. My client is sitting up in the bed visibly upset by what just went on. Her husband is by her side. I walk over to her and notice blood stains on her sheet. I place my hand on her arm and she tells me she would like to have an epidural. Knowing that she is upset and wants to avoid interventions if possible, I tell her that she is almost there and that we need to take each contraction one at a time. I breathe with her and notice a sense of calmness come over her. Minutes pass and a doctor walks into the room and asks her if she wants her amniotic sac broken; she pauses before answering and says, "yes." Shortly afterwards, she begins to feel a lot of pressure and instinctively gets into a hands and knees position and begins pushing with her contractions. Her doctor tells her she cannot birth her baby in that position because she will "tear like heck" (his actual words) and he makes her turn over. She tells him that being on her hands and knees is the most comfortable position for her and then asks him what position he would like for her to be in. She then lies down on her left side and labors there for a little while. The urge to push gets stronger. Noticing this, the nurse walks over to her and places her in a semi-sitting position. The nurse takes one of my client's legs and holds it up and back and instructs me to do the same with the other leg. The nurse counts to ten and tells my client to hold her breath with each push. Several minutes later, a baby girl is born. Mom lifts her baby to her chest and is happy that she is finally able to hold her baby in her arms. My client has the most blissful look on her face and it seems that everything that has happened up until this point, at least for now, has been forgotten. I stay for a short while, congratulate them, and then leave.

It is almost 4am as I walk down the hall to exit the hospital and head to my car. My thoughts about the birth consume me. Thoughts about how my client became more stressed by the staff trying to draw blood and how I wanted to scream into the phone, "Please, just leave her alone!" Thoughts about how the doctor gave her the "option" of breaking her amniotic sac and how I wanted to say, "Why suggest an intervention that she does not necessarily need?" Thoughts about when she got into a position that felt right for her body to birth in, she was forced to change and how I wanted to say, "This is what her body is telling her to do. Why change this for your convenience?" Thoughts about how the nurse instructed my client to hold her breath and push to the count of ten—moms need to breathe and babies need oxygen! I couldn't help but wonder how much better this mom's birth experience could have been if she had been left to labor without interference from others and had a nice, quiet environment.

In the end though, mom and her baby were healthy, and this was her birth not mine. I find comfort in knowing that I helped to calm her and avoid the drug that I knew she did not really want, nor probably need. These pleasant thoughts are what give this birth an ending for me as I look forward to the next birth I will attend. I am a doula.

ON THE BUSINESS SIDE: NOTES FROM THE OFFICE

BirthWorks on Facebook

Women are attracted to our organization because of its unique philosophies, evidence-based curriculum, and the comprehensive nature of our certification materials, as well as our educational and inspiring workshops.

BirthWorks currently has 5,000 friends on our Facebook pages and that number grows daily. You can help spread the word about BirthWorks by encouraging your friends to follow us on Facebook. You can ask birth-related questions, post inspirational quotes, or mention birth-related stories you've seen in the news. Also, be sure to watch Facebook for great deals on products and/or services.

Become a BirthWorks Ambassador

Our goal is to have an Ambassador in every state by the end of 2014! If you are a student in one or both of our certification programs, being an Ambassador will help you make contacts to build your own small business, and at the same time promote the BirthWorks name. You can also be an Ambassador for BirthWorks, even if you are not currently enrolled in one of our certification programs. If you, as a member, are attracted to our philosophies and want to help us further our mission, and would like to become an Ambassador for BirthWorks, please write to Mali Schwartz, chair of our Ambassador committee. Mali's email is: malischwartz@verizon.net.

Board Positions Open

BirthWorks continues to undergo exciting changes! In order to enhance the support we can provide to our members, as well as the birthing and parenting community, we are expanding our Board of Directors. BirthWorks is currently accepting applications for the following positions: Director of Public Relations, Director of Marketing, and Director of Fundraising.

Not only is this an opportunity to contribute your time and expertise to BirthWorks, it is a great way to keep your skills up-to-date and looks great on your resume! If are interested in applying for one of these positions, or you have questions about the requirements of a particular position, please contact the BirthWorks office by calling 1-888-TO BIRTH (862-4784) or via email at info@birthworks.org.

Help Spread our Message

GoodSearch.com and GoodShop.com are search engines that donate half their revenues to the charities their users designate. You use them as you would any search engine, and they are powered by Yahoo. Enter BirthWorks International as the charity you want to support.

BirthWorks Online Store

Please note that all orders from the online store, or those made through the office, will be sent by priority mail and childbirth preparation workbooks will be sent by media mail. This means you need to get your orders in at least two weeks in advance of your classes so you receive them in time. If necessary, rush orders are available at an additional cost. You can also call the office to request UPS or FedEx options. Be sure to look for postal slips when looking for your package as it has come to our attention that some orders have not been picked up.

iGive - You Save and We Grow

BirthWorks invites you to make a difference by taking a few moments of your time and registering with iGive to donate to BirthWorks International every time you shop at participating businesses.

After you register with iGive, which only takes a few minutes, whenever your make a purchase with a participating business, such as Amazon.com, a portion of your sale will go to BirthWorks. Right now there are over 1,000 participating stores, so sign up now!

Use this direct link to sign up now:
http://www.igive.com/C61Z1X0.

Give a Gift of BirthWorks

BirthWorks helps women have better birth experiences and now you can help someone else do the same by giving them the gift of BirthWorks. If you believe in helping more women to become trained to teach childbirth classes in their communities, you can gift tuition for the childbirth educator certification program, or for the childbirth educator and/or doula workshops. If you believe in helping to train more women to care for new mothers in the postpartum period, send a gift to go towards development of our postpartum doula certification program. And remember, your gift is tax-deductible. Just click on the "Donations" tab on our website.

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Are you interested in hosting a childbirth educator and/or doula workshop for BirthWorks in your community? Could you benefit from getting a reduced training fee? We are looking for women who are, or would like to be, connected to their birthing community by bringing BirthWorks to their area. Before applying, please have a location for the workshop in mind, suggestions for advertising in your area, and allow for six months planning time. Write to sandyr@birthworks.org for more information about this unique and rewarding opportunity.

CHILDBIRTH EDUCATOR & DOULA TRAINING & CERTIFICATION

Training and Certification

BirthWorks has been an internationally recognized childbirth education program for over 25 years. Its innovative and experiential design develops a woman's self-confidence, trust, and faith in her innate ability to give birth and nurture her child.

BirthWorks childbirth classes are also approved by DONA (Doulas of North America) International to fulfill the childbirth educator requirement for their birth doula certification.

BirthWorks began offering doula training in 2006. The same philosophies embodied in our childbirth education classes are carried through in our doula trainings. Be able to offer women an extension of your childbirth classes by taking the BirthWorks Doula Training.

For information about attending BirthWorks childbirth education classes or doula trainings in your area, as well as information about BirthWorks childbirth educator workshops or finding a BirthWorks doula, visit www.birthworks.org.

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January 9-11: Charlottesville VA
April 17-19: Los Angeles CA
June: Auckland NZ

Doula Education

December 5-7: Des Moines IA

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March 26-29: San Antonio/Austin TX
June: Christchurch NZ

New Childbirth Educator Students

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Kathleen Rucka, VA

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Postpartum Online Doula Program currently in development at BirthWorks.

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Cathy Daub
Kathleen Furin
Sally Dear-Healey
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Reviewers Needed

We need reviewers for new childbirth educators-in-training. If you are certified and have been teaching BirthWorks classes for awhile, and want to become a reviewer, please contact the BirthWorks office at 1-888-TO BIRTH (862-4784) or info@birthworks.org. This is a great way to give back and help other women who are working on their certification.

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