

Birthing

Alternative Birthing Practices

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The Mother Friendly Childbirth Initiative

The First Consensus Initiative of the Coalition for Improving Maternity Services

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Mission

The Coalition for Improving Maternity Services (CIMS) is a coalition of individuals and national organizations with concern for the care and wellbeing of mothers, babies, and families. Our mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs.

Preamble

Whereas:

- In spite of spending far more money per capita on maternity and newborn care than any other country, the United States falls behind most industrialized countries in perinatal* morbidity* and mortality, and maternal mortality is four times greater for African-American women than for Euro-American women;
- Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes, yet in the United States, midwives are the principal attendants at only a small percentage of births;
- Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence;
- Increased dependence on technology has diminished confidence in women's innate ability to give birth without intervention;
- The integrity of the mother-child relationship, which begins in pregnancy, is compromised by the obstetrical treatment of mother and baby as if they were separate units with conflicting needs;
- Although breastfeeding has been scientifically shown to provide optimum health, nutritional, and developmental benefits to newborns and their mothers, only a fraction of U.S. mothers are fully breastfeeding their babies by the age of six weeks;
- The current maternity care system in the United States does not provide equal access to health care resources for women from disadvantaged population groups, women without insurance, and women whose insurance dictates caregivers or place of birth;

Therefore,

We, the undersigned members of CIMS, hereby resolve to define and promote mother-friendly maternity services in accordance with the following principles:

Principles

We believe the philosophical cornerstones of mother-friendly care to be as follows:

Normalcy of the Birthing Process

- Birth is a normal, natural, and healthy process.
- Women and babies have the inherent wisdom necessary for birth.
- Babies are aware, sensitive human beings at the time of birth, and should be acknowledged and treated as such.
- Breastfeeding provides the optimum nourishment for newborns and infants.
- Birth can safely take place in hospitals, birth centers, and homes.
- The midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth.

Empowerment

- A woman's confidence and ability to give birth and to care for her baby are enhanced or diminished by every person who gives her care, and by the environment in which she gives birth.
- A mother and baby are distinct yet interdependent during pregnancy, birth, and infancy. Their interconnectedness is vital and must be respected.
- Pregnancy, birth, and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies, fathers, and families, and have important and long-lasting effects on society.

Autonomy

Every woman should have the opportunity to:

- Have a healthy and joyous birth experience for herself and her family, regardless of her age or circumstances;
- Give birth as she wishes in an environment in which she feels nurtured and secure, and her emotional well-being, privacy, and personal preferences are respected;
- Have access to the full range of options for pregnancy, birth, and nurturing her baby, and to accurate information on all available birthing sites, caregivers, and practices;
- Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests suggested for use during pregnancy, birth, and the postpartum period, with the rights to informed consent and informed refusal;
- Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs.

Do No Harm

- Interventions should not be applied routinely during pregnancy, birth, or the postpartum period. Many standard medical tests, procedures, technologies, and drugs carry risks to both mother and baby, and should be avoided in the absence of specific scientific indications for their use.
- If complications arise during pregnancy, birth, or the postpartum period, medical treatments should be evidence-based.

Responsibility

- Each caregiver is responsible for the quality of care she or he provides.
- Maternity care practice should be based not on the needs of the caregiver or provider, but solely on the needs of the mother and child.
- Each hospital and birth center is responsible for the periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks, and rates of use of its medical procedures for mothers and babies.
- Society, through both its government and the public health establishment, is responsible for ensuring access to maternity services for all women, and for monitoring the quality of those services.
- Individuals are ultimately responsible for making informed choices about the health care they and their babies receive.

These principles give rise to the following steps, which support, protect, and promote mother-friendly maternity services:

* see glossary below

Ten Steps of the Mother-Friendly Childbirth Initiative

For Mother-Friendly Hospitals, Birth Centers, and Home Birth Services*

To receive CIMS designation as "mother-friendly," a hospital, birth center, or home birth service must carry out the above philosophical principles by fulfilling the Ten Steps of Mother-Friendly Care:

A mother-friendly hospital, birth center, or home birth service:

1. Offers all birthing mothers:
 - Unrestricted access to the birth companions of her choice, including fathers, partners, children, -family members, and friends;
 - Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula*, or labor-support professional;
 - Access to professional midwifery care.
2. Provides accurate descriptive and statistical information to the public about its practices and procedures for birth care, including measures of interventions and outcomes.
3. Provides culturally competent care—that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion.
4. Provides the birthing woman with the freedom to walk,

continued on page 2...

move about, and assume the positions of her choice during labor and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy (flat on back with legs elevated) position.

5. Has clearly defined policies and procedures for:

- collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary;
- linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support.

6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, -including but not limited to the following:

- shaving;
- enemas;
- IVs (intravenous drip);
- withholding nourishment or water;
- early rupture of membranes*;
- electronic fetal monitoring;
- other interventions are limited as follows:
 - Has an oxytocin* use rate of 10% or less for induction and augmentation*;[†]
 - Has an episiotomy* rate of 20% or less, with a goal of 5% or less;
 - Has a total cesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals;
 - Has a VBAC (vaginal birth after cesarean) rate of 60% or more with a goal of 75% or more.

7. Educates staff in non-drug methods of pain relief, and does not promote the use of analgesic or anesthetic drugs not specifically required to correct a complication.

8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.

9. Discourages non-religious circumcision of the newborn.

10. Strives to achieve the WHO-UNICEF "Ten Steps of the Baby-Friendly Hospital Initiative" to promote successful breastfeeding:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff;
2. Train all health care staff in skills necessary to implement this policy;
3. Inform all pregnant women about the benefits and management of breastfeeding;
4. Help mothers initiate breastfeeding within a half-hour of birth;
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants;
6. Give newborn infants no food or drink other than breast milk unless medically indicated;
7. Practice rooming in: allow mothers and infants to remain together 24 hours a day;
8. Encourage breastfeeding on demand;
9. Give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants;
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.

[†] This criterion is presently under review.

*** Glossary**

- Augmentation:* Speeding up labor.
- Birth Center:* Free-standing maternity center.
- Doula:* A woman who gives continuous physical, emotional, and informational sup-port during labor and birth—may also provide postpartum care in the home.
- Episiotomy:* Surgically cutting to widen the vaginal opening for birth.
- Induction:* Artificially starting labor.
- Morbidity:* Disease or injury.
- Oxytocin:* Synthetic form of oxytocin (a naturally occurring hormone) given intravenously to start or speed up labor.
- Perinatal:* Around the time of birth.
- Rupture of Membranes:* Breaking the "bag of waters."

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Attending births is like growing roses. You have to marvel at the ones that just open up and bloom at the first kiss of the sun but you wouldn't dream of pulling open the petals of the tightly closed buds and forcing them to blossom to your time line.

-Gloria Lemay



HypnoBirthing®: The Missing Link In Childbirth Education

By Aryn A. Whitewolf, Ct. Ht., HBCE

I brought HypnoBirthing® to Whatcom and Skagit Counties almost two and a half years ago, and in that time I have been fortunate to have helped more than 50 couples learn a more natural, comfortable, and effective way of bringing their babies into the world. I have also been honored by positive acceptance from the already established birthing community in both Counties. It is safe to say that HypnoBirthing® is here to stay, and can no longer be thought of as a "fad" or a "peculiar" way to birth. For those couples seeking a truly positive and empowering birth, HypnoBirthing® will be their birth education class of choice.

The last weekend in September 2002, I had the honor to be a part of an event of great importance to the world wide natural birthing community. And yet, it went relatively unnoticed by anyone except those present. It was the 1st Annual International HypnoBirthing® Practitioners Conclave, held in Phoenix, Arizona. HypnoBirthing® Educators from as far away as Australia and England came together to share friendship, stories, and information on the "fastest growing natural childbirth education program in the world." During the three-day event, each of us had an opportunity to attend workshops, address concerns, and learn new techniques aimed at enhancing our individual practices. We learned infant massage, discussed the "myth" of the necessity of continual medical intervention in the absence of distress, and we tackled the skills needed to run a successful business.

Even though this natural childbirth technique continues to grow in popularity, there is always more to learn. I am fortunate to be a part of an international group of childbirth educators that are eager to always learn "new" positive natural childbirth practices. We are a community of people passionate about our chosen work. Many in our group spend countless hours researching all the newest birthing information,

and sharing that information with others in our profession. It is my practice to pass on as much of this new information as I can in my HypnoBirthing® classes. Indeed, HypnoBirthing® would never have come into it's own if it's founder, Marie Mongan, had not read Dr. Grantly Dick Reed's book, Childbirth Without Fear, and questioned her own Physician in the 1950's about allowing her to experience her own child's birth as Dr. Reed recommended. Her successful two-hour birth opened the door over 50 years ago to her understanding that there truly was a better way to birth.

While I truly believe that all women have the right to birth as they choose, it saddens me to know that there are women who, through lack of education and information, voluntarily opt for major abdominal surgery over vaginal birth in the lack of true distress and necessity. The media and society's attitude that all birth should be considered a medical incident constantly feed the idea that birth is a "messy" or "horrific" experience. And yet, time and time

again I have heard medical personnel, midwives, doulas, and clients refer to HypnoBirthing® as the "missing link" in childbirth education that could and does create a positive mind set and therefore a more comfortable and positive birth. The practice of vaginal birth after cesarean (VBAC) is a very hot issue in the birthing world, and a woman who chooses to have a VBAC is usually told that she should reconsider because of the many dangers in which she is putting herself and her unborn baby. I am proud to say that many of these alternative minded women find their way to my HypnoBirthing® class and they can, and do have successful VBAC's. To date, our 2nd largest local HypnoBirthing® baby was a 10lb. 12oz. VBAC birth, at home in a water tub, and Mom raves about her birth in a positive way to this day.

I love what I do, and I rarely think of it as work. I think of my role more as the holder of ancient knowledge that I am honored to pass on to those who seek it out. For many generations women passed down to each other the information on how to birth. And, once a woman knows how to birth and what to expect during labor, her self-empowerment expands and her fear diminishes. There is nothing that compares to playing a part in a calm, focused, positive birth. To assist a couple in experiencing labor as a "labor of love", and feel their boundless joy and deep connection to each other and their child is priceless.

When I think of the future of HypnoBirthing® in our area, it warms my heart to know that every day someone takes the first step toward a positive birth experience by deciding to learn about this truly wonderful childbirth technique. So while the world keeps moving on in ways that seem dark and negative, here in Whatcom and Skagit Counties, one small bright fire called HypnoBirthing® keeps shining and growing and doing its best to bring hope, joy, and peace to the world one birth at a time.

Your questions are always welcomed.
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Position Paper: The Doula's Contribution to Modern Maternity Care

The birth of each baby has a long lasting impact on the physical and mental health of mother, baby and family. In the twentieth century, we have witnessed vast improvements in the safety of childbirth, and now efforts to improve psychosocial outcomes are receiving greater attention.

The importance of fostering relationships between parents and infants cannot be overemphasized, since these early relationships largely determine the future of each family, and also of society as a whole. The quality of emotional care received by the mother during labor, birth, and immediately afterwards is one vital factor that can strengthen or weaken the emotional ties between mother and child. (1-5) Furthermore, when women receive continuous emotional support and physical comfort throughout childbirth, their obstetric outcomes may improve. (6-11)

Women have complex needs during childbirth. In addition to the safety of modern obstetrical care, and the love and companionship provided by their partners, women need consistent, continuous reassurance, comfort, encouragement and respect. They need individualized care based on their circumstances and preferences. The role of the doula encompasses the non-clinical aspects of care during childbirth.

This paper presents the position of DONA on the desirability of the presence of a doula at childbirth, with references to the medical and social sciences literature. It also explains the role of the doula in relation to the woman's partner, the nurse, and medical care providers. This paper does not discuss the postpartum doula, who provides practical help, advice, and support to families in the weeks following childbirth.

Role of the Doula

In nearly every culture throughout history, women have been surrounded and cared for by other women during childbirth. (12) Artistic representations of birth throughout the world usually include at least two other women, surrounding and supporting the birthing woman. One of these women is the midwife, who is responsible for the safe passage of the mother and baby; the other woman or women are behind or beside the mother, holding and comforting her. The modern doula is a manifestation of the woman beside the mother.

Doulas are trained and experienced in childbirth, although they may or may not have given birth themselves. The doula's role is to provide physical, emotional, and informational support to women and their partners during labor and birth. The doula offers help and advice on comfort measures such as breathing, relaxation, movement and positioning. She also assists families to gather information about the course of their labor and their options. Perhaps the most crucial role of the doula is providing continuous emotional reassurance and comfort.

Doulas specialize in non-medical skills and do not perform clinical tasks, such as vaginal exams or fetal heart rate monitoring. Doulas do not diagnose medical conditions, offer second opinions, or give medical advice. Most importantly, doulas do not make decisions for their clients; they do not project their own values and goals onto the laboring woman. (13)

The doula's goal is to help the woman have a safe and satisfying childbirth as the woman defines it. When a doula is present, some women feel less need for pain medications, or may postpone



them until later in labor; however, many women choose or need pharmacological pain relief. It is not the role of the doula to discourage the mother from her choices. The doula helps her become informed about various options, including the risks, benefits and accompanying precautions or interventions for safety. Doulas can help maximize the benefits of pain medications while minimizing their undesirable side effects. The comfort and reassurance offered by the doula are beneficial regardless of the use of pain medications.

The Doula and the Partner Work Together

The woman's partner (the baby's father or another loved one) plays an essential role in providing support for the woman. A doula cannot make some of the unique contributions that the partner makes, such as intimate knowledge of the woman and love for her and her child. The doula is there in addition to, not instead of, the partner. Ideally, the doula and the partner make the perfect support team for the woman, complementing each other's strengths. In the 1960's, the earliest days of fathers' involvement in childbirth, the expectation was that they would be intimately involved as advisors, coaches and decision-makers for the woman. This turned out to be an unrealistic expectation for most men because they had little prior knowledge of birth or medical procedures and little confidence or desire to ask questions of medical staff. In addition, some men felt helpless and distressed over the woman's pain and were not able to provide the constant reassurance and nurturing that women need.

With a doula present, the pressure on the father is decreased

and he can participate at his own comfort level. Fathers often feel relieved when they can rely on a doula for help; they enjoy the experience more. For those fathers who want to play an active support role, the doula assists and guides them in effective ways to help their loved ones in labor. Partners other than fathers (lovers, friends, family members) also appreciate the doula's support, reassurance and assistance.

Doulas as Members of the Maternity Care Team

Each person involved in the care of the laboring woman contributes to her emotional well-being. However, doctors, nurses, and midwives are primarily responsible for the health and well-being of the mother and baby. Medical care providers must assess the condition of the mother and fetus, diagnose and treat complications as they arise, and focus on a safe delivery of the baby. These priorities rightly take precedence over the non-medical psychosocial needs of laboring women. The doula helps ensure that these needs are met while enhancing communication and understanding between the woman or couple and the staff. Many doctors, midwives and nurses appreciate the extra attention given to their patients and the greater satisfaction expressed by women who were assisted by a doula. (14)

Research Findings

In the late 1970's, when Drs. John Kennell and Marshall Klaus investigated ways to enhance maternal-infant bonding they found, almost accidentally, that introducing a doula into the labor room not only improved the bond between mother and infant, but also seemed to decrease the incidence of complications. (6,7) Since their original studies, published in 1980 and 1986, numerous scientific trials have been conducted in many countries, comparing usual care with usual care plus a doula. Table 1 summarizes the findings of these studies, confirming the value of the doula. As can be seen in Table 1, obstetric outcomes were most improved and intervention rates most dramatically lowered by doulas in settings where the women had no loved ones present, the intervention rates were routinely high (as indicated by the data for the control groups), and the doulas were not health care professionals.

Table 1. Summary of findings of randomized controlled trials of doulas or health care professionals acting as doulas.

Key to abbreviations: n/a = not assessed; c/s = cesarean section rate; mod = moderate; NICU = neonatal intensive care unit admission;

PPD = postpartum depression; + = positive; E = experimental (supported); C = control group; O = observed group

Author, date of study	Loved ones present?	Epi- dural	Oxy- tocin	Forceps/ VTE	C/S	Appar- atus -7/8/5	NICU/Inc. Newborn Resp. stay	BF @ 4-6 wks.	mod to high PPD scores @ 6 wks	+ birth experience	+ mid/Cl/mage
Studies of doulas											
Sava '80 ^a	E 32	N	n/a	60%	1%	19%*	n/a	n/a	n/a	n/a	n/a
	C 93	N	n/a	17%	4%	27%	n/a	n/a	n/a	n/a	n/a
Klaus '86 ^b	E 186	N	n/a	26%	1%	7%	2%	n/a	n/a	n/a	n/a
	C 279	N	n/a	13%	3%	17%	5%	n/a	n/a	n/a	n/a
Hofmeyr '91 ^c & Wolman '92 ^d	E 92	N	n/a	8%	n/a	2%	n/a	51%*	11%*	58.7%	59%*
	C 97	N	n/a	10%	n/a	4.4%	n/a	29%	29%	34%	34%
Studies of trained doulas											
Kennell '91 ^{***}	E 212	N	0.8%*	17%*	8.2%	9.0%	n/a	1.4%*	n/a	n/a	n/a
	O 200	N	21.6%	23%	21.3%	3%	n/a	1.7%	n/a	n/a	n/a
	C 304	N	33.3%	43.6%	26.3%	18%	n/a	3.4%	n/a	n/a	n/a
Kennell '93 ^{***} & '94 ^{***}	E 300	Y	67%	n/a	n/a	15%*	n/a	15.4%*	n/a	n/a	n/a
	C 270	Y	78%	n/a	n/a	34.8%	n/a	34.4%	n/a	n/a	n/a
Gordon '91 ^{***}	E 169	Y	61.7%	61.3%	18.3%	6.6%	n/a	n/a	87.3%	n/a	43.5%*
	C 209	Y	62.5%	59.8%	27.2%	15.3%	n/a	n/a	84.2%	n/a	51.7%
Studies of nurses, midwives, or students acting as doulas											
Langer '93 ^{***}	E 361	N	47%	n/a	2.8%	3.4%	3.8%	n/a	1.2%*	n/a	47.0%
	C 363	N	37%	n/a	3.4%	2%	3.5%	n/a	7%	n/a	28.8%
Hodnett '97 ^{***} , '99 ^{***}	E 72	Y	61%*	4%	18%	7%	n/a	n/a	n/a	n/a	n/a
	C 73	Y	80%	22%	24%	18%	n/a	n/a	n/a	n/a	n/a
Finger '88 ^{***}	E 20	Y	30%	47%	n/a	0%	0%	47%	n/a	n/a	n/a
	C 14	Y	68%	64%	n/a	4%	6%	57%	n/a	n/a	n/a

* statistically significant difference

** This study consisted of three groups, the first two of which were randomly allocated: doula-accompanied woman (E); observed woman (O) (a silent observer was in the room behind a curtain); and control (C), who received usual care without a doula or an observer. Group C was added after the trial, when it became clear that the presence of a silent observer improved outcomes, possibly by influencing staff behavior or by reassuring that the women were not alone.

Questions to ask a doula

To discover the specific training, experience and services offered by anyone who provides labor support, potential clients, nursing supervisors, physicians, midwives, and others should ask the following questions of that person.

- What training have you had? (if a doula is certified, you might consider checking with the organization)
- Tell me about your experience with birth, personally and as a doula.
- What is your philosophy about childbirth and supporting women and their partners through labor?
- May we meet to discuss our birth plans and the role you will play in supporting me through childbirth?
- May we call you with questions or concerns before and after the birth?
- When do you try to join women in labor? Do you come to our home or meet us at the hospital?
- Do you meet with us after the birth to review the labor and answer questions?
- Do you work with one or more back up doulas for times when you are not available? May we meet them?
- What are your fee and refund policies?

Services and Costs

There are two basic types of doula services: independent doula practices and hospital/agency doula programs. Independent doulas are employed directly by the parents. They usually have telephone contact and at least one prenatal meeting with their clients to establish a relationship. When labor begins, the doula arrives and stays with the woman until after the birth. A postpartum meeting to process the birth is usually included in the doula's service. Most doulas charge a flat fee for their services, and many base their fees on a sliding scale. Some doula programs are associated with or administered by a hospital or community service agency. The doulas may be volunteers or paid employees of the hospital or agency. These programs vary widely in their design. In some, the hospital or agency contracts with an independent community-based doula group to provide the doulas. Others train and employ their own staff of doulas. Payment of the doula may come from the institution, the client, or it may be shared by the two. Some hospital/agency services are set up as on call doula services. A rotating call schedule ensures that there are one or more doulas available at all times. They meet the client for the first time and establish their relationship during labor.

Other hospital/agency doula programs make doula services available to expectant mothers or couples, who may meet and choose their doula, or have one assigned to them, along with a backup doula. They may work with their doula in much the same way that private doulas and clients work together. There is growing third party reimbursement for labor support. Grant funding is often available, and some Medicaid-funded health

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This paper was written by Penny Simkin and Kelli Way, and reviewed and edited by Connie Livingston, Director of Publications, and the 1998 DONA Board of Directors.

For more information about doulas, contact:

Doulas of North America (DONA)
(888)788-DONA
www.DONA.org

To purchase copies of this paper, contact DONA at the number above or order them on-line in the Doula Boutique on the DONA website at www.dona.org.
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The extent and magnificence of the medical discoveries made during the last hundred years is beyond both praise and gratitude. But now that many of the troubles and dangers have been overcome, we must move on - not only to save more lives, but actually to bring happiness to replace the agony of fear. For although the consciousness of a woman's discomfort can now be dispelled, it is only at a price, for with it goes the awareness of birth and the joyful sensations and emotions that should accompany it. Now we must bring a fuller life, truer to natural law, to women.
-Dr. Grantly Dick-Read, M.D.

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Labor Support Terminology

The terminology describing labor support can be confusing. When a person uses any of the terms below to describe herself, she may need to clarify what she means by the term.

"Doula" - a Greek word meaning "Woman's servant." In labor support terminology, "doula" refers to a supportive companion (not a friend or loved one) professionally trained to provide labor support. She performs no clinical tasks. "Doula" also refers to lay women who are trained or experienced in providing postpartum care (mother and newborn care, breastfeeding support and advice, cooking, child care, errands, and light cleaning) for the new family. To distinguish between the two types of doulas, one may refer to "birth doulas" and "postpartum doulas."

"Monitrice" - a French word originally used by Fernand Lamaze to refer to a specially trained nurse or midwife who provides nursing care and assessment, in addition to labor support. Today, "monitrice" is often used as a synonym for "birth assistant" or "labor assistant."

"Labor Support Professional," "Labor Support Specialist," "Labor Companion" - synonyms of "birth doula."

"Birth Assistant," "Labor Assistant" - sometimes these terms are used as synonyms for "doula" but also may refer to lay women who are trained to assist a midwife (vaginal exams set up for the birth, fetal heart checks, etc.) as well as to provide some labor support.

Whatcom County Doula Association



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International Definition of a Midwife

“A **midwife** is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.”

- Jointly developed by the International Federation of Midwives and the International Federation of Gynaecology and Obstetrics
- Adopted by the International Confederation of Midwives Council 1972.
- Adopted by the International Federation of Gynaecology and Obstetrics 1973.
- Later adopted by the World Health Organization
- Amended by the International Confederation of Midwives Council, Kobe, October 1990
- Amendment ratified by the International Federation of Gynaecology and Obstetrics 1991
- and the World Health Organization 1992.

Certified Midwife (CM)

A **Certified Midwife (CM)** is an individual educated in the discipline of midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.

Certified Midwife (CM) is also used in certain states as a designation of certification by the state or midwifery organization.

Certified Nurse-Midwife (CNM)

A **Certified Nurse-Midwife (CNM)** is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.

Certified Professional Midwife (CPM)

A **Certified Professional Midwife** is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the **North American Registry of Midwives (NARM)** and is qualified to provide the midwifery model of care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings.

Direct-Entry Midwife (DEM)

A direct-entry midwife is an independent practitioner

educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide the Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings.

Lay Midwife


The term “Lay Midwife” has been used to designate an uncertified or unlicensed midwife who was educated through informal routes such as self-study or apprenticeship rather than through a formal program. This term does not necessarily mean a low level of education, just that the midwife either chose not to become certified or licensed, or there was no certification available for her type of education (as was the fact before the Certified Professional Midwife credential was available). Other similar terms to describe uncertified or unlicensed midwives are traditional midwife, traditional birth attendant, granny midwife and independent midwife.

Licensed Midwife (LM)

A licensed midwife is a midwife who is licensed to practice in a particular jurisdiction (usually a state or province).

MANA. Definitions. 8 Sept. 2002. Midwives Alliance of North America. 13 Dec. 2002. < <http://www.mana.org/definitions.html>>.

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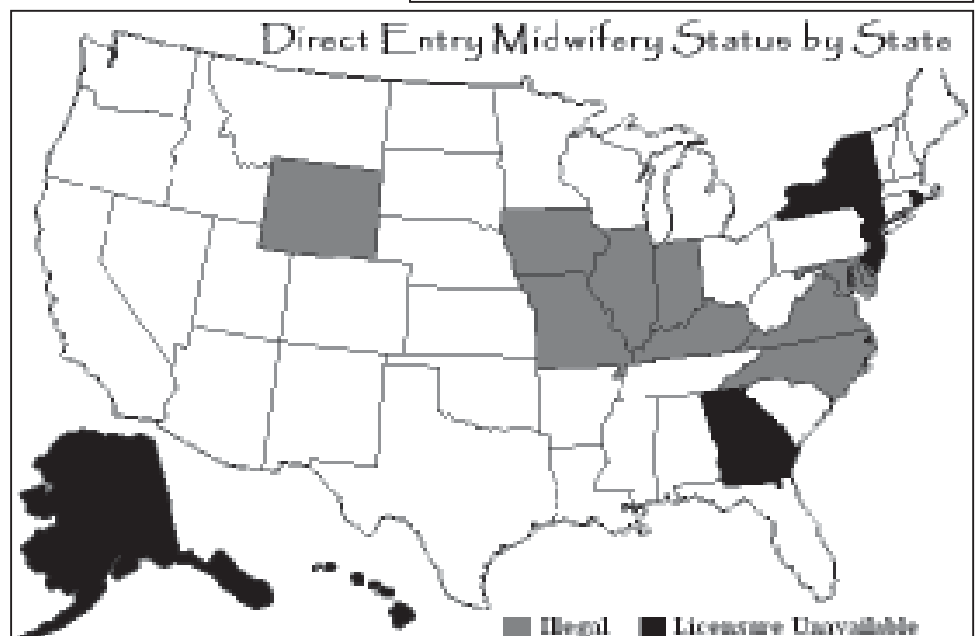
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Update

Julie Samms CD (DONA)

Greetings! It's been a while hasn't it? As you can see the newsletter has undergone some major changes in celebration of our third year of publication. Some of the changes are obvious and others are less so. I would like to thank the Lynden Tribune for being so patient and helping me through the transition to a professionally printed format. I would also like to thank all of our faithful readers and supporters that have kept the newsletter going these past two years.

Due to the increasing size of the newsletter I am actively looking for more information and new advertisers. We are going out to 1,500 birth enthusiasts this issue and are continuing to grow. If you have a birth related service you would like to list in the resource directory or an ad you would like to place please contact me at 734-4334 or e-mail birthing@arczip.com.

With the change of season comes many changes for my family. We have weathered the moving crisis and after three months are beginning to feel somewhat normal again. It is wonderful to be back in town. I have missed the ability to walk as my primary mode of transportation. Living out of town for the past year has really made me realize how much I dislike commuting. No longer!

Initially we were forced to be without a car due to lack of a running vehicle. But gradually it became less of an issue and more of a life-style choice. It is truly liberating to not have to worry about gas, oil, maintenance and car insurance. Not to mention the release from irritating vehicles that don't quite run right. Ideologically, it is also nice to know that I'm not adding to the massive vehicular pollution problem. I'm sure I will own a vehicle again, but I hope that I will never again be dependent on it.

We are eagerly awaiting the arrival of our third baby, due in March. My oldest son is hopeful that it will be a girl. My daughter doesn't seem to have a preference but has taken eagerly to singing to my expansive belly. Occasionally she will look up at me and say "The baby can.. hear me?" then she laughs like there was never anything more amusing.

As for myself, I am enjoying being big and pregnant. And I get BIG when I'm pregnant. I am just beginning to collect my birth supplies and deciding whether or not to pursue a waterbirth. It appeals to me, as I am a very water centered person. And I think that I would benefit from it immensely. But my last two labors were very quick and I wonder if there will be time to mess with filling a tub, none the less using it. I'm leaning towards an inflatable children's pool so that if I don't use it, at least my kids will.

One of the most exciting projects I've been working on the past few months is the creation of the Whatcom County Doula Association. Look for more information about this group in the next newsletter. In the meantime, if you are looking for a doula the database is up and running!

We are also looking forward to our first Doula Retreat this summer out on Orcas Island. I personally am really interested in working with Gloria Lemay as well as visiting the San Juans. In the five years I've lived in Bellingham somehow I've never been out to the islands. This retreat promises to be an incredible introduction to the natural beauty of our coastline. Because we will be at the YMCA camp Orkila, we will be free to use their facilities when we aren't workshoping with Gloria. There is a climbing wall, canoeing, rowboats, a heated outdoor pool, both high and low ropes courses, crafts and endless hiking and walking trails. I am really excited. I hope to see many of my fellow doulas from across the state as well as across the country.

The Whatcom County Doula Association proudly announces the first annual

Doula Retreat

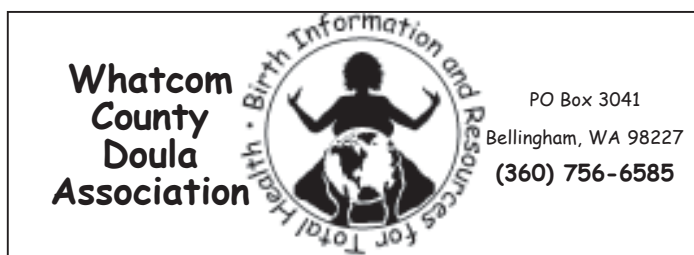
Featuring Advanced Doula Training with Gloria Lemay

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Enjoy the beauty of the San Juan Islands while communing with your doula sisters from all over the country.

Accommodations and meals are provided. Babes in arms are welcome. Cost for the weekend is \$250.

For more information contact the Whatcom County Doula Association at
(360) 756-6585, or e-mail us at birthing@arczip.com.



Speaking of fellow doulas, the opportunity to participate in a doula training here in Bellingham has come around again. If you are looking for a doula training course this is a good opportunity to avoid the hassel of training in Seattle. Shellie Moore is a DONA certified doula trainer and this independent course fulfills DONA's requirements for certification. And incidentally, the independent training courses are about half the cost of taking the course down in Seattle. See the back page for more information.

This is an e-mail that I recieved recently and thought you all would enjoy.

Top 10 Labor Tips

1. Relaxation techniques work best when integrated into daily life, rather than just labor . . . Practice daily. Become a relaxation expert.
2. Giving birth is a part of living . . . dont stop living to give birth.
3. Plan a labor project that will include physical movement, contact with normal daily life, and uses mental activity. (Ideas: garden, bake, write letters, lunch with friends)
4. Avoid excessive support in early labor. This may make you feel weak and dependent.
5. Water is your friend, dehydration is your enemy. Drink 4 ounces/hr. When the labor gets tough . . . get in the water. Water has many benefits and no risks.

Perhaps we share stories in much the same spirit that explorers share maps, hoping to speed each others journey, but knowing the journey we make will be our own.
-Gloria Steinem

6. Eat to energize your body and mind for the work that lies ahead. Labor requires physical stamina & mental energy.
7. In active labor, notice what works and do more of that. Be willing to try a variety of coping techniques.
8. Be active, walk between contractions. Change position every 30 minutes. This allows the baby to navigate with ease.
9. Use the bathroom every hour. A full bladder can hinder your progress and make contractions more intense.
10. In truth, one contraction at a time is not too difficult. Remember, the prizes of life are at the end of each journey, not near the beginning.

A nice little bit of wisdom I thought. I would love to hear your feedback about our new format or any of the content. The next issue will be due out this spring, either in early March or mid-April depending on the timing of our baby. In the meantime, enjoy the rain and remember that your body is your ally, not your enemy.
With Love,
Julie



Resource Directory

Doulas

-Whatcom County-

Archer, Colleen (360) 758-9934
cta9@hotmail.com
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cassidykt@yahoo.com
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hugyourdoula@aol.com
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- Davis, Elizabeth. **Heart and Hands**
- Dunnewold, Ann & Sanford, Diane G. **Postpartum Survival Guide**
- Gaskin, Ina May. **Spiritual Midwifery**
- Kitzinger, Sheila. **Complete Book of Pregnancy and Childbirth**
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- Simkin, Penny; Whalley, Janet; Keppler, Ann. **Pregnancy, Childbirth & the Newborn**
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Part 2 - May 30-31, 2003

✓the art and science of labor support

✓methods of pain relief

✓comfort measures

✓coping tools

About the course: This 32 hour course covers the essential elements of doula practice. The course meets the training requirements for certification with Doulas of North America (DONA) and includes hands-on, multisensory experiences for all learning styles.

Course Instructor: Shellie Moore is a DONA certified Doula Trainer. She has attended more than 145 births as a doula in a variety of settings.

Logistics: The course is \$250 (Part 2 only-\$150 for CB educators or L&D nurses)

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Birthing

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