Midwifery

...where the heart is

edited by Desiré Dubounet
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This Book is an intro and a support for midwives and they are encouraged to get
A midwife measures the height of the mother’s fundus at about 26 weeks to determine the probable gestational age of the fetus.

Midwifery is a health care profession in which providers offer care to childbearing women during pregnancy, labour and birth, and during the postpartum period. They also care for the newborn and assist the mother with breastfeeding.

A practitioner of midwifery is known as a midwife, a term used in reference to both women and men, although the majority of midwives are female. In addition to providing care to women during pregnancy and birth, many midwives also provide primary care to women, well-woman care related to reproductive health, annual gynecological exams, family planning, and menopausal care.

Midwives are autonomous practitioners who are specialists in low-risk pregnancy, childbirth, and postpartum. They generally strive to help women to have a healthy pregnancy and natural birth experience. Midwives are trained to recognize and deal with deviations from the normal. Obstetricians, in contrast, are specialists in illness related to childbearing and in surgery. The two professions can be complementary, but often are at odds because obstetricians are taught to «actively manage» labor, while midwives are taught not to intervene unless necessary. Midwives refer women to general practitioners or obstetricians when a pregnant woman requires care beyond the midwives’ area of expertise. In many jurisdictions, these professions work together to provide care to childbearing women. In others, only the midwife is available to provide care. Midwives are trained to handle certain more difficult deliveries, including breech births, twin births and births where the baby is in a posterior position, using non-invasive techniques.

Not only do midwives give the option for a natural birth, they offer lower maternity care cost, reduced mortality and morbidity related to cesarean and other interventions, lower intervention rates, and fewer recovery complications.
Etymology
The term midwife is derived from Middle English: mid = «with» and Old English: wif = «woman».

Early Historical Perspective
Midwives are mentioned in the Old Testament: Exodus, Chapter 1. The Bible describes how the children of Israel (Hebrews) were enslaved in Egypt and they multiplied greatly. The Egyptians became fearful of the potential power of so many Hebrews. Pharaoh, therefore, commanded the Hebrew midwives (named Shiprah and Puah) to kill all male babies delivered to the Hebrew women. The midwives, however, “feared God” and disobeyed Pharaoh by allowing the male babies to live. When Pharaoh asked the midwives why they had disobeyed his orders, the midwives told him the Hebrew women had easier labors than Egyptian women and delivered their babies before the midwife arrived. “And God dealt well with the midwives” (Exodus, Chap. 1, verse 20).

In ancient Egypt, midwifery was a recognized female occupation, as attested by the Ebers papyrus which dates from 1900 to 1550 BCE. Five columns of this papyrus deal with obstetrics and gynecology, especially concerning the acceleration of parturition and the birth prognosis of the newborn. The Westcar papyrus, dated to 1700 BCE, includes instructions for calculating the expected date of confinement and describes different styles of birth chairs. Bas reliefs in the royal birth rooms at Luxor and other temples also attest to the heavy presence of midwifery in this culture.

Midwifery in Greco-Roman antiquity covered a wide range of women, including old women who continued folk medical traditions in the villages of the Roman Empire, trained midwives who garnered their knowledge from a variety of sources, and highly trained women who were considered female physicians. However, there were certain characteristics desired in a “good” midwife, as described by the physician Soranus of Ephesus in the 2nd century. He states in his work, Gynecology, that “a suitable person will be literate, with her wits about her, possessed of a good memory, loving work, respectable and generally not unduly handicapped as regards her senses [i.e., sight, smell, hearing], sound of limb, robust, and, according to some people, endowed with long slim fingers and short nails at her fingertips.” Soranus also recommends that the midwife be of sympathetic disposition (although she need not have borne a child herself) and that she keep her hands soft for the comfort of both mother and child. Pliny, another physician from this time, valued nobility and a quiet and inconspicuous disposition in a midwife. A woman who possessed this combination of physique, virtue, skill, and education must have been difficult to find in antiquity. Consequently, there appears to have been three “grades” of midwives present in ancient times. The first was technically proficient; the second may have read some of the texts on obstetrics and gynecology; but the third was highly trained and reasonably considered a medical specialist with a concentration in midwifery.

Midwives were known by many different titles in antiquity, ranging from iatrinē (Gr. nurse), maia (Gr., midwife), obstetrix (Lat., obstetrician), and medica (Lat., doctor) [. It appears as though midwifery was treated differently in the Eastern end of the Mediterranean basin as opposed to the West. In the East, some women advanced beyond the profession of midwife (maia) to that of gynaecologist (iatros gynaikēios, translated as women’s doctor), for which formal training was required. Also, there were some gynecological tracts circulating in the medical and educated circles of the East that were written by women with Greek names, although these women were few in number.
Based on these facts, it would appear that midwifery in the East was a respectable profession in which respectable women could earn their livelihoods and enough esteem to publish works read and cited by male physicians. In fact, a number of Roman legal provisions strongly suggest that midwives enjoyed status and remuneration comparable to that of male doctors. One example of such a midwife is Salpe of Lemnos, who wrote on women’s diseases and was mentioned several times in the works of Pliny.

However, in the Roman West, our knowledge of practicing midwives comes mainly from funerary epitaphs. Two hypotheses are suggested by looking at a small sample of these epitaphs. The first is the midwifery was not a profession to which freeborn women of families that had enjoyed free status of several generations were attracted; therefore it seems that most midwives were of servile origin. Second, since most of these funeral epitaphs describe the women as freed, it can be proposed that midwives were generally valued enough, and earned enough income, to be able to gain their freedom. It is not known from these epitaphs how certain slave women were selected for training as midwives. Slave girls may have been apprenticed, and it is most likely that mothers taught their daughters.

The actual duties of the midwife in antiquity consisted mainly of assisting in the birthing process, although they may also have helped with other medical problems relating to women when needed. Often, the midwife would call for the assistance of a physician when a more difficult birth was anticipated. In many cases the midwife brought along two or three assistants. In antiquity, it was believed by both midwives and physicians that a normal delivery was made easier when a woman sat upright. Therefore, during parturition, midwives brought a stool to the home where the delivery was to take place. In the seat of the birthstool was a crescent-shaped hole through which the baby would be delivered. The birthstool or chair often had armrests for the mother to grasp during the delivery. Most birthstools or chairs had backs which the patient could press against, but Soranus suggests that in some cases the chairs were backless and an assistant would stand behind the mother to support her. The midwife sat facing the mother, encouraging and supporting her through the birth, perhaps offering instruction on breathing and pushing, sometimes massaging her vaginal opening, and supporting her perineum during the delivery of the baby. The assistants may have helped by pushing downwards on the top of the mother’s abdomen.

Finally, the midwife received the infant, placed it in pieces of cloth, cut the umbilical cord, and cleansed the baby. The child was sprinkled with “fine and powdery salt, or natron or aphronitre” to soak up the birth residue, rinsed, and then powdered and rinsed again. Next, the midwives cleared away any and all mucus present from the nose, mouth, ears, or anus. Midwives were encouraged by Soranus to put olive oil on the baby’s eyes to cleanse away any birth residue, and to place a piece of wool soaked in olive oil over the umbilical cord. After the delivery, the midwife made the initial call on whether or not an infant was healthy and fit to rear. She inspected the newborn for congenital deformities and testing its cry to hear whether or not it was robust and hearty. Ultimately, midwives made a determination about the chances for an infant’s survival and likely recommended that a newborn with any severe deformities be exposed.

A 2nd-century terracotta relief from the Ostian tomb of Scribonia Attice, wife of physician-surgeon M. Ulpius Amerimnus, details a childbirth scene. Scribonia was a midwife and the relief shows her in the midst of a delivery. A patient sits in the birthing chair, gripping the handles and the midwife’s assistant stands behind her providing support. Scribonia sits on a low stool in front of the woman, modestly looking away while also assisting the delivery by dilating and massaging the vagina, as encouraged by Soranus.

The services of a midwife were not inexpensive; this fact that suggests poorer women who could not afford the services of a professional midwife often had to make do with female relatives. Many wealthier families had their own midwives. However, the vast majority of women in the Greco-Roman world very likely received their maternity care from hired midwives. They may have been highly trained or only possessed a rudimentary knowledge of obstetrics. Also, many families had a choice of whether or not they wanted to employ a midwife who practiced the traditional folk medicine or the newer methods of professional parturition. Like a lot of other factors in antiquity, quality gynecological care often depended heavily on the socioeconomic status of the patient.

During the Christian era in Europe, midwives became important to the church due to their role in emergency baptisms, and found themselves regulated by Roman Catholic canon law. In Medieval times, childbirth was considered so deadly that the Christian Church told pregnant women to prepare their shrouds and confess their sins in case of death. The Church pointed to Genesis 3:16 as the basis for pain in childbirth, where Eve’s punishment for her role in disobeying God was that she would “multiply thy sorrows, and thy conceptions: in sorrow shalt thou bring forth children.” A popular medieval saying was, “The better the witch; the better the midwife”; to guard against witchcraft, the Church required midwives to be licensed by a bishop and swear an oath not to use magic when assisting women through labour.

Later historical perspective

In the 18th century, a division between surgeons and midwives arose, as medical men[who?] began to assert that their modern scientific processes were better for mothers and infants than the folk-medical midwives.[citation needed]

At the outset of the 18th century in England, most babies were caught by a midwife, but by the onset of the 19th century, the majority of those babies born to persons of means had a surgeon
involved. A number of excellent full-length studies of this historical shift have been written.

German social scientists Gunnar Heinsohn and Otto Steiger theorize that midwifery became a target of persecution and repression by public authorities because midwives not only possessed highly specialized knowledge and skills regarding assisting birth, but also regarding contraception and abortion. According to Heinsohn and Steiger’s theory, the modern state persecuted the midwives as witches in an effort to repopulate the European continent which had suffered severe loss of manpower as a result of the bubonic plague (also known as the black death) which had swept over the continent in waves, starting in 1348.

They thus interpret the witch hunts as attacking midwifery and knowledge about birth control with a demographic goal in mind. Indeed, after the witch hunts, the number of children per mother rose sharply, giving rise to what has been called the «European population explosion» of modern times, producing an enormous youth bulge that enabled Europe to colonize large parts of the rest of the world.

While historians specializing in the history of the witch hunts have generally remained critical of this macroeconomic approach and continue to favor micro level perspectives and explanations, prominent historian of birth control John M. Riddle has expressed agreement.

**United States**

There are two main divisions of modern midwifery in the US: nurse-midwives and direct-entry midwives.

**Nurse-midwives**

Two Certified Nurse Midwives from Colorado pose with new mother and her son, born at Presbyterian-St. Lukes Medical Center in Denver.

Nurse-midwives were introduced in the United States in 1925 by Mary Breckinridge for use in the Frontier Nursing Service (FNS). Breckinridge chose the nurse-midwifery model used in England and Scotland because she expected these nurse-midwives on horseback to serve the health care needs of the families living in the remote hills of eastern Kentucky. This combination of nurse and midwife was very successful. The Metropolitan Life Insurance Company studied the first seven years of the service and reported a substantially lower maternal and infant mortality rate than for the rest of the country. The report concluded that if this type of care was available to other women in the U.S., thousands of lives would be saved, and suggested nurse-midwife training
should be made available in the U.S. Breckinridge founded the Frontier School of Midwifery and Family Nursing in 1939, the first nurse-midwifery education program in the U.S.[citation needed]

The Frontier School is still educating nurse-midwives and has added distance learning to its methodology. In 1989 the program became the first distance option for nurses to become nurse-midwives without leaving their home communities. The students do their academic work on-line with the Frontier School of Midwifery and Family Nursing faculty members and they do their clinical practice with a nurse-midwife in their community who is credentialed by Frontier as a clinical faculty member. This community based model has graduated over 1200 nurse-midwives.

In the United States, nurse-midwives are variably licensed depending on the state as advanced practice nurses, midwives or nurse-midwives. Certified Nurse-Midwives are educated in both nursing and midwifery and provide gynecological and midwifery care of relatively healthy women. In addition to licensing, many nurse-midwives have a master’s degree in nursing, public health, or midwifery. Nurse-midwives practice in hospitals, medical clinics and private offices and may deliver babies in hospitals, birth centers and at home. They are able to prescribe medications in all 50 states. Nurse-midwives provide care to women from puberty through menopause. Nurse-midwives may work closely with obstetricians, who provide consultation and assistance to patients who develop complications. Often, women with high risk pregnancies can receive the benefits of midwifery care from a nurse-midwife in collaboration with a physician. Currently, 2% of nurse-midwives are men. The American College of Nurse-Midwives accredits nurse-midwifery/midwifery education programs and serves as the national professional society for the nation’s certified nurse-midwives and certified midwives. Upon graduation from these programs, graduates sit for a certification exam administered by the American Midwifery Certification Board.[citation needed]

Direct-entry midwives

A direct-entry midwife is educated in the discipline of midwifery in a program or path that does not require prior education as a nurse. Direct-entry midwives learn midwifery through self-study, apprenticeship, a private 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.

Under the umbrella of «direct-entry midwife» are several types of midwives:

A Certified Professional Midwife (CPM) 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 US credential that requires knowledge about and experience in out-of-hospital settings. At present, there are approximately 900 CPMs practicing in the US.[citation needed]

A Licensed Midwife is a midwife who is licensed to practice in a particular state. Currently, licensure for direct-entry midwives is available in 24 states.[citation needed]

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 (CPM) credential was available].[citation needed]

The American College of Nurse-Midwives (ACNM) also provides accreditation to non-nurse midwifery programs, as well as colleges that graduate nurse-midwives. This credential, called the Certified Midwife, is currently recognized in only three states (New York, New Jersey, and Rhode Island). All CMs must pass the same certifying exam administered by the American Midwifery Certification Board for CNMs.

The North American Registry of Midwives (NARM) is a certification agency whose mission is to establish and administer certification for the credential “Certified Professional Midwife” (CPM). The CPM certification process validates entry-level knowledge, skills, and experience vital to responsible midwifery practice. This certification process encompasses multiple educational routes of entry including apprenticeship, self-study, private midwifery schools, college- and university-based midwifery programs, and nurse-midwifery. Created in 1987 by the Midwives' Alliance of North America (MANA), NARM is committed to identifying standards and practices that reflect the excellence and diversity of the independent midwifery community in order to set the standard for North American midwifery.

Practice

Midwives work with women and their families in many different settings. While the vast majority of nurse-midwives work in hospitals[who?], some nurse-midwives and virtually all direct-entry midwives[who?] work within the community or home. In many states[which?], midwives forming midwifery centers where a group of midwives work together. Midwives generally support and encourage natural childbirth in all practice settings. Laws regarding who can practice midwifery and in what circumstances vary from state to state.

United Kingdom

Midwives are practitioners in their own right in the United Kingdom, and take responsibility for the antenatal, intrapartum and postnatal care of women, up until 28 days after the birth, or as required thereafter. Midwives are the lead health care professional attending the majority of births, mostly in a hospital setting, although home birth is a perfectly safe option for many births. There are a variety of routes to qualifying as a midwife. Most midwives now qualify via a direct entry course, which refers to a three- or four-year course undertaken at university that leads to a degree [diploma courses in midwifery have been discontinued] in midwifery and entitles them to apply for admission to the register. Following completion of nurse training, a nurse may become a registered midwife by completing an eighteen-month post-registration course (leading to a degree qualification), however this route is only available to adult branch nurses, and any child, mental health, or learning disability branch nurse must complete the full three-year course to qualify as a midwife. Midwifery students do not pay tuition fees and are eligible for financial support for living costs while training. Funding varies depending on which country within the UK the student is located and whether they are taking a degree or diploma course. Midwifery degrees are paid for by the National Health Service (NHS). Some students may also be eligible for NHS bursaries.

All practising midwives must be registered with the Nursing and Midwifery Council and also must have a Supervisor of Midwives through their local supervising authority. Most midwives work
midwifery within the National Health Service, providing both hospital and community care, but a significant proportion work independently, providing total care for their clients within a community setting. However, recent government proposals to require insurance for all health professionals is threatening independent midwifery in England.

Midwives are at all times responsible for the woman for whom they are caring, to know when to refer complications to medical staff, to act as the woman’s advocate, and to ensure the mother retains choice and control over her childbirth experience. Many midwives are opposed to the ‘medicalisation’ of childbirth, preferring a more approach to care, ensuring a satisfactory outcome for mother and baby.

**Midwifery training**

Midwifery training is considered one of the most challenging and competitive courses amongst other healthcare subjects[citation needed]. Most midwives undergo a 32 month vocational training program, or an 18 month nurse conversion course (on top of the 32 month nurse training course). Thus midwives potentially could have had up to 5 years of total training. Midwifery training consists of classroom based learning provided by select Universities in conjunction with hospital and community based training placements at NHS Trusts.

Midwives may train to be community Health Visitors (as may Nurses).

**Community midwives**

Many midwives also work in the community. The role of community midwives include the initial appointments with pregnant women, managing clinics, postnatal care in the home, and attending home births.[citation needed]

**Canada**

Midwifery was reintroduced as a regulated profession in Canada in the 1990s. After several decades of intensive political lobbying by midwives and consumers, fully integrated, regulated and publicly funded midwifery is now part of the health system in the provinces of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, and Nova Scotia, and in the Northwest Territories and Nunavut. Midwifery legislation has recently been proclaimed in New Brunswick where the government is in the process of integrating midwifery services there. Only Prince Edward Island, Yukon and Newfoundland and Labrador do not have legislation in place for the practice of midwifery.

Midwives in Canada come from a variety of backgrounds including: Aboriginal, post nursing certification, direct-entry and “lay” or traditional midwifery. However, after a process of assessment by the provincial regulatory bodies, registrants are all simply known as ‘midwives’, ‘registered midwives’ or by the French-language equivalent, ‘sage femme’, regardless of their route of training. From the original ‘alternative’ style of midwifery in the 1960s and 1970s, midwifery practice is offered in a variety of ways within regulated provinces: midwives offer continuity of care within small group practices, choice of birthplace, and a focus on the woman as the primary decision-maker in her maternity care. When women or their newborns experience complications, midwives will work in consultation with an appropriate specialist. Registered midwives have access to a variety of medical resources and are able to provide comprehensive care to their patients.

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to appropriate diagnostics like blood tests and ultrasounds and can prescribe a limited schedule of medications. Founding principles of the Canadian model of midwifery include informed choice, choice of birth place, continuity of care from a small group of midwives and respect for the woman as the primary decision maker. Midwives typically have hospital privileges and support women’s right to choose where she will have her baby. As fully integrated health care providers, Canada’s midwifery homebirth outcomes have been excellent.[citation needed]

Five provinces offer a four year university baccalaureate degree in midwifery. In British Columbia, the program is offered at the University of British Columbia. Mount Royal University in Calgary, Alberta offers a Bachelor of Midwifery program. In Ontario, the Midwifery Education Program (MEP) is offered by a consortium of McMaster University, Ryerson University and Laurentian University. In Manitoba the program is offered by University College of the North. In Quebec, the program is offered at the Université du Québec à Trois-Rivières. In northern Quebec and Nunavut, Inuit women are being educated to be midwives in their own communities. A Bridging program for internationally educated midwives is in place in Ontario at Ryerson University. A federally funded Multi-jurisdictional Midwifery Bridging Program is offered in Western Canada. Regulated provinces and territories admit internationally educated midwives to their regulatory body if they can demonstrate competency through a Prior Learning and Experience Assessment (PLEA) process.

The legal recognition of midwifery has brought midwives into the mainstream of health care with universal funding for services, hospital privileges, rights to prescribe medications commonly needed during pregnancy, birth and postpartum, and rights to order blood work and ultrasounds for their own clients and full consultation access to physicians. To protect the tenets of midwifery and support midwives to provide woman-centered care, the regulatory bodies and professional associations have legislation and standards in place to provide protection, particularly for choice of birth place, informed choice and continuity of care. All regulated midwives have malpractice insurance. Any unregulated person who provides care with ‘restricted acts’ in regulated provinces or territories is practicing midwifery without a license and is subject to investigation and prosecution.

Prior to legislative changes, very few Canadian women had access to midwifery care, in part because it was not funded by the health care system. Legalizing midwifery has made midwifery services available to a wide and diverse population of women and in many communities the number of available midwives does not meet the growing demand for services. Midwifery services are free to women living in midwifery regulated provinces.

New Zealand

Midwifery regained its status as an autonomous profession in New Zealand in 1990. The Nurses Amendment Act restored the professional and legal separation of midwifery from nursing, and established midwifery and nursing as separate and distinct professions. Nearly all midwives gaining registration now are direct entry midwives who have not undertaken any nursing training. Registration requires a degree in midwifery. This is a three year full time programme of 45 weeks per year.

Women must choose one of a midwife, a General Practitioner or an Obstetrician to provide their maternity care. About 78 percent choose a midwife (8 percent GP, 8 percent Obstetrician, 6 percent unknown.). Midwives provide maternity care from early pregnancy to 6 weeks postpartum. The midwifery scope of practise covers normal pregnancy and birth. The midwife will either consult or transfer care where there is a departure from normal. Antenatal and postnatal care is normally provided in the woman’s home. Birth can be in the home, a primary birthing unit, or a hospital. Midwifery care is fully funded by the Government. (GP care may be fully funded. Private obstetric care will incur a fee in addition to the government funding.)

Netherlands

Midwives are called verpleegkundige (female midwives), verpleegmeester (male midwives), or verloskundige (general) in Dutch. Midwives are independent specialists in physiologic birth. In the Netherlands, home birth is still a common practice, although rates have declined during the past decades. In the period of 2005-2008, 29% of babies were delivered at home rather than in a hospital. Midwives are generally organized as private practices, some of those are hospital-based. In-hospital outpatient childbirth is available in most hospitals. In this case, a woman’s own midwife delivers the baby at the delivery room of a hospital, without intervention of an obstetrician.[dead link] In all settings, midwives will transfer care to an obstetrician in case of a complicated childbirth or need for emergency intervention.

Apart from childbirth and immediate postpartum care, midwives are the first line of care in pregnancy control and education of mothers-to-be. Typical information that is given to mothers includes information about food, alcohol, life style, travel, hobbies, sex, etc. Some midwifery practices give additional care in the form of preconceptional care and help with fertility problems. Education in midwifery is direct entry, i.e. no previous education as a nurse is needed. A 4-year education program can be followed at four colleges, in Groningen, Amsterdam, Rotterdam and Maastricht.

All care by midwives is legal and it is totally reimbursed by all insurance companies. This includes prenatal care, childbirth (by midwives or obstetricians, at home or in the hospital), as well as postpartum/postnatal care for mother and baby at home.

Japan

In Japan, midwifery was first regulated in 1868. Today, midwives must pass a national certification exam. Up until March 1, 2003 only women could be midwives.

Balochistan (Tribal Pakistan)

In Balochistan, midwives are the third most powerful leaders in the community, and the most powerful among women. People say that they give life to a child as the majority of tribal areas have no doctors. Midwives also solve problems between women. If there is a conflict between a man and a woman, the man has more power, and he will go to the tribal chief instead.

Mozambique Desire’s Country

When a 16-year-long civil war ended in 1992, Mozambique’s health care system was devastated and one in ten women were dying in childbirth. There were only 18 obstetricians for a population
of 19 million. In 2004, Mozambique introduced a new health care initiative to train midwives in emergency obstetric care in an attempt to guarantee access to quality medical care during pregnancy and childbirth. These midwives now perform major surgeries including Cesareans and hysterectomies. As the figures now stand, Mozambique is one of the few countries on track to achieve the United Nations Millennium Development Goal (MDG) of reducing the maternal death rate by 75 percent by 2015.

**Traditional Non-Western Societies**

**The Karbis of Goria Ghuli**

The village of Goria Ghuli is an example of a rural and traditional village. The village has no electricity, and they have no access to a telephone. The primary health facility is in Sonapur, which is about 7 kms from the village. This health facility has 3 doctors, 2 lady health visitors, 6 auxiliary nurse midwives, 3 microscopists, and 2 pharmacists. The Karbis believe that good health “is the outcome of a pious life and illness is the punishment meted out by spirits.” The Karbis have specialists or healers who are not alike; midwives, or ethnogynacologists are one of these specialists. The village has two different categories of midwives. The first is known as the ‘traditional’ midwife, who is also an herbalist. The second is the ‘nurse’ midwife; these are the ‘government’ midwives. Traditional midwives are favored in the village. They receive some informal training that is used to help with before, during, and after pregnancy care of villagers. This information is transferred from generation to generation. In the village there are 3 ethnogynacologist, which can be approached at any time for assistance at the time of delivery. She, and usually another elderly woman in the village help during and after the delivery. If for any reason there are complications, the village midwife will forward the ‘patient’ to the ‘nurse’, and if she is unable to help then they are forwarded to the Primary Health Center. These midwives do not take on the traditional role of a midwife that we may see in the United States, for example. Rather, a huge role of the midwife is as an herbalist for the village.

**The Maya of Guatemala**

This study was specifically in San Pedro. The midwives of San Pedro have many roles in the society, and are respected highly for them. The shamans of San Pedro are rapidly declining which has caused an increase in the number of midwives, in order to care for the people. They call the midwife, “iyom”. The Maya believe that being pregnant is to be “yawa”, meaning ill. The midwife is an obstetrical and religious specialist all at once. She provides prenatal care, massage, attends delivery, and takes care “takes charge of” mother and child after birth. Midwives in this society are similar to shamans, in that her calling is divine. She is the connection between the spiritual and real world, and in order to protect her ‘patients’ she performs rituals to keep them safe. The load of work for these midwives is huge. There are not many, and they serve most women in the village. (This case study was done in 1975, this society has changed since)
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Birth of a Midwife

For ages the expertise and experience of the elders was handed down to younger generations. It was not a matter of choice, merely a matter of survival. If they didn’t share their knowledge of the way life revealed itself, then that knowledge was lost. Midwifery is not different by any means.

A woman who has been at birth and experienced the needs and desires of laboring mothers has gained an inconceivable amount of knowledge regarding compassion. A woman who has seen the outcomes of birth to be both wonderful and surprising has witnessed nothing less than a miracle. It is with each labor and birth that a midwife learns more about the processes of childbearing and the similarities of women who labor. Each birth is unique and so every midwife’s tale is its own. Knowledge is not gained by reading a book, but rather by the experiences life has offered.

Midwifery is, in essence, life’s lesson and apprenticeship. Share with other midwives and those who desire to learn the gifts you have witnessed. There are many of us who are passionate about being at birth and dream of being able to serve women during labor. Few are given the opportunity. It seems that students of birth need to „prove” their dedication and love of childbirth to validate their claim to midwifery. I myself must regularly define my calling to this path. But how can it be defined? Some of us have wanted this since we were children: playing with our dolls, breastfeeding and diapering, playing doctor and giving birth to our dolls half the size of our own pint-sized bodies. Others may know that they are to become midwives from the moment they take their first breath. For still others, it can come later in life while attending a friend or relative during their birth. For me, it was the homebirth of my third child that took me to the depths of the universe and my soul. It wasn’t until then that I heard the call or remembered what my purpose was on Earth. Midwifery. Midwifery. Midwifery.

The hardest part of learning midwifery is being included in the birth setting itself. There are many ways to study the scientific and obstetrical arts of midwifery. There are schools, study groups, conferences, Internet classes, and intensive hands-on programs.
These types of learning offer an essential insight into the world of midwifery, but they are not the real midwifery we lovers of birth struggle for. We desire the intimate relationships prenatal, birth and postpartum care offer. We want to serve our mentors and our women and really learn the secrets only a practiced midwife can share. The desire is to learn the way our grandmothers and their grandmothers did, by being taken under the wing of a respected, beloved midwife of our village. These ladies are the true bearers of birth, their wisdom entangled in countless babies’ and families’ lives.

Practicing midwives, seasoned midwives, please open yourselves up to those who desire knowledge. Tell your birth stories, reveal your intuitions, have an apprentice. The saying goes, “It is only with giving do you receive.” Take two apprentices—one who has been with you and understands your practice, and one who is willing to learn. Two apprentices. What a concept! One to attend the midwife, one to attend the laboring family. Three midwives to better serve the family.

It is in sharing these life’s lessons that a midwife is born, not by reading a book, or by knowing how babies grow and come out. Midwifery is born by attending laboring women. It is hard to open yourself up and give your life’s path to others. Some midwives say that they haven’t found someone enough like them or someone with the same beliefs as their own, or whatever the story may be. Remember: life is a journey for each of us. Our paths unfold at their own times, making each of us charmingly different, but not unworthy of the knowledge. Find the beauty in our differences. Some midwives have opened up, only to be abandoned or left in the middle of an apprenticeship, left to feel hurt and resentful. Please, try again. Find a lover of birth and try again.

Midwifery has come back strong in the past three decades. It was never gone or lost, only kept within the heartsong of those who remembered. Midwifery is like a tree with many roots and branches. Please, elder midwives, whisper your tale to others. It is a matter of survival and keeping midwifery alive. Each tale is its own. I hope your tale will include the birth of another midwife or two.

What Midwives Want from Their Clients

- Honesty
- Legal Status
- Protocols
- On Time
- Obligations
- Pay
- Trust

This list was written by a certified midwife and contains suggestions and input from midwives across the United States.

Be honest

One would think that this would go without saying, but unfortunately, it does not. Not only does this quality stand as the first and foremost obligation of a woman to her midwife (and the midwife to her client, of course), but it permeates all the other qualities listed below, as well. Without honesty there can be no trust, and without a trusting bond between midwife and client, there can be no safe working relationship.
There are many reasons why a woman would be untruthful. Perhaps a woman has had several abortions and has not told her husband. If an oral history is taken with the husband present, she may hide the information from her midwife. A woman may be too embarrassed to let her midwife know that she has herpes. Or perhaps she has learned from interviewing other midwives that she has a certain risk factor that would preclude a homebirth. She may think that if she hides the information from the present midwife, she can get the homebirth she wants. But there are dangers inherent in these scenarios. Each woman has the right to choose her birth place and attendant. Conversely, midwives have the right to choose their clients according to self-imposed limits and protocols. Some midwives do not hesitate to take women who have had multiple abortions or who have herpes; others do not feel comfortable doing so. Most midwives will not assist at the delivery of twins or breeches; others do not take VBACs. And there are some conditions for which few midwives would agree to be the primary caregiver, such as pre-existing medical/health problems which require the care of an OB. In these cases, the midwife might be able to co-manage your care with her backup doctor.

Unfortunately, there are some women who so desperately desire a homebirth and/or midwifery care that they are willing to do almost anything to get it. This is unfair and potentially dangerous to everyone involved. If you have any medical condition or significant past OB history, you must tell your midwife, even if other midwives have turned you down. Without thorough knowledge of your history, the midwife cannot make safe decisions regarding your care. Remember, however, that what one midwife may not feel qualified to handle, another may feel perfectly comfortable handling.

If you have special requirements or requests of a midwife, such as religion, lifestyle, philosophy, education/training or legal status, make these clear during the initial phone contact and ask if she can meet them. There is no point in signing up with a midwife only to discover later that there is something about her that you find unacceptable. Most midwives know other midwives in their area, and can refer you to another who might better suit your needs.

Know and respect the legal status of midwives in your community

In states in which midwifery is illegal, you must do everything in your power to protect your midwife from prosecution. This may mean not giving her name to certain doctors, not putting her name on the birth certificate, not mentioning her name to friends and relatives who do not support your birth choices, and more. If this is not acceptable to you, then choose a CNM who can work legally in your state.

Agree to abide by the midwife’s protocols

The safest midwife is the one who knows her own limitations and does not exceed them. Of course, these limits change as she gains more experience, either becoming stricter or more lax as she sees fit. But they are her limits, and no one has the right to try to get her to change or exceed them. If she does not feel qualified, comfortable or experienced enough to handle a situation, then it may well be dangerous for her to do so. It is disappointing to be turned down, transferred out...
or transported from the place and personnel you planned for your baby's birth, but no midwife wants to endanger the health and safety of mother or baby for any reason.

Protocols cover more than just delivery choices, however. They also apply to the ways in which your midwife handles your pregnancy. Most midwives rely on good nutrition as their main ally in preventing complications. But they also have other tools available to them, such as herbs, homeopaths, chiropractic, accupuncture or allopathic medications to treat problems that may arise. She may order certain tests from a lab to screen her clients for potential medical problems. These are all procedures that you may wish to discuss with her before you hire her as your caregiver. Once you are working with her, it is unfair to refuse tests or procedures which she has stated her protocols require.

Be on time for appointments

Most midwives want to see clients once a month through 28 weeks, once every two weeks from 28 to 36 weeks, then once a week until delivery. Extra visits may be scheduled under certain circumstances. If you must be late for an appointment, call. This allows the midwife to either tell you to come in as soon as possible; come in later in the day; or reschedule for another day. Whatever she decides, she will know when to expect you, and she can plan some other way to fill your missed appointment time. This of course, also applies if you must cancel an appointment. And, unless you are experiencing an emergency or personal/family crisis, if you cancel less than 24 hours before your appointment time you may be expected to pay for the missed visit. Even if your midwife does not ask for payment, offer it. It shows her that you acknowledge and appreciate that her time is valuable.

Please honor your midwife's prenatal visit schedule. Most midwives are willing to be flexible when scheduling appointments, but they need uninterrupted family time, too. Many midwives schedule regular or occasional evening or weekend appointments and will do their best to accommodate their clients’ work schedules. However, that doesn’t mean a client should ask for an appointment at any time that is convenient. If you had chosen a doctor for your prenatal care, you would have been seen during regular office hours. Extend the same courtesy to your midwife.

Ask your midwife what her policy is for accepting phone calls at home, and how late you can call. Midwives who are present for the birth aren’t always available to take such calls. But it is nice when they are! Please don’t call them in the middle of the night unless you have a true emergency. The midwife is not expected to have time for phone calls at this time. You must reserve her time to attend to you and your baby.

Understand and meet your obligations to your midwife

Most midwives require their clients to become knowledgeable about pregnancy, labor, delivery, midwifery care, homebirth preparation, parenting, basic childcare/first aid, and other subjects by reading and/or attending classes. This basic information is necessary for you to become a responsible partner in your own health care; you cannot give an informed consent if you are uninformed. If you know what normal is, you won’t become frightened unnecessarily. And more important, you will be able to immediately report to your midwife anything outside of normal, so that she can move quickly to take care of it. In addition, if you know ahead of time how your midwife handles various complications, her actions will allay your fears rather than add to your anxiety.

Most midwives also require their clients to meet certain physical requirements regarding the birth site. These may include having running water available and a way to boil it; having a telephone or other communications device; maintaining a certain level of cleanliness; and having certain supplies on hand. If the midwife arrives for your birth and these obligations are not met, it could jeopardize the health of mother or baby. If you are having difficulty meeting any of these requirements, discuss it with your midwife as soon as possible so that other arrangements can be made well ahead of the due date.

Pay your midwife what she asks

There are a few spiritual communities that still provide for their midwives by paying for housing, food, vehicles and other needs. But most midwives charge for their services. Fees may range from a barter of goods, to a sliding scale, to a set fee. Whatever it is, if you engage the midwife’s services you need to honor your obligation to pay her fee. If a client does not pay for services rendered, she is robbing the midwife of money she needs to meet her own family's expenses.

It is best if you and your midwife can agree in advance on a payment schedule. Some midwives ask for a deposit up front; some ask for a minimum amount payable at each visit; others ask that the full fee be paid by a certain date; some practitioners offer a discount if the fee is paid early or require a penalty if it is paid late; still others will accept barter for some or all of their fee.

Of course, we all occasionally have emergencies which stretch our budgets. If such an event occurs, call your midwife and renegotiate her payment plan. Do not expect her to absorb the cost of your financial emergency by not paying her. And please, do everything in your power to pay the full fee before your baby is born.

While a national study comparing doctor/midwife care has found that midwives spend 10 times as many hours with their clients during the course of pregnancy, labor, delivery and postpartum, you would be hard-pressed to find a midwife who is paid what any physician is paid. Most midwives charge between one-quarter and one-half the fee charged by doctors in the same area. And there is an even greater savings to consumers seeking a homebirth, because unless there is an emergency, they don’t have a hospital fee to pay. So, if you can, give your midwife a bonus above her normal fee: if she offers a sliding scale, pay the upper fee for your income bracket; buy her a nice gift; offer her your services, whether it’s mending a fence or typing letters for her. This not only helps to compensate her for those who have not paid, but allows her to offer her services at reduced rates to women of more modest means.

Trust in birth and in your midwife

If you have been honest with your midwife, a bond of trust will develop during the prenatal visits. She will trust you to accept her advice and information, and you will trust your midwife to help you to make those decisions that are in the best interest of you and your baby. The more you and your midwife honor and respect one other, the more each of you can just relax and allow the birth to unfold naturally. This, of course, means that you need to trust in birth as well. If you believe that the birth process can work without medical intervention, then it probably will. But not always. Dutch midwives have a saying, “Nature is not always mild.” Just because you do everything “right,” there is no absolute guarantee that you will have a perfect birth and perfect baby. Sometimes
birth needs technical assistance. Sometimes a baby is born sick or malformed. Sometimes a baby

dies, regardless of what the mother did prenatally to ensure a healthy birth. You must be willing
to accept responsibility for your decisions and actions and not assign "blame" to another. No one
has all the answers: not doctor, nor midwife, nor you. Together, you and your caregiver make the
decisions that affect your pregnancy, labor, delivery and postpartum. But the final responsibility
is yours.

All of the above suggestions apply whether you birth at home, a birthing center or in a hospital. If
you act responsibly throughout your pregnancy, labor, delivery and postpartum, then the chances
are greatly in your favor for having a positive experience.
Answering the Question of Homebirth

by Vanessa Manz

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It is inevitable. In every single childbirth education class and doula prenatal meeting I lead, I am asked “the question.” It never fails. Sometimes a particularly well-read mother or partner asks it at our first meeting before we even start getting down to business. Other times it doesn’t come up until the last meeting, after we’ve watched videos of particularly beautiful births and are saying, “Goodbye, until the baby comes.” But most often the question is asked when we talk about interventions.

So what is this powerful question? In some way, shape or form, my clients ask, “Can I have a homebirth?” And, sadly, my response is always along the lines of: “What county do you live in?” Because in Western Pennsylvania where I live, teach and doula, homebirth midwives are no longer attending births or, at least, they’re not advertising their services. You have to know someone, who knows someone, who can put you in touch with someone.

Because I am a doula and instructor of hypnosis for childbirth, the majority of my students and clients are seeking a natural birth experience. The majority also are low-risk, younger than 40 and somewhat knowledgeable about birth.

They come to me because they want a different experience than they have had with a prior birth or than the horror stories they have heard in the media or from friends. I teach them about all the terminology, the tests and ways to negotiate to get what they want. I talk to them about strategies to get care providers to slow down and listen to them and that, when all else fails, to bring a man in a suit (perhaps the father or grandfather of the baby) to intimidate their care providers into their desired gentle, natural birth, is to give birth at home. But, living in Pittsburgh, they do not have that option.

How to Perform a Dilation Check without a Vaginal Exam

Editor’s Note: Sharon Craig of Kabul, Afghanistan, learned this trick from midwife Molly Caliger while studying with the Russian Birth Project in St. Petersburg, Russia. This “trick of the trade” originally appeared in Midwifery Today, Issue 78.

This technique is based on the fact that as labor progresses, the uterine muscle of the cervix (lower uterine segment) is pulled up and the muscle fibers in the uterine fundus increase and become larger. A practitioner who has mastered this skill can know how dilated the cervix is by how many fingers fit between the uterine fundus (the uppermost part of the uterus) and the xiphoid process (the lowest part of the sternum). Each finger that can fit indicates two centimeters of cervix that still needs to dilate before reaching complete dilation.

So, taking into account existing IUGR or preterm fundal sizes, if you can fit five fingers between the fundus and the xiphoid process, the cervix is closed. If you can fit two fingers, the cervix is six centimeters dilated. This technique is tricky to learn, but very helpful to use to determine progress without being invasive, and can be done at the same time as assessing intensity and timing of contractions.

While homebirth is not technically illegal in the state of Pennsylvania, meaning there are currently no laws regulating birth in the home, it is “illegal”—tolerated in practice, but midwives (traditional as well as certified professional midwives) can be ordered to cease and desist for practicing without a license. This leaves it up to the discretion of the local law enforcement to pursue cases against midwives who attend homebirths that result in transfers to hospitals or result in poor maternal or fetal outcomes.

The profession’s questionable status combined with the prominence of several major medical systems in Pittsburgh has led to the prosecutions of a number of Western Pennsylvania midwives, making it nearly impossible to locate a midwife willing to attend a homebirth in this part of the state. The birthing culture here is a conservative, medically managed model of care. When I began researching resources for my students and clients in 2007, I was able to find only three midwives within driving distance of Pittsburgh and none were willing to be put on my referral list. Instead, moms-to-be network on local attachment parenting and natural living e-mail groups, posting requests for information on midwives and receiving referral information privately.

When I am with a birthing mother in her home, helping her to relax and nest, watching her go from uncertain to confident and comfortable in her temporary role, I cannot help but think about what is to come. How we will soon interrupt this wonderful birthing dance and move her to a new place with new people, bright lights and invasive exams and monitors. We are going to ask her to let go of her inward focus and answer questions about her pain level, contraction frequency and duration, and many other things so that “we” can figure out what her body is doing and how to “fix it” or make it go faster and “better.”

How, when we arrive and check in, there is very little I, as the doula, can do to stop the cascade of interventions if, for some reason, her body takes longer than average to dilate, her baby descends more slowly than desired, or her urge to push is delayed or takes longer than is deemed “necessary.” It feels like a crime that this mother is not allowed to remain in her own space, with a watchful and respectful birth attendant.

As a doula, the best solution I have found is encouraging my clients and students to stay at home as long as possible. However, the expectation of having to move can prolong a labor if the mother is holding back or fearful about leaving the comfort of her home to transition into a new place. If this anticipation of moving causes tension, the mother may arrive at her birthing location and find she is not as far along as she had hoped—and the cascade of interventions begins.

For doulas, who are not able to perform dilation checks, it can be difficult, especially with first-time moms, to tell when the time has come to move from home to the birthing center or hospital. A woman can experience transition-like sensations at different times during her birth, and it can be hard to gauge where she is without the luxury of additional time. While precipitous births in cars are rare, it is still something that can happen if the couple waits too long to transition out of the home. No doula wants to bear the responsibility of having suggested they wait longer.

The irrational “illegality” of homebirth robs women of the opportunity to birth unmolested. It robs babies of the opportunity to have a truly natural birth, and it robs families of the empowerment
that comes from taking charge of their care. As a doula, I teach the ultimate contradiction: parents have the right and power to make decisions about their and their child's care, but they don't have the option to give birth in their own homes. But I've been getting "that question" more often, and more families here are beginning to stand up for their rights in hospital settings. My hope is that they will take this a step further and demand the right to birth at home.

Vanessa Manz is a professional doula and childbirth educator in Pittsburgh, Pennsylvania. Normalizing homebirth and midwifery care as the standard for low-risk mothers is her passion and she hopes to become a CPM after her children are grown.
A Midwife’s Perspective: Labor and Birth in the Water

by Jill Cohen
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The benefits of water
It was late in the evening. I sat staring into the fire, waiting as I often do for the phone to ring. Midwives frequently have a sixth sense about birth, and on this particular evening, my senses proved true—at 10:30pm the phone indeed rang. At first all I heard was the echo of deep breaths and water running. I knew this was labor. Water and labor fit hand-in-hand for most laboring women. The shower or bath warms, secludes and relaxes a woman so she can open more easily at her own pace. It creates a womb-like environment in which a woman can feel safe. It may not take the pain away, but it enables a woman to cope through her intense sensations, relaxed and with least resistance, creating more comfort. Water forms a warm, wet buffer around her, keeping outside forces and interventions at bay. Yet if the woman should need assistance or monitoring it can be accomplished easily in her watery environment.

I waited for the contraction to pass as I listened intently for the mystery woman on the other end of the phone to finally identify herself. I could tell by the echo that she was in her bathroom, and could tell by the sound of running water that she was in the bath. The tempo of her breath told me I would be heading over soon... as soon as I could ascertain who she was! After her breathing slowed and she paused to collect herself, I heard her giggle a “Sorry!” I knew right away it was my dear friend Hazel. This was her fourth child—I was out the door!

Water Birth

Water is often used by women to ease the discomforts of labor. Whether standing in a shower, sitting in your own bathtub at home, or fully reclining in a large tub built just for laboring, many women find instant relief of their labor discomfort from the use of water. Their relaxed bodies release fewer stress hormones and their labors proceed more quickly and easily, with less discomfort. No wonder that the idea of water immersion is so appealing to many women.

Laboring in the water
I walked in to find her children sound asleep and her partner sitting at the edge of their large tub, a glass of cold water and bendable straw in hand to help keep Hazel well-hydrated. Before she could utter a word, another contraction arrived and she went deep into herself. Because water can speed labor along once the woman is over 5 centimeters dilated, and I guessed that Hazel was at least that, I busied myself preparing her birthing room. I then settled into the bathroom with my water Doppler and monitored our little friend. All was well. Hazel needed to pee, so she got out and onto the toilet. Another big contraction, wide eyes and pop went the bag of waters. They were clear and smelled sweetly of baby. It was time to decide where this child would be born.

Without hesitation, Hazel chose the tub. As soon as she was situated, I heard the familiar sound of relief I hear so often when women sink into warm water. It is music to a midwife’s ears, as is the steady heart rate of a baby about to be born. Hazel pushed with the next contraction as she pulled her legs back and sang that magical birth song, low and deep. With that push we saw the baby’s head. Two more pushes and the head was born.

As we waited for the next contraction, we had time to see this little child and appreciate the peacefulness of his/or her entrance. Water is vital to life—we cannot live without it. Its ability to nourish, nurture, propagate and promote life fits so well in the birthing world. I believe that because babies come from a watery environment, when they are born into water it feels familiar to them. Under normal circumstances, babies will not breathe until they hit air. When they emerge into water their house gets bigger, but they still think they are in the womb. This little one was wide-eyed and waiting. It is always amazing to see such peaceful passage.

Within a few moments, another contraction came and the baby was gently born. Hazel instinctively reached down and brought her baby to the surface. There was no need to suction—this little boy flexed, stretched, yawned and pinked up without even crying.

Misperceptions
Misunderstandings abound about the use of water in birth, such as risk of infection, risk to the baby, and lack of ability to monitor effectively. There is now much research-based evidence to indicate that with proper preparation and protocol the risks are no more than for air birth. So for those women and practitioners who choose water to facilitate birth, go for it! But first, be informed: Investigate what standards should be used. Plan what kind of tub you will use, where to put it, and find your water source. Remember that water is a different medium to work with. Familiarize yourself with it; think about its potentials; imagine its relation to birth. Merge with it and feel its effects.

For me, the rewards of using water in labor and birth is summed up in that magic sound of relief in a woman’s moan as she enters the warm water, and the magic moment as baby comes forth with that peaceful look that tells me the passage has been safe and gentle.

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Midwifery
Baby coming before the midwife birth instructions

Post these instructions in a prominent place (like your fridge) and become thoroughly familiar with them. These instructions are primarily the responsibility of the father/partner.

- Try to remain calm. If the baby is coming on its own, chances are that everything will go smoothly.
- The mother will know the best position for her to take for the birth of her baby.
- If the mother feels an urge to push, ask her to blow through the next contraction and to continue to blow through contractions until the urge to push is overwhelming.
- The mother should pant... the baby out, letting her skin stretch slowly. Support the baby with two hands as it comes out.
- Attendant should (if possible) wash hands before delivery, but never leave the birthing woman alone. Try to have some clean towels within reach.
- The baby’s head is often bluish, this is normal. The baby’s body will probably come out with the next contraction. If, after two more contractions, the body does not come out hook your finger under the baby’s armpit and pull during the next contraction.
- When the baby’s head is out, check and see if the cord is around the baby’s neck. If it is around the neck, try to pull it over the baby’s head. If it is too tight, try to slip the baby through the cord.
- Avoid putting tension on the cord.
- Wipe the baby’s mouth and nose with a towel. Usually the baby will be pink and crying by now.
- Put the baby on the mother’s chest and keep warm with a towel or blanket.
- If the baby does not breathe right away or remains limp:
  - Talk to your baby and ask him/her to be present
  - Rub the baby’s back and soles of feet
  - Gently breath into the baby’s mouth
  - Call 911 if the baby has not taken a breath and it has been 3 minutes since birth
- Put the baby to the mother’s breast.
- Do not pull on or cut the cord. WAIT.
- The placenta will come out in 5-30 minutes. There may be a gush of blood with it.
- If there is a lot of bleeding after the initial gush with the placenta and the uterus doesn’t harden after the placenta comes out, have the mother nurse her baby immediately. If that doesn’t work massage the uterus and call 911.
- Have the mother drink plenty of fluids.
- Keep the mother and baby warm and dry. The midwife will be here soon.
- Be proud of yourselves! Congratulations.

Important Phone Numbers
Student/Other Midwife Other
Backup MD & Hospital Phone
Emergency Hospital Phone
Baby’s Care Provider Phone
Ambulance 911

On the back of this sheet please write out directions to your house from a major intersection or landmark AND directions from your house to the nearest hospital.

The SCIO Universal Electrophysiological Biofeedback System can safely measure over the skin (transcutaneous) skin electro-potential down to the micro-volt range. Virtual and mathematical calculations of the attained data can provide CNS (Central Nervous System) biofeedback data, so as to include (simple EEG (electroencephalography), 3-lead ECG (simple stress electrocardiography), global transcutaneous EMG (electromyography). The system can measure the transcutaneous skin resistance by application of a medical safe micro-current volumetric pulse, so as to measure GSR (galvanic skin response) and TVEP (transcutaneous volumetric evoked potential).

The system is designed for the detection of stress and reduction of stress through CNS biofeedback data or stress lifestyle questionnaires. The stress and lifestyle questionnaires provide educational feedback through library referenced functions. And the device can be used for the treatment of muscular re-education from injury, muscle weakness, sport muscular enhancement or various dystonias. The applied volumetric pulse can be used to detect and affect in established modalities such as pain [TENS (transcutaneous electro nerve stimulation)], trauma/wound healing, change stability imbalance, redox potential and electrophysiological reactivity.

The device after 20 years of use is quality tested, clinically evaluated and scientifically validated as safe and effective.
Early Trauma, Its Potential Impact on the Childbearing Woman, and the Role of the Midwife

by Penny Simkin

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Early childhood influences, whether remembered or not, are the foundation for later development into adulthood. The child learns about her world at a young age: whether the world is a safe or unsafe place; whether other people, especially those who have power over her, can be trusted or not; and whether kindness, love and respect really exist in people. Early influences determine how people will function—the kinds of relationships they form, how they handle adversity and whether they find joy in life. Life experiences may facilitate or obstruct healthy growth and maturation. We are beginning to recognize that these complex psychosocial factors also play a greater role in perinatal care and outcomes than we ever suspected.

A shocking number of adults were born and/or grew up in harmful, dangerous, adverse circumstances. Each year, in the US alone, over a million cases of child abuse—neglect, sexual or physical assault, and emotional abuse—are reported. These reported cases almost surely represent the tip of the iceberg. Abuse is a private, lonely matter that is easily hidden, and the victim is at enormous disadvantage in stopping it.

While many survivors grow up to function well, develop close friendships, raise families, take pleasure in life and become skilled and productive, these accomplishments often come after overcoming much psychological distress.

The effects of abuse and other trauma clearly continue long after the abuse ends. The protective survival techniques that a child relies on to deal with the abuse and accompanying fear and anxiety often become exaggerated, maladaptive or even self-destructive, as the child grows up and applies them inappropriately to situations that in some way resemble the abuse. Some examples include: avoiding people and situations that might seem risky; trusting people who have authority over her; dissociating mind from body (“checking out,” “leaving my body,” “going blank”) at stressful or threatening times; using alcohol or drugs to forget or to calm oneself; making unhealthy and unsafe lifestyle choices, engaging in elaborate control rituals to avoid threat and danger. To relate this more specifically to childbearing, the survivor may deny her pregnancy or hide it from others; avoid or postpone prenatal care; have anger, trust, or abandonment issues with her midwife; or make maternity care choices out of ignorance, anger, fear or anxiety.

Memories

A victim’s conscious memory of her past abuse is often partly or totally blocked, which may result from dissociation during the abuse or other mechanisms to protect herself when the trauma is too horrible to deal with. Blocked memories tend to surface in midlife under circumstances of emotional or physical stress, or during particular life transitions, one of which comes during the childbearing year, encompassing pregnancy, birth and new parenthood, including breastfeeding. When memories surface, the survivor suffers pain and anguish and often benefits from therapy.
and/or support through the long and difficult healing process. Within a typical midwifery practice, some women survivors have no memory, while others may be well along the healing journey. Whatever their degree of healing, survivors may experience some replay of their abuse before, during or after birth. Those who are recovering are more likely to recognize the present experience as a trigger and to know ways to put it into perspective (e.g., talking about it, self-calming techniques). Others may be re-traumatized—something all midwives want to prevent.

### Relationship between a Female Survivor and Her Midwife

Not surprisingly, women who were violated, neglected or hurt during childhood by adults in authority and power, whom they loved and trusted and on whom they were dependent, may sadly find that their relationship with a midwife raises past issues with their mothers or other powerful figures in their early lives. If we try to see the relationship through the eyes of a troubled survivor, we realize that midwives or doctors are powerful figures—knowledgeable, comfortable in their own “territory” (office, clinic or hospital) and authoritative within their field of maternity care. They remain clothed and upright. They may do painful or intrusive things to the woman. The woman, on the other hand, has less knowledge, is in a strange environment, remains partially unclothed, is lying down and submits to the procedures being done to her. Even when a midwife intends to be kind and sensitive, her client may find many aspects of the relationship very stressful.

She also may find this power differential confusing, more so if the midwife is the same gender as her abuser(s). Her contacts with her midwife may evoke the same feelings and reactions she had at the hands of her abuser. Her body may tense, she may feel panicky and unable to speak on her own behalf, or she may react with anger or resistance. Depending on the degree of recovery, she may or may not recognize the connection between these reactions and her previous abuse.

Women who were victimized by a male (which is most often the case) sometimes choose a female midwife in the belief that a female will be safer. Because of their more personal and less interventional style of care, midwives attract a higher percentage of middle-income survivor clients (that is, those who have a choice of providers) than do medical doctors. If, however, the female midwife then does some of the things the woman expected to avoid by going to a midwife (for example, limiting time for appointments; performing tests, vaginal exams and other invasive procedures; leaving at shift changes; going on vacation near the due date; discontinuing the relationship at 4 or 6 weeks postpartum, etc.), the woman may feel betrayed or abandoned, even when these things have been discussed and the intention is to enhance the well-being of mother or baby. She may replay some of the old experiences of being let down, confused or hurt by her mother’s complicity (knowing or unknowing) in the abuse and/or failure to protect her. The midwife may resemble her mother, who didn’t protect her.

Thus, even though she chose her, a survivor may have difficulty trusting her midwife during the emotionally demanding time of pregnancy. Sometimes midwives feel as though they are being tested and having to prove themselves to their client, while the client believes that she is trying to gain some control, establish herself as an equal, and assure herself that she can trust her midwife. It is not surprising, therefore, that most survivors do not disclose their abuse history to their midwives—out of shame, guilt, fear of being labeled or out of a sense that it will not help. Those who do tell their midwives usually find that the disclosure improves the relationship. Most midwives want to help and, when they understand, they are better able to provide appropriate care.

Being challenged is always difficult, and midwives are as likely as anyone else to become defensive, hurt or angry. If you are the midwife in such a situation, it helps to remind yourself that you are not really the target of her dissatisfaction; you resemble in some way someone from years ago, who taught her to be skeptical or untrusting. Try to see beneath the surface, recognize that the survivor has special needs, and treat her as kindly, patiently and respectfully as you treat all the women in your practice. Be as flexible as possible without compromising safety or your own boundaries.

### How Pregnancy and Birth Trigger Abuse Memories

The physical experience of pregnancy and birth (fatigue, enlarging body, clumsiness, aches and pains, fetal movements, contractions, the urge to push, the baby’s descent and birth) may evoke feelings of being out of control, ugly or dependent, and trigger “body memories”—that is, extreme pain and tension—or psychological reactions of fear, panic, dissociation, withdrawal or flashbacks. Clinical care activities and a challenging or complicated pregnancy and birth also bring up numerous potential triggers, such as vaginal exams, breast exams, injections, blood draws, bladder catheters, intravenous fluids, transfer to the hospital, which may be followed by administration of an epidural, episiotomy, forceps or vacuum extractor, restriction to bed (with or without “restraints” in the form of tubes, belts, monitors, blood pressure cuffs, oxygen masks). To survivors, these may become metaphors for the abuse—invasion of body boundaries, exposure of sexual body parts, physical restraint in the “victim” position (lying down while others stand) and powerlessness.

Control issues also arise. When she was vulnerable and not in control in the past, the survivor was hurt. Having lived in constant but unpredictable danger or having been assaulted when her guard was down, she may become extremely vigilant and guarded so as never to be caught by surprise. A timid, unassertive, compliant woman may have learned as a child that the only hope
of safety lies in not breaking other people’s rules. She knows that if she breaks the rules, she is bad and deserves punishment. On the other hand, some survivors become angry and distrustful, which may translate into actions designed to keep her birth, her midwife and other staff under her control. These may include careful questioning of the midwife about her philosophy of care and use of interventions, preparing a detailed and specific birth plan that includes lists of things the midwife should not do, suspicion of the nurse’s intentions, bringing many people to the hospital for “protection” from unanticipated staff actions, or giving birth at home where she is more in control.

This desire to remain in control may also translate into actions to keep control over her own behavior when she is in pain. Some women want a hospital birth because they desire an epidural before the labor pain reaches a point where they can no longer behave normally. They may worry about behaving in a shameful way—wincing, writhing, crying out—when in pain. The epidural enables them to control their facial expressions, actions, speech, thoughts and responses to others. The tradeoffs involved with an epidural—a degree of helplessness in both physical movement and in self-care—bother some survivors more than others.

The fear of losing control makes some laboring women struggle against their contractions. Relaxation may be impossible and suggestions from well-meaning midwives, doulas, or nurses to “relax,” “surrender,” “yield,” “open up” may remind the survivor of other times when she was made to do these things and was hurt. Other suggestions, meant to reassure, such as “Trust your body” and “Do what your body tells you to do” are incomprehensible to the survivor whose body has been a source of anguish, pain and betrayal. Her efforts to keep labor under her control may actually slow or stop progress. In fact, I believe that some women, in a conscious or unconscious need to avoid pain or injury to the vagina, have controlled their labor (even when Pitocin and an epidural were used) to the point that a cesarean for failure to progress became the only solution. I wonder how many cesareans for “failure to progress” are done to survivors who have a deep fear for their vaginas. A cesarean bypasses and thus protects the vagina.

During traumatic and abusive situations, many people dissociate. In a sense they “leave their bodies,” altering their consciousness to take themselves away from horrible thoughts, pain and memory. Dissociation is a powerful survival technique when abuse or trauma cannot be avoided. The same thing may be done during a frightening labor. If survivors perceive their ability to dissociate as an indicator of strength or a helpful way to manage under difficult circumstances, they will welcome dissociation during labor. If they connect dissociation with victimization, they will want to remain present and aware.

One issue that is unique to home- or birth center births is transfer to the hospital if problems arise. Unplanned transfer carries the potential for trauma, especially if the midwife does not remain with her client. Issues of abandonment, helplessness, or, as one woman said, “being thrown to the wolves,” sometimes come up for the woman. It is traumatic if the woman and her partner, exhausted and worried, are left alone while the midwife arranges transfer, packs up her gear and rides in a separate car. All midwives should consider the emotional impact of transfer and try to minimize the distress that may accompany it. A doula can be worth her weight in gold in situations like this, by remaining with the woman throughout the entire process of transfer and until the baby is born.
Midwifery

Survivors are sometimes unprepared for the baby’s needs and demands. Having to always be available at the baby’s beck and call may feel like abuse by their baby “perpetrator” at times. Giving the baby total access to their breasts (feeding on the baby’s demand or cue), especially if their breasts were a major target of the abuse, may trigger resentment, guilt and memories of a childhood when they could not say no. On the other hand, they may become fiercely protective of their tiny baby, somehow identifying with the baby’s helplessness. Others fear that they or their partner might abuse their child, just as they themselves were abused. Having the baby with them in bed or having the father bathe with the baby sometimes evokes suspicion in the survivor mother that her partner will sexually abuse their child.

Some Practical Tips for Midwives

The following tips are not intended as a comprehensive discussion of everything a midwife should know in order to provide the most appropriate care for survivor clients. I hope these tips help you understand your clients better, but also whet your appetite to learn more about working with survivors during the childbearing year.

- Be aware that many pregnant women in your practice have been traumatized or abused earlier in their lives and may not disclose this—for any number of reasons. They may have no memory of the abuse. They may believe that it is not relevant, since it happened long ago. They may believe they are “over it.” They may not want you to know. They may feel you’ll perceive them as damaged, weak or shameful. They may believe that having that information will not make any positive difference in how you will care for them.

- It is not necessary to be told by a woman that she has an abuse or trauma history in order to know in order to provide the most appropriate care for survivor clients. I hope these tips help you understand your clients better, but also whet your appetite to learn more about working with survivors during the childbearing year.

- Be aware of the many ways that a history of trauma or abuse may affect a pregnant survivor (many of which are discussed in this article) and use the “Midwife’s Motto” to guide you if you feel tension or negativity in your relationship: “She has good reason for feeling this way, behaving this way, believing these things, and saying these things. I may be the target of her negative emotions at the moment, but I am not the cause.” The motto can keep you from becoming defensive or wrongly blamed. You’re more likely to use your more powerful position in a constructive and appropriate way and avoid being drawn into an unhealthy dynamic of guilt, resentment, co-dependency, belligerence, or hurt.

- Use good communication skills. Learn to read between the lines and recognize when a question or statement may have a deeper emotional meaning that should be addressed. For example, if she asks, “How often do you do vaginal exams?” you may simply answer, “Not very often. Only when I need to.” If you then follow up with, “How are you with vaginal exams?” you may discover that she dreads them, which was the real reason she was asking.

- Treat all her requests and preferences as valid, even if they seem unwise, inconvenient or unsafe. Find out what is behind her requests, then bring up your concerns. You can have a discussion between equals. Hold the intention of resolving differences with win-win results, while maintaining safety.

Conclusion

This paper describes many of the ways early abuse or trauma may negatively affect the survivors’ later experiences with childbearing and offers some tips for midwives for providing sensitive and effective care and support. This work can be extremely rewarding, especially when a survivor gains confidence and self-esteem through her childbearing experience. In fact, when a woman identifies and voices her needs and then is cared for in a sensitive and respectful way, she learns good things about herself and finds empowerment in childbirth. Every woman deserves such thoughtful treatment and a good or great birth experience.

Penny Simkin, PT, is a childbirth educator and doula who trains doulas through Seattle Midwifery School and Florida School of Traditional Midwifery, and in workshops throughout North America. She has authored numerous articles, pamphlets and books, including the Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia (2000), The Birth Partner, and Pregnancy, Childbirth and the Newborn. She is a founding member of DONA International and The Pacific Association for Labor Support.

Recommended Resources

For further information on ways to improve maternity care for abuse and trauma survivors, please read the following:

pictures on China, AC Milan, San Antonio spurs, Dennis Johnson

The first sport study with the Quantum Xrroid technology was on members of the Cleveland Browns football team in 1998. The results were amazing and all of the participants went all Pro over the next five years. Having worked with the power lifting team of Hungary in 1991 they went from moderate to gold medal performance.

AC Milan bought some systems and their injury level dropped 91%. This was because the system can stimulate and accelerate healing of injured tissue. They asked for us to develop the device to sharpen the athletic skills of the clients. With this in mind we developed a way to sharpen coordination endurance and strength. AC Milan won the European championship the next two years. We worked with Dennis Johnson ex twice NBA MVP in the San Antonio Spurs system. The results were amazing.

The Chinese Olympic team had us do a study. Out of their 467 athletes in the 2008 Olympic Games, they assigned 150 of the sick, old, weak, and tired to us. The study was to see if we could repair injured tissue and get an athlete back onto the field. The results were astounding. Out of the hundred medals won by the Chinese our 30% of the injured performers won 33 % of the medals. Our athletes were not supposed to win. And because of this Dreir’ was awarded an honorary Gold medal.

Sports medicine has entered the energetic arena. There are those who want to win and they differ from those who want to conform.

Some of the best cyclists in the world have used the SCIO to win championships.
Craniosacral Therapy in the Midwifery Model of Care

by Kara Maia Spencer
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Photos provided by the author

How can the gentle touch of craniosacral therapy (CST) prevent and heal birth trauma? This relaxing bodywork is growing in popularity among midwives, doulas and childbirth professionals as a modality complementary to holistic maternity care. Mothers are seeking out craniosacral therapists as well, to assist themselves and their babies in achieving optimal health in the childbearing year.

Craniosacral therapy is a gentle, non-invasive and powerful hands-on therapy that benefits whole body health, treats a multitude of conditions and is effective for infants, children and adults. Though the craniosacral therapist uses a very light touch, the bodywork is deeply transformative and healing—physically, emotionally, mentally and spiritually.

The soft, hands-on bodywork techniques of the craniosacral therapist are non-invasive and serve to relieve pain and dysfunction in the body. The body's physical release of myofascial restriction facilitates the innate potential for increased wellness and a peaceful consciousness.

The craniosacral system develops shortly after conception, when the first cell divides in the womb and forms the primal midline that becomes our spine. From that moment onward, the health of all our systems is organized around the midline—the spine. Our bones, joints and muscles should be balanced to be healthy, but like a tree that has grown twisted due to the wind, our spines and connective tissues can be affected by tension, trauma and injury throughout life—beginning with the prenatal and birth experiences.

Craniosacral therapy is a gentle way to relieve restrictions in the body to increase the capacity of the individual’s nervous system for health, harmony and well-being. The body naturally seeks homeostasis—and craniosacral therapy facilitates this balancing. When an individual experiences restriction or trauma, whether through a challenging birth or an injury or emotional shock to the nervous system, the body alters its priority from actualization to survival mode. The sooner that trauma, shock and restriction are released from the body, the easier and faster the healing process.

Craniosacral therapy is wonderful for all ages and conditions—from those with severe conditions to those looking for preventive health care. In an ideal world, all pregnant women and infants would receive craniosacral therapy to promote healthy births, babies and families, thus saving on health care costs in the long run!

What Is Craniosacral Therapy?

The craniosacral system (CSS) consists of the brain and spinal cord, the three membranes that completely surround it, the craniosacral fluid within the membranes and the fascial connections to the bones of the cranium, cervical vertebrae and sacrum. The dura mater is the tough outer membrane that connects to the cranium and sacrum and contains the entire fluid craniosacral system. The CSS has a slow, gentle rhythm that resonates throughout the entire body.

Through gentle soft tissue release, the practitioner works with the craniosacral rhythm to release tension in the fascia and balance the ligaments, muscles and bones. The craniosacral rhythm can be felt as a result of subtle palpation through contact with the cranium, spine, and sacrum—as well as throughout the entire body. If there is not movement or expression of the craniosacral rhythm and tide throughout the body’s tissues, then restriction, dysfunction and pain settle into the body.

The craniosacral therapist assesses the body for restrictions and uses a very light touch to encourage expansion, mobility and healing. Craniosacral therapy effectively creates deep change through gentle touch by addressing issues at the core of the body’s health. During craniosacral therapy the practitioner uses no more pressure than 5 gm (the amount needed to hold a nickel) to assess, resolve and prevent restrictions in the body. The treatment is deeply relaxing and recipients often experience a sense of timelessness or “stillpoint.”

Unique from other systems of the body, the CSS actually slows down and enters into stillpoints. These rests are a therapeutic time of revitalization for the CSS—similar to rebooting a computer. After facilitating a craniosacral stillpoint, the individual’s CSS functions more strongly and is better coordinated; the body is using its own innate ability to heal.
Regular craniosacral therapy sessions can help to maintain health, well-being and immunity, as well as to ward off depression, musculoskeletal dysfunction and stress. Craniosacral therapy is recommended for pregnant and postpartum women and new babies—as well as for women of all ages and in all stages of life.

**Craniosacral Therapy for Pregnancy and Postpartum**
Craniosacral therapy assists the pregnant woman along her journey into mothering by releasing restrictions in the body and pelvis to co-create an optimal birthing experience. During pregnancy, one of the primary focuses is to release restrictions in the pelvis to resolve back and hip pain and tension and to prepare for an optimal labor and birth, including promoting optimal fetal positioning. Craniosacral bodywork assists the baby in the womb to have optimal labor, birth and bonding.

Craniosacral supports the pregnant women’s inner resources for health, facilitating global balance in the body, heart and spirit. Through light touch, a therapist can balance the pelvis and uterus in pregnancy to ease and prevent ligament pain, posterior babies and low back, hip or rib pain. During labor and birth, women have obtained profound benefit from midwives and doulas trained in craniosacral therapy who are able to support them with comfort measures to balance and unwind the pelvis, uterus and sacrum.

During the postpartum period, craniosacral therapy restores musculoskeletal reintegration, emotional balance and pelvic health and helps alleviate the discomforts of newborn care and mothering. Craniosacral therapy is even more effective for infants when the mother is simultaneously treated. The mother can be treated while holding the baby or while the baby lies on the mother’s belly; the baby also receives treatment this way.

**Craniosacral Therapy for Infants**
Craniosacral therapy is a wonderful and gentle bodywork modality for infants, babies and children. It promotes health, as well as minimizing or eliminating the effects of birth trauma. Craniosacral therapy is performed with the baby or child wearing comfortable clothing, while the practitioner uses light touch that is soothing and relaxing. Babies enjoy craniosacral therapy. Sessions for babies are usually 15 – 45 minutes long and can even be performed with the baby in the parent’s arms.

Newborns benefit profoundly from craniosacral therapy because of the intense pressures on the cranium and body during the short, but dramatic passage from the womb to first breath. Craniosacral bodywork for infants in the early postpartum period can prevent numerous breastfeeding challenges by enhancing their tongue thrust, sucking reflex and latch. Babies born by cesarean or instrument delivery are especially in need of craniosacral therapy to ease the unnatural forces that their bodies experienced in birth.

This natural relief from tension is easily done through the craniosacral practitioner’s loving touch. Craniosacral therapy gently facilitates the release of restrictions in the myofascial tissues surrounding the tongue, facial bones, cranial bones, cranial nerves, sacrum and more, thus encouraging the increase in vitality and coherence of the craniosacral rhythm.

To the observer, the therapist may appear to be “doing nothing” during a craniosacral session, because he or she is just gently contacting various parts of the body with a light touch. However, this conscious touch is specifically palpating the inherent breath of life within the body and its resonance throughout the fluid dynamics, tissues and bones. This conscious relationship with the recipient’s inner healer allows a profound release of tension that occurs as a result of the light touch.

This bodywork assists babies in releasing restrictive patterns in the body before they become issues later in life, thus preventing future disease and dysfunction. Craniosacral therapy is extremely valuable for a baby who experienced a challenging labor and birth or is experiencing health issues. A spectrum of breastfeeding challenges can be treated with craniosacral bodywork including poor latch, reflux, colic, unwillingness to nurse or even painful nipples in mom.

Further reasons to treat a child include: middle ear infections, headaches, learning disabilities, trauma, autism, ADHD, difficult mobility, developmental delays, behavioral changes, cerebral palsy, chronic pain, genetic disorders, neurological conditions, torticollis, hearing problems, disease prevention, promotion of well-being and more.

**Paths for Midwives to Learn Craniosacral Therapy**
Craniosacral therapy has roots in cranial osteopathy, yet it has developed into a unique therapy that has many different schools, philosophies and practitioners. Many health care practitioners practice craniosacral therapy in their work, including midwives, naturopathic physicians, acupuncturists, massage therapists, chiropractors, osteopaths, allopathic physicians and dentists.

Numerous resources are available to midwives for further research and study of craniosacral therapy. Carol Gray in Portland, Oregon, is a homebirth midwife, childbirth educator and craniosacral therapist who teaches workshops in Craniosacral Therapy for Pregnancy, Birth, and Postpartum and Craniosacral Therapy for Infants (www.carolgray.com). Carol Phillips, DC, is a chiropractor, doula, and craniosacral therapist who teaches Dynamic Body Balancing: Craniosacral & Myofascial Unwinding, specializing in pregnancy and infant craniosacral (www.newdawnpublish.com).

The Upledger Institute is a craniosacral school founded by Dr. John Upledger, who was responsible for beginning to educate people beyond the osteopathic and chiropractic professional community in craniosacral therapy and for conducting extensive research into the validity and efficacy of craniosacral therapy. His teachings brought craniosacral therapy to the varied health professions so now dentists, midwives and massage therapists all can learn these gentle techniques. The Upledger Institute teaches ShareCare classes to anyone who wants to practice gentle craniosacral
techniques on their family. The ShareCare class is especially beneficial for parents of children with special needs (www.upledger.com).

Biodynamic craniosacral therapy is a branch of the modality that deepens the practice of craniosacral therapy to include the understanding of embryology, pre- and perinatal psychology and the deeper tides of the craniosacral rhythm. The craniosacral tides are perceived as an expression of the primal "breath of life"—the inspiration of spirit spiraling into the most sacred of fluids within the brain and moving in coherence with the heart.

Ray Castellino, co-founder of the BEBA Institute and featured in the documentary What Babies Want, is a biodynamic craniosacral therapist and teacher. Completion of foundational training in biodynamic craniosacral therapy is a prerequisite for attending the Castellino Prenatal & Birth Therapy Training and a list of recommended trainers can be found on his Web site (www.castellinotraining.com).

Healing with the Inner Midwife

A light touch is all that is needed to access one's inner healing potential. Dr. Upledger speaks of "the inner physician"—the natural force for homeostasis that is accessed within the core through craniosacral therapy. I believe that a more appropriate term would be "the inner midwife." Truly, the hands-on therapy of craniosacral allows the recipient to midwife his or her own healing on a deep, primal level through enhancing the inner drive for balance. Craniosacral therapy brings to light the innate design for health that is within each woman and child and offers midwives a profound tool for natural healing in the childbearing year.

Kara Maia Spencer, LMT, CD, CBE, is a craniosacral therapist, licensed massage therapist and birth and postpartum doula with a private practice in Eugene, Oregon. Further resources about craniosacral therapy for mothers and babies are available at Kara’s Web site at www.maiahealingarts.com. Kara is also a childbirth educator, doula trainer and healing arts educator. She is the founder of the Maia Institute of Co-Creative Healing at www.maiainstitute.com, which offers Co-Creative Birthing classes online and more. She also teaches Birth Arts International Doula workshops, www.birtharts.com.
Disturbing “New” Trends in Tear Prevention Threaten Midwives’ Autonomy

by Tine Greve

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During the last 20–30 years, birth statistics in the Scandinavian countries have shown an increase in the frequency of third- and fourth-degree perineal tears from approximately 1% to a disturbing 3–4%. In 1998, a study was published in the Scandinavian Journal of Obstetrics and Gynecology showing that support of the perineum during crowning of the head decreased the frequency of third- and fourth-degree perineal tears. The significant difference in the frequency of tears in the two hospitals in the study was, according to the authors, only due to the use of perineal support with the modified Ritgens manoeuvre. Their conclusion stated that all women had to give birth in a semi-declined, back-lying position, in order for the midwife to have “good ocular surveillance of [the] perineum” and to perform the modified Ritgens manoeuvre on every birthing woman. Now, this has become the new routine in many Scandinavian hospitals. The main author of the study, Dr. Pirhonen, has toured Norway, introducing the modified Ritgens manoeuvre as the only way to reduce the number of tears.

Going through different studies on third- and fourth-degree tears, I find a great variety of risk factors: high birth weight, primiparas, maternal age, long second stage, use of vacuum/forceps, episiotomy, use of oxytocin, epidural, perineal oedema, etc. Evident risk factors, which come up in many studies, are birth weight, primiparas and long second stage. Factors like episiotomy, use of oxytocin and epidural seem to be risk factors in some studies and in other studies seem to have a protective effect. But I haven’t found any good scientific studies that have looked at the birthing woman’s position during crowning, vocal support, or a natural, physiological birthing process.

Twenty to thirty years ago, it was good hospital routine to perform episiotomies on most primiparas (and multiparas, if you had the time). The birthing woman would be lying on her back with her legs in stirrups, and the perineum was supported using different techniques, even though there was no scientific evidence for this practice. During the 1980s, midwives became more aware of the physiology of childbirth and some studies showed an increased risk of third- and fourth-degree tears if episiotomy was performed routinely and not just on indication. So, during a short time span, practice changed from routine episiotomies and full perineal support to no episiotomies and a hands-off approach, and “alternative” (read physiological) birthing positions were introduced. I’m certain, even though I don’t have many scientific, well-performed studies to prove it, that women giving birth have benefitted from the change in the regime by having better birth experiences, less perineal pain and a better sex life postpartum.

Even though this new approach theoretically should decrease the frequency of third- and fourth-degree perineal tears, there has been an increased frequency during the last 20 years. And this brings us back to Dr. Pirhonen. In the study, he implies that the rise is the fault of midwives, because they stopped performing perineal support to all birthing women. Could it actually be that we were wrong? That the lack of perineal support is the sole reason for this rise in tear...
frequency? I don’t think so. During the same period of time, there has also been an increased use of inductions, augmentation and epidurals. With an eye on the physiology of birth, I would like to take a look at possible biases in the results of the Pirhonen study.

When talking to midwives, who primarily work with physiological childbirth, I get the impression that the rate of third- and fourth-degree tears in their birthing women is less than 1% (which is also my own experience, from almost 10 years of working in an alternative birth care unit). In addition, when they do occur, it does not necessarily surprise the midwife. I often hear descriptions like, “but you know, the baby had his hand next to his head,” “it was an occiput posterior,” “the baby weighed almost five kilos,” or “she just pushed right through.” Oftentimes, third- and fourth-degree tears occur even though the midwife did provide good perineal support. Many midwives describe the perineal damage coming not from the head of the baby, but from a protruding elbow or shoulder. Midwives do not say this to defend themselves or their skills, but merely to state that this happens when there are irregularities. So, in normal, physiological birth, it seems that third- and fourth-degree tears are more likely to happen when there are any forms of malposition or mechanical mismatch.

I’ve also talked to midwives working in hospital settings, where many women use epidurals and augmentation. When this “new” Pirhonen regime was introduced in Norway, midwives began to pay more attention to their practice on tear prevention. They became aware of the difference in the way women with and without epidurals and augmentation pushed. A woman in physiological birth is much more likely to follow her body’s signals. Those who have observed physiological birth know that when the head is crowning, the woman often stops pushing, even though she is having a contraction. She will often start panting or grunting and at the same time, if she is free to move, retract the leg where the first shoulder is facing. This creates a twist in her hip, allowing the first shoulder to descend into the pelvic outlet. She responds to her body’s signals by moving in ways that delay the crowning, which makes the perineum stretch and less likely to tear. A woman giving birth with augmentation and epidural does not have the same experience during the second stage. She is numb; she might not get the pushing urge, and she might need vocal guidance and support in order to know when to push and when not to push. If she’s pushing by will alone and not with the guidance of an urge, she does not have the same control of the strength of her pushes. This may result in pushing too early (before the head is fully rotated and/or on the pelvic floor), leading to the risk of prolonged second stage. Also, she is more likely to push too hard, and her contractions might be stronger due to the augmentation. If she pushes very hard on strong contractions, the crowning may occur so fast that the perineum is not allowed to stretch slowly, increasing the risk of rupture. It is obvious that perineal support in these situations can provide good tear prevention.

This might be important to have in mind if you start looking at the risk factors for tears described earlier in this paper: primiparas (more likely to have inductions, prolonged labour, epidurals and augmentation), high birth weight (more likely to have inductions, prolonged labour, epidurals and augmentation), and long second stage (more likely to occur if there is a malposition or mechanical mismatch). So could it be that it is not the support of the perineum itself, but to whom we provide perineal support, that could be the clue to success? Understanding physiological birth, we also have the knowledge of how interferences in the birthing process can influence the outcome. (5)

So, imagine a woman in labour, in the beginning of the second stage, having been able to follow her body through the birthing process, not influenced by painkillers or Pitocin. She’s standing on the floor, leaning on her partner, just starting to push. You, the midwife, can see the black hair of the baby in the vulva. Now you ask her to lie down on her back, feet in the stirrups (so you can get a “good ocular surveillance of [her] perineum”), and you support her perineum by using the modified Ritgen’s manoeuvre. Yes, she might not suffer any severe perineal tears; but what about her birth experience, her breastfeeding start, her bonding with the baby? And what was the initial risk of her having severe perineal trauma?

This is supposed to be the regime if Dr. Pirhonen’s rules are to be followed. Seen in the light of what happened when the change in regimes went from episiotomy and support to no episiotomies and hands-off, I do understand the logic in providing perineal support to all birthing women. Midwives who were not good enough at evaluating which women still needed perineal support and, therefore, did not provide support to those who actually needed it, might to some extent, have contributed to this increased rate of third- and fourth-degree tears.

The Ritgen maneuver is an obstetric procedure used by midwives and doctors in order to control the delivery of the fetal head. It involves applying an upward pressure from the coccygeal region to extend the head during actual delivery, thereby protecting the musculature of the perineum. The maneuver dates back to 1855, when Ferdinand August Marie Franz von Ritgen described it in a German magazine for “birth knowledge.” Where the original Ritgen maneuver is performed between contractions, the Modified Ritgen Maneuver is performed during a contraction, but without the woman pushing. The modified Ritgen maneuver is first described in the 14th edition of Williams Obstetrics, from 1971.

So how do we solve this? By following Dr. Pirhonen’s recommendations and providing perineal support to all women? Or, should it be possible for the midwives to do individual evaluations of each birth and provide support to those at risk of severe perineal damage?

Looking at the fact that midwives who work with physiological childbirth have a very low incidence of third- and fourth-degree tears, I do think it should be possible for midwives to do this evaluation. It requires that the midwives be taught physiological birth in midwifery school, that they are aware of risk factors, that they learn the skills of good perineal support when it is needed and that they are allowed to work autonomously. In addition to this, midwives must also be aware of means to reduce the risk factors for perineal damage. Is it being a primipara that enhances risk or is the increased incidence of induction, augmentation, epidural and prolonged labour in primiparas that creates a larger risk for perineal damage?

My conclusion is this: Help those with initial risk factors, like primiparas and those with high birth weight babies, reduce their risk by avoiding the use of induction, augmentation and epidural. Give women the possibility to go through a natural, physiological birthing process without disturbances. When risk factors are manifest, do provide good perineal support.

Hands off when not needed! Hands on when needed!

Author’s Note: In this article I have chosen not to address the effects of preventive measures, e.g., maternal diet, ante- and intra-partum massage, etc. You can read about those in various other Midwifery Today articles. You can learn more about the subject of this article at the Midwifery Today conference in Philadelphia, Pennsylvania, April 14–18, 2010.
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Other Resources:
• Tear Prevention and Treatment Handbook

References:
How to Build a Birth Network

by Cynthia Yula and Katie Heffelfinger

[Editor’s note: This article first appeared in Midwifery Today issue 56, Winter 2000.]

This article is a blueprint for a grassroots movement—a program of birth activism that can be set up in any community to stimulate better birth practices, political activism, and media savvy for the birth community. Two successful birth networks—one in Nashville, Tennessee, and the other in Philadelphia, Pennsylvania—were started by the writers of this article. The program we developed can augment collaborative marketing efforts for birth professionals and create pockets of activism to promote birth change and the midwifery model of care.

We believe that women in our culture need to be educated toward a much healthier attitude about what normal is, what our bodies can do, and what powers we possess. We all know that some women make uninformed choices, can’t feel connected to their bodies, and buy into mainstream views as reality. We believe that women in our culture need to be educated toward a much healthier attitude about what normal is, what our bodies can do, and what powers we possess. We all know that some women make uninformed choices, can’t feel connected to their bodies, and buy into mainstream views as reality. We must educate ourselves to our own bodies, to normal, to our strength, and to our own health.

Goal

Step 1: Contact other childbirth activists

Goal

Introduce other birth change agents to your city’s birth network, raise their awareness of the benefits and options available within a midwifery model of care, and encourage them to include a midwifery model in their own classes and practice.

Process

Write or call the local midwives, doulas, independent childbirth educators and others interested in childbirth, and invite them to join the birth network now growing in their community:

• Explain how businesses informed by this model can benefit from group networking and media coordination.

• Offer to e-mail them literature such as the Citizens for Midwifery’s “Midwifery Model of Care” pamphlets or Coalition for Improving Maternity Services’ (CIMS) Mother-Friendly™ Childbirth Initiative (MFCI), the latter of which might be used to develop the philosophical base for the network and can act as an organizational starting point.

• Ask them whether there’s any educational literature they would consider essential to the newly forming movement.

Make a follow-up call a week or two later. If you provided them with literature at their request, ask them whether they’ve had a chance to go over the information, and whether they think it might be useful either for the birth network or for use in their classes. The exchanges of insight that this might spark are what will constitute the birth network’s very first breath of life outside of the womb! If you tracked down the literature they referred to, thank them and let them know that you’d like to bring it to the group’s first meeting for discussion.

Let them know when and where the first meeting will be held, and invite them to bring their insights and their love for better birth.

At your first meeting you may want to make an opening statement, to help everyone get oriented and inspire them to participate. As an example, here’s a version of the opening statement we made at the Philadelphia Birth Network’s first meeting:

We are all very different types of people. Our lifestyles are different. Our needs are different. Our personal philosophies range from one end of the spectrum to the other. We all have different comfort zones. We all need a network of services to keep our lives running the way we are accustomed. Birth and pregnancy have always been a personal experience heavily influenced by cultural norms. Today we have many choices that are encouraged by our culture. Some women want pain medications while others want a more natural experience of everything about the birth. Some women find comfort in a hospital setting while others prefer to stay at home for their birth.

The goal of the Philadelphia Birth Network is to refer professionals who will be truly supportive of pregnant families’ choices, and to encourage families to make healthy choices. Whatever your vision is of your birth and pregnancy, we are here to listen, support and encourage. A mom knows best her level of comfort, physically and emotionally. As a team of midwives, doulas, physicians, massage therapists, and body workers, we are united to provide services and education to pregnant families.

Our city, defined by an influx of new cultures and traditions, is growing up! As it does, the flavors of families will undoubtedly broaden. We must embrace diversity. No matter what the vision of the mother is, we must do our best to accommodate her requests by matching the family to the provider.

The first meeting is also a time to draft a mission statement and to determine how the birth network will be organized. We address these subjects in the next section.

Step 2: Coordinate your efforts

Goal

Inform, educate, and build community. Specifically, bring a diverse group of childbirth activists together to educate the community about the midwifery model of care, and to demonstrate how businesses inspired by this model can benefit from group networking and media coordination.
Midwifery

Process
Build relationships over the phone and in face-to-face groups. Determine responsible persons for setting up media and networking contacts within the community. Make arrangements to form committees and to develop a responsible team of activists.

• Encourage communication within childbirth groups and with individuals.
• Find out what the needs are within the community and develop task forces to solve problems within the community. Need statistics? Go gather them!
• Coordinate get-togethers to facilitate conversation.
• Develop common long-term goals.

The key to success is teamwork! Local and regional birth change agents need to work together to arrange for the most time- and cost-effective use of resources to facilitate change. Here are a few ideas:

• Market individual ideas as group ideas, to dilute the workload, increase the client base and pool community contacts.
• Foster strength within the birth community through shared activities and events.
• Form a task force to make presentations at a hospital or other settings in need of change.
• Compile a comprehensive contact list of parenting organizations and professional groups with a mission similar to yours: include name, address, phone, e-mail address (the most cost-effective means of contact!), Web site, birthday (a nicety), and professional alliance. Don’t overlook health-care professionals, hospitals and clinics, out-groups, and birth centers.
• Coordinate referrals. Use a computer, and some kind of database that can be searched. (Outlook allows you to input information that can be queried, but there are many more databases on the market that work just as well, if not better.) If a mom calls and wants a midwife who will come to her homebirth, you’ll then be able to search for “homebirth, midwife” and give her a quick referral to the homebirth midwives available to her. Having a searchable database makes life way easier for anyone who’s answering the phones. Those without computers are just a printout away from having a current, paper database.
• Develop an electronic newsletter, and send it to group members as well as to clients, contacts, and other interested parties in the birth community.
• Get CIMS designation for the hospital and medical practices in the community.

List of Potential Networking Connections
• Maternity stores
• Doulas
• Birthing centers
• Midwives
• Midwife-hearted physicians
• Local childbirth education associations
• Prenatal exercise classes
• Lactation educators and consultants
• La Leche League
• Twin clubs/special needs clubs
• Mothers of preschoolers
• Adoption agencies and lawyers
• Childbirth educators
• Director of education at hospitals
• Church groups
• Prenatal groups (bed rest)
• Early pregnancy groups
• Breast pump rental locations
• Maternity tours
• Baby/furniture stores
• Baby fair
• Military bases
• Local newspaper health editors
• Preschools
• Adoption private classes
• Preterm or private classes
• Breastfeeding prep classes
• Cesarean awareness classes
• VBAC classes
• Grandparents classes
• Massage therapists/chiropractors
• Pharmacies
• Libraries and post offices
• Bookstores
• Diaper Delivery Services
• Housekeeping services
• Manicurist/Pedicurist
• Church leaders
• Political leaders
• Fire department
• Moose/Elk lodges
• (daddies matter too!)

Organization
When you’re ready to schedule your meetings, call everyone. Twice! Ask for phone numbers of their childbirth friends; call them. Twice-once to connect with them and spark enthusiasm about the birth network, and a second time to invite them to the meeting they’ll be looking forward to after your first call.

At your very first community meeting, determine:
• The mission statement: Why are we here? Look to your community to see what it needs. Consider what draws you together, as well as what graces you with diversity.
• Interim officers: Secretary (possibly the most important role) and president (or coordinator), at minimum. If possible, a media representative, treasurer, and an events coordinator would be helpful.
• Degree of parliamentary procedures and by-laws: It’s often easier to let a committee decide on a reasonable response to a controversial issue. As the community evolves, however, different
needs will be perceived. A strong, large group will need strong procedures. A fluid, evolving
group will need less procedure and more room. There might not be a need to have by-laws
and procedures in place until three to five months into the group’s evolution.

• Dues: Is this a dues paying organization, and if so, will there be benefits? What need is there
in the community? In the past, The Greater Philadelphia Network asked for $35 a year. The
Nashville Birth network asked members to choose between active and regular membership.

Regular members paid only $29 per year, and were obliged to answer incoming calls to a message-linked voice mailbox on a rotation basis. (Active members acted as liaisons between the public and the birth network, and encouraged callers interested in their birth services to interview at least three other professionals besides themselves.)

Our membership money was enough to generate a Baby Expo in Philadelphia and a Baby Fair in
Nashville!

Handling the money

• We asked members of our birth network to make checks out to the treasurer’s name. Since
you are at the grassroots level you don’t need to be concerned with reporting the money
made. (Check with your local authorities about any possible loopholes.) Since the network reinvests its money into the marketing of the network you won’t see a profit, and the network is a “marketing collaborative” as opposed to a non-profit.

• Members should be informed that the money paid to the network for membership or donation
will go directly into the marketing of the network, and therefore indirectly into their own
birth services. The profit end will come from the thriving of your own birth business, as your
services are demanded by the droves of families who will find out about you through the
network’s marketing efforts.

As you create a structure that suits your group’s temperament, try to plan around the following
pitfalls:

• One person gets an idea and cannot carry it through. Make sure that committees have the
support they need, especially when dealing with the community-at-large in the name of the
group. If you find that you are lagging, don’t be afraid to ask for help. Everyone is counting on
everyone else to carry out the plans. If you need help, call your coordinator and explain your
need.

• One person is taking on too many responsibilities. Volunteering takes time; overworked folks
need help from others. Ask everyone to be “real” with the time that they are able to give.

Look for someone with the ability to delegate, and use him or her! As a leader, don’t hog leadership;
rather, optimize on the strong leadership abilities of the women around you. The leader’s primary
responsibility should be delegating and implementing, coordinating and making it happen.

Keep in mind

• Poor communication kills. The secretary must be able to disseminate info very well without
taking over.

• No backbiting. Especially the leadership! You must learn to hold your tongue before hurting
people’s feelings or making a major social faux pas. When facts are scarce keep it to yourself.
Nothing nice to say—keep it to yourself. The goal is unity.

• Ideas need funding. Every proposal should include some ideas to help fund it, right at the
brainstorming session. This is the most effective use of your time and energy.

• Attendance drops. Meeting attendance will fall off—it naturally happens! The strong people
left will be doing most of the work; the occasional member can fill in where s/he can. It really
only takes a small group of five to 10 to lead the rest, and a small group of leaders ensures
smoother interaction. Here are ideas to stimulate the group:

• Find ways to excite folks into coming to the gathering.

• Plan a series of events/goals on a timeline—work toward them.

• Offer special speakers, incentives and door prizes.

• Assign special jobs: “you bring donuts next time.”

• Make Each Person Feel Special—you can do this by giving them jobs that you know they will
enjoy and do well with.

• Plan for a babysitter to come to watch the kids while you are holding the meetings.

(Everyone can chip in a few dollars to pay the sitter.)

• If meeting attendance falls to a level where only one or two other people come, re-think the
group. This is not a failure! What can those who are left do?

• Evaluate reasons why people might have given up, such as personality, inexperience,
unknown factors, or just plain giving up.

• Do something that makes them want to come, like bringing in a good speaker.

• Don’t fret. Links will be made and connections forged. Allow that to happen. Once you give
a birth network life, you have to let it make new choices, like a growing child.

• Wait a few months and try again; shift the targeted location; try to rally new leadership.

You might avoid many of these pitfalls, if you nurture community spirit from the beginning. Here
are a few ways of bringing a diverse group of childbirth activists closer together:

• Communication. With one or two positive communications a week, folks feel looked after, you
know-loved! Call or send loving reminders to folks who haven’t attended lately; encourage
everyone to bring a new friend; and be sure to compliment the forward movement or
exceptional idea of one of your members, including new moms. (Remember: new moms are
most likely to join your network and promote the excellence of the care that you have given!)

• E-mail is easiest, fastest, and most inexpensive. Set up a format that includes a set of notes
from the last meeting, an agenda for the next one, and a call for new ideas.

• If you must, snail mail—but it is costly and slow. Make sure that your dues can cover the costs,
and send your mailings out well in advance of when they need to reach people.

• Social support. Regular get-togethers like potlucks and “Kawfee Klatches” allow members to
relax with each other and build friendships and trust. (Such gatherings should not replace the
regular meetings, however, since they tend to be less economically stimulating than the more
structured, formal meetings.)

• Common interests. To nurture bonds among group members, you might unite around La Leche
League participation, or form groups around a common interest in church, politics, exercise, a
particular hobby, or homebirth.

• Economic support and development. Brainstorm together over low cost advertisements and
projects more easily done in a group. A few examples: setting up a referral line or group phone,
creating an online newsletter to inform the public about the services offered by members of
the birth network, getting a doula group set up at the local hospital, and other special projects
mentioned in the fourth and last step of this article.

Step 3: Inform the public

Goal

Use regional and local media avenues to let the public know about the midwifery model of care,
and about the wonderful services and events your birth network provides to the community.

Process

Pick up your phone book. Use your town’s network of outreach capabilities to reach the public.
The media is especially powerful, when it’s used ethically and for the purpose of education.
Television and radio have the potential to alert many people at once about issues critical to their
health and well being.

Seek a place in:

• TV health segments
• Newspaper “help available” sections
• Radio “top personality” programs
• Association journals and monthly newsletters
• Free local informative publications for expectant parents

Story concepts

News is information. News is what is significant, interesting or unusual to the readers who subscribe
to the community’s paper. The news editor, in turn, measures midwifery-related information on
how much it will interest the community. To tap this interest, focus on the human-interest story,
and have your tasks ready to go along with the national news. (Timing is everything!)

• Pick a “real world” family to introduce to the community. Offer to provide the names of local
couples who decided to have homebirths-if you have their permission, and if this is prudent
in your area.
• Have the local Citizens for Midwifery group provide a contact person who is a homebirth
mother as well as an activist and birth change agent-someone who is able to present a clear
view of the benefits of the midwifery model of care versus the medical model of care.
• Rally local people around a new clinical study, e.g., breastfeeding is best, episiotomies are not
necessary. Use science to put across your mission.
• Remember that newspapers are generally short on space.
• Bear in mind that the reader is busy, and wants a concise report of the “who, what, when, why,
how, and how much” of the event in concise language.

For example:

• If you are writing a press release, be sure it has an angle. Example: a notable person is scheduled
to talk about the midwifery model of care. As you write the press release, you should ask
yourself: “what would readers want to know about the upcoming program?”
• Bear in mind that the reader is busy, and wants a concise report of the “who, what, when, why,
where, and how” of this event.
• Remember that newspapers are generally short on space.

While you cannot control what the media airs or prints, you can educate the public on the clinical
breakthroughs and benefits of the midwifery model of care. The birth change agent has a social
responsibility to inform and report on this effective method of care, one that has saved lives that
may otherwise have been lost or impaired due to the medical model’s view of childbirth.

Midwifery’s alternative and potentially preferred model of care for the pregnant woman is a
forward-thinking topic for your community to explore. Please know that what you are doing is of
local, national, and even global importance!
Step 4: Cultivate special projects

The group now has a network in place, media contacts have been established, and the group can mobilize the network and media as needed to move certain areas forward. Follow-up and tenacity will be the keys to the birth network’s continued evolution.

The group should begin working on other projects and connections at this time. These projects, based on the group’s evolving needs and concerns, will be what keeps it all going. Projects might include:

- Getting a doula group set up at a local hospital.
- Running a referral line, group phone number for perinatal services.
- Publishing a newsletter to tell the public about your birth network’s services. (You could supplement membership dues with advertisements, to pay for production and distribution.)
- Planning another baby fair or expo, in conjunction with local stores and colleges.
- Celebrating the midwifery model with some other newsworthy even

Step 5: All midwives are educators.

While not all midwives are preceptors (clinical teachers who train students), educating birthing families is an integral part of midwifery care. As such, learning principles of adult education can help midwives become more effective for their clients and also will help those who train students to be better preceptors.

Parents will most often parent their children the way they were parented; our early experiences, good or bad, influence us. It can be the same in clinical midwifery education: we often train midwives the same way we were trained. If weak areas existed in our own clinical training, we have to work hard to improve and create better learning experiences for our own students.

Being a good midwife does not necessarily make one a good teacher. Knowledge of basic educational principles will help a person be a more effective teacher. Theories of education regarding how people learn best are tremendously varied. Some of the early work focused on Bloom’s Taxonomy of Intellectual Behavior (1956), which defines the three overlapping learning domains: cognitive, affective and psychomotor. Further research by Howard Gardner (1983) led to the proposal of the Theory of Multiple Intelligences, using seven styles of learning: verbal/linguistic, logical/mathematical, visual, kinesthetic, musical, interpersonal and intrapersonal. A more modern approach focuses on only four types of learners: visual, aural (hearing), read/write and kinesthetic.

Midwifery programs are often written using woman-centered learning, which is more empathic and connected. It involves the learner in the process and is less hierarchical. Many of the concepts in woman-centered learning also are present in constructivism (Bruner 1990), which is the belief that people actively construct new knowledge as they interact with their environment. When people take notes or use learned material in a practical way, such as to restate or teach, they learn it better.

Constructivism Promotes Learner Involvement

A constructivist perspective views learners as actively engaged in making meaning based on their prior knowledge and experiences. Teaching with that approach focuses on what students can analyze, investigate, collaborate, share, build and generate, based on what they already know, rather than what facts, skills and processes they can memorize and regurgitate. Some of the ways the tenets of constructivism apply to training midwives are:

- Students’ prior experience and learning is recognized and valued.
- New knowledge is constructed using the individual student’s prior knowledge.
- Students learn from each other as well as from the teacher.
- Students learn better by doing.
- Allowing and creating opportunities for all to have a voice promotes the construction of new ideas.
- Learning is particularly effective when constructing something for others to experience.

Ways to Incorporate Constructivist Learning Principles in Clinical Education:

- Observe students teaching clients.
- Role-play complications. For example, get out the pelvis and baby and have the student show you how to get some pesky shoulders unstuck.
- Ask her, “How would you handle this?” at every opportunity. And listen to the response.
- Provide opportunities for hands-on involvement, early and often.
- If you have more than one student, have the students work together. They can practice clinical skills on each other, do group research projects, etc.
- Recognize that your student has her own world-view; respect it and know that changing it takes work.

Being an effective clinical teacher is important, no matter what type of midwife you are or where you practice. Clinical experience is the core of midwifery education. All midwifery educators can improve in this area.

I was trained much the same way as most direct entry midwives (DEM) in the US in the early seventies: a combination of self-teaching and informal apprenticeship. Many of us started attending births with very little experience and even less training. We learned from experience and shared knowledge with our peers, doctors, chiropractors and anyone else we could. Very soon we had our own students. Our students had advantages we did not, especially more formal one-on-one apprenticeships. Some midwives included classes and directed learning activities. Others focused only on the clinical aspects of training; and their students relied on self-study, distance learning and any related training they could find.

The midwife credentialing process of the North American Registry of Midwives (NARM) was designed to fully incorporate and support the apprenticeship model of training through the Portfolio Evaluation Process (PEP). As direct entry midwifery schools formed, the Midwifery Education Accreditation Council (MEAC) began accrediting schools and NARM included a track for those who graduated from an accredited program. While NARM remains committed to the PEP, the philosophical trend is toward all midwives attending an accredited school, regardless of whether they are direct entry midwives or nurse-midwives.
Some have expressed concern about the loss of the “apprenticeship model” of training. Midwives have been trained throughout the ages using the apprenticeship model. While the science of midwifery is taught in the classroom and in books, the art of midwifery is taught in a one-on-one relationship between preceptor and student. We are fortunate in this country to have such a diverse range of training options for women to become midwives. As long as NARM continues to offer the PEP, the apprenticeship model will remain a viable method of becoming a midwife.

The Midwives Alliance of North America (MANA) created the core competencies, or standards of learning, for direct entry midwives. It also provides clear and written objectives for clinical practice that were written largely by early midwives, most of whom were self-taught and apprenticeship-trained. The values of the apprentice model are built into the system.

One of the drawbacks to the apprentice model has been the reliance on only one midwife for the bulk of a student’s education. Midwifery is so complex, and so many diverse approaches are possible for handling the same situations, that the more places students can learn from the better. Today’s midwifery students have more options. They may get their didactic instruction or academics from one place, their clinical training from a number of places and their one-on-one training with one or two midwives, in a high volume birth center or from working in hospitals in the developing world.

Nurse-midwifery students have long had the advantage, in the clinical part of their training, of clear written objectives, skill check-off sheets and other written guidelines. Now, with NARM and MEAC, direct entry students have the same options. These are important tools for clinical training.

Direct entry midwives in the US face an uphill battle to have our training models recognized with the same validity as the American Council of Nurse Midwives (ACNM) models. American College of Obstetrics and Gynecology (ACOG) recently released a Statement of Position which essentially says that all midwives who do not graduate from a program accredited by ACNM’s agency, the American Midwifery Certification Board, are “lay midwives” and are unsafe and not trained. This is a slap in the face to all the work that direct entry midwives have done with our training models and our credentialing processes.

The MANA study (Johnson and Daviss 2005) was an important step in demonstrating the safety of midwifery care by certified professional midwives (CPMs). More research needs to be done on the effectiveness of various educational models. Since ACOG has recognized that midwives do not need to be trained as nurses first, with the certified midwife (CM) recognized by ACNM, the next step is just a turf battle between accrediting agencies.

Unfortunately, research is limited on midwifery education for direct entry midwives in the US. If our position in relation to out-of-hospital deliveries is that mandatory CPM training is as valid as that required for a certified nurse midwife (CNM), we need to ask whether the evidence supports our assumptions. We do not truthfully know. We can make educated guesses, but we do not have the research to support our position either way.

In my experience as a midwifery educator over the last 30 years, I have witnessed tremendous growth and change in how we train midwives. MEAC and NARM have helped us raise the bar. However, I still see the quality of direct entry midwifery education all over the map, from excellent to poor. This includes those who graduate from MEAC programs and those who don’t. We still need to ask: How do midwives think their training prepared them for practice? Are students learning what they are taught? How do students graduating from self-study and apprenticeship-only models hold up in comparison to graduates from accredited schools? How does distance education compare to onsite programs?

To answer some of these and other questions, I conducted a short, informal study that focused on the clinical aspects of training midwives. However, we still need more formal and detailed research.
Vaginal Births After C-section Are Not Necessarily Riskier in a Birth Center than in the Hospital

by Judy Slome Cohain

[Editor’s note: This article first appeared in Midwifery Today Issue 77, Spring 2006.]

Abstract: Recent research concluded that VBACs are riskier in a birth center than in the hospital. This conclusion is only true if the woman is sure she will not have any more pregnancies and if she does not suffer from „Fear of Hospitals.” Since childbirth centers offered a VBAC rate of 87%, whereas US hospitals currently offer a VBAC rate of less than 10%, the woman has a much higher risk of a repeat cesarean if she delivers in hospital, which increases her risk on subsequent pregnancies. judyslome@hotmail.com

The results of the National Study of Vaginal Birth After Cesarean (VBAC) in Birth Centers shows that childbirth centers are not necessarily more dangerous than hospitals for women who plan to have more children.

The results of the National (US) Study of Vaginal Birth After Cesarean in Birth Centers (1) has made the following blanket statement: Vaginal births after c-section are riskier in a birth center than in the hospital. If one could be absolutely sure that this will be the woman’s last pregnancy and the woman is not afraid of delivering in hospital, the conclusion may be true. However, the conclusions made by this study should not be the basis for changing protocols, but rather for improving the information upon which women base their choices.

The birth center study involved 1353 low-risk women who attempted VBAC in childbirth centers. They were compared to 21,000 low-risk women who attempted VBAC in four hospital-based studies.

The researchers concluded that in childbirth centers, the neonatal mortality rate for low-risk VBAC was 1/500 and in hospitals, it was 1/1000. (Low-risk women were defined as women having only one previous cesarean and delivering before 42 weeks.) The study implies that one baby per 1000 will be saved if all of the women who chose childbirth centers had delivered in the hospitals where the hospital research was carried out.

Note: The risk of neonatal death due to uterine rupture in a hospital with less than 3000 births per year is 3.4 times greater than in a hospital with more than 3000 births per year.(3)

Women who go on to have another pregnancy will find that the added safety of the hospital may be outweighed by the risk of having two cesarean scars, due to the higher repeat c-section rate in hospital.

The United States national hospital repeat c-section rate in 1995 was 72%. (2) This is more than five times the 13% repeat c-section rate found among the 1400 births in US childbirth centers from 1990–2000. After two cesarean surgeries, a woman experiences a much higher rate of complications in subsequent pregnancies.

In addition, the neonatal mortality rate for women with a history of two c-sections attempting a VBAC is 20/1000 (2%). By delivering a baby in a hospital a woman might lower her risk of losing the
baby by 1/1000, but she raises the risk of losing her baby in subsequent pregnancies to 20/1000 if she attempts a VBAC.

In pregnancies where an attempted VBAC follows two c-sections a woman has five times the risk of uterine rupture (3%) than a woman with one scar, and she risks the placenta growing into the uterus (which ends with hysterectomy), placenta previa and stillbirth. Among women who experience uterine rupture, about 20% will require a hysterectomy. No one has researched the unexplained stillbirth rate after two c-sections.

In addition, the population of women who deliver in childbirth centers is very different from the hospital population. At least some, if not all, of the women who have good outcomes in childbirth centers would have disastrous outcomes in the hospital due to extreme anxiety and fear. To date, the syndrome „Fear of Hospitals” has yet to be made a diagnosis by the American College of Obstetricians and Gynecologists (ACOG). However, „Fear of Labor” is officially recognized. This unique female pathologic hysteria is treated with an elective cesarean section. Women who fear going to hospitals logically seek out alternatives to hospitals. Since anxiety has been shown to adversely affect the progress of labor, these women obviously have better outcomes outside of the hospital. These are the women whose labors do not progress in the hospital. The treatment they are given is labor augmentation, such as Pitocin or prostaglandins. Labor induction and augmentation after a cesarean section is known to be dangerous and leads to high uterine rupture rates and high neonatal mortality rates.

How do we know what would have been the outcomes of the 1353 VBAC births in the childbirth centers if they had delivered in hospitals? The answer is: we don’t. At present these are the only data we have. This is inadequate to be the basis of changing current protocols. The following research-based conclusions can be drawn:

1. A woman with a low-risk pregnancy should deliver a first birth with a trained midwife or doctor, who has a documented cesarean section rate of 4% or less, in a place where she is comfortable. A woman with the syndrome of „fear of hospitals” should be particular about having her first birth in a safe environment with a low c-section rate.

2. Women with one cesarean scar should be informed that:
   1. They are taking an increased risk of 1/1000 of losing the baby if they deliver in a childbirth center, and
   2. They increase their risk of a repeat c-section by delivering in hospital.

Most of us were born in ways that hurt and frightened us, and instead of remaining open to the vastness of who we are, we shut down, receiving only a portion of what was available when our soul anchored into our body. As a result, instead of knowing who we are at birth, often we rediscover who we are in our 40’s, 50’s or 60’s after years of piecing together life’s puzzle.

Birth therapy
As past life therapist since the ’80’s, the first session after taking a history was guiding the client to re-experience their birth this lifetime. As each client re-experienced their birth, their whole life suddenly made sense to them and to their history. They would say, “Wow, I have been acting this out my whole life.” Everything they were motivated to heal in adult life was right there at their birth. In every case of birth therapy, I saw how the experience of birth gives rise to the emotional homework of an entire lifetime. Seeds of physical, emotional and mental patterns are sown as a ‘blueprint’ that is set into place from the birth experience, and later followed throughout the child’s and adult’s life, until resolved. I knew that every birth contains this potential to make a difference. I saw how utmost care is needed to protect everything surrounding birth. I knew that being harmless and kind at birth could change a lifetime, and I understood that creating a birth of love and trust influences many lifetimes. My personal observation from the experience of birth and life: Sacred Birthing creates Sacred Living creates Sacred Deathing and so on...

• Birth therapy for an adult brings to consciousness and witnesses the unmet needs at our own birth. This is what is discovered viscerally in adult birth therapy:
• Birth is a microcosm of our life, what happens at birth happens again and again throughout life.
• When received in love, the first decision of life is “the world is a friendly place.” If pain or fear greets a newborn, this first decision becomes “the world is a hostile place”, the foundation of a filter that shields us from life. All later belief systems will support a baby’s first decision.
• Birth is the first stress out of the womb – what happens at birth becomes baby’s pattern for handling stress through life, until resolved.
• The newborn’s first relationships become archetypal patterns duplicated through life until resolved. How each one relates to baby is how baby will perceive all future relationship. Do Babies Like Their Birth? Sunni Karl 2006©
When we remember, we realize that every person can remember. And since we all remember, then the subconscious realm making it conscious, bringing holding patterns of a lifetime to resolution.

Difficult temperaments are created by the fear and pain they experience in the womb and at birth. Difficult babies have had difficult births. Easy babies have had births that did not scar or hurt them. Only when a baby is at ease physically, can her emotional and spiritual body also be at ease. Only then, is the whole being of a baby the way Nature intends.

Dr. Joseph Chilton Pearce, author of Magical Child, Crack in the Cosmic Egg, and enumerable other books on the study of what he calls the unfolding of intelligence in children, said, “Nature prepared us to be radically more creative, intelligent and powerful than we currently are.” What can we do now to reverse that? What can we do that will affect a whole lifetime and support our evolution? When you affect a birth, you affect the whole life of the child, and every resonant relationship in the child’s life.

As a birth therapist, I was taught how a newborn baby feels, by hearing one experience after another from my adult clients. What do we do that hurts a baby? What do we do that makes them scared? This is what I was shown:

• Drugs for pain eliminate the innate inner communication between mother and baby, leaving baby emotionally abandoned and physically toxic. Baby is abandoned, alone and scared.

• Personal laws, rules we live by, come out of the pre-birth and birth time, until resolved. E.g. “No one listens to me;” “I never get what I need when I need it,” or “I am not wanted,” “I am not good enough”, (the desired gender, or appearance.)

• Baby takes the words and thoughts of anyone within the area of birth, as directives for life until resolved.

• The emotions present at birth are familiar and most sought after by the baby/child/adult, until resolved.

Babies’ temperaments are created by the fear and pain they experience in the womb and at birth. Difficult babies have had difficult births. Easy babies have had births that did not scar or hurt them. Only when a baby is at ease physically, can her emotional and spiritual body also be at ease.

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By Sunni Karll

Sunni Karll is a birth therapist and a midwife. Author of Sacred Birthing, Birthing A New Humanity, midwives help birth be a most supportive experience? We are able to make a difference. Birth is a microcosm for a lifetime. How can we, as parents and midwives help birth be a most supportive experience?

By Sunni Karll

Making a Difference: A Blueprint For Harmony

As Published in Midwifery Today, Summer 2001

I used to think that bonding was simply about feeling connected with your baby. As I first held my babies, my heart opened and I knew ours was an ancient connection. Through later years and my work as a midwife, I saw far more than warm feelings happening while bonding. I wish to show this larger picture of bonding that has changed my practice.

Horses Bond Too

I have a friend who is exceptional with animals. This was especially noticeable with his horses, for they would always approach you as if in greeting, instead of walking away. When I asked him why his horses were so wonderfully friendly, he said it was from what was done with them at their birth.

He told me that when a foal is born, he held his muzzle lightly and would breathe and talk close to his nostrils for five of every fifteen minutes of the first hour and then fifteen minutes every hour for the next few hours. This allows the foal to smell and hear you and orients the baby horse towards people. He said that without that, the horse would never develop a connection with people because this connection was not hereditary or able to be taught. This connection needed to be imprinted at birth for it to be part of the horse’s makeup.

This is exactly what is happening with baby. As she is held in the crook of your arm and you talk and coo to her, she is right where she can best see, hear and smell you. This is her introduction to the outside world. This develops her connection with people. Newborns are voracious observers.
of every interaction in the room. Their memory banks and cellular memory indelibly imprints all birth encounters as archetypal experiences. It is as if baby were saying, "I will create my life out of the actions and reactions you are showing me." In this way, our children truly are the product of our refinement.

**Working Backwards**

When I was ten, I told my mother that I would deliver babies when I grew up. Through many years of fulfilling other commitments, I held this dream, forgot it and finally could act on it after my children were grown. Before becoming a midwife, I was a Waldorf teacher and a Past Life Therapist. As a Waldorf kindergarten teacher (1978 – 1986) one transformative practice was the ‘Child Study’. One child was chosen each week as the subject of the Child Study, who either had problems integrating into the class, a behavioral difficulty, or a teacher who did not know how best to support her. Through an exhaustive series of questions to the parents, an image appeared of the child’s conception, womb life, birth and earliest infancy. We clearly saw where the child was in pain, the reason for her actions and how best to fill her inner soul-need. With all of the teachers’ attention, the child received the group energy of caring. She arrived the next morning in a more balanced state, healed from the inside out.

Through the years of child study, what stood out for me were two unexpected revelations that would steer my life’s direction. First, it was repeatedly obvious that circumstances of conception, pregnancy and birth were directly related to what the child lacked emotionally years later. Second, there was a direct correlation between every dyslexic child and every forces delivered without exception. Could dyslexia be the result of the damage inflicted at birth and not heredity, as typically thought? These two realizations had an incredible impact on me. I had thought that being a kindergarten teacher was a good place to affect a child’s life. However, even these very young children were already wounded and expressing hurt. I wondered if I could better serve by keeping this damage from occurring in the first place.

Then as a Past Life therapist (1987-1993) I found that The Netherton method of non-hypnotic Past Life Therapy easily untied all kinds of problems by finding their source in other lifetimes. Here I found another link to the importance of birth. As each client re-experienced their birth, their whole life suddenly made sense to them and to their history. They would say, “Wow, all the pieces of my life just came together,” or, “I have been acting this out my whole life.” Boundaries dissolved and holding patterns in their life were relieved. Again, I saw how the experience around birth gave rise to the emotional ‘homework’ of an entire lifetime. It seemed to be that a template is set into place from the birth experience that baby later follows in her development. From the time baby comes down the birth canal until baby falls into her first deep sleep, are the seeds of patterns that will be seen later in life. So why not take utmost care to protect everything surrounding these first hours of birth? By seeing this wholeness and working backwards, I knew that an entire lifetime could be influenced by creating a birth of love and trust. Since an entire life is determined from the experience of birth, every birth contains this potential to make a difference.

**Birth Creates Our Template**

Bonding. During these precious two hours, in this time that will never come again, are hidden the makings of an entire life. All that happens, whether physically, mentally, emotionally or spiritually, will be encapsulated into a template, a matrix and pattern for the baby’s lifetime. Bonding is the space and time where all levels of the baby are open and asking to receive the energetic imprint of her new world. Unhealed needs from other lifetimes are like magnets that attract the parents who will give us the kind of birth and life we need to heal. Then in the womb we add a ‘nebulous matrix’ made up of mom and dad’s influences from conception and pregnancy. The birth we choose as baby soul will offer the appropriate happenings to recapitulate these earlier impulses into our template. The template energetically absorbs the imprint of any incident into each energy center of the body and is the exact picture of healing that baby needs for this lifetime. Baby, with this imprintated pattern, will repeatedly pull these occurrences into her life. In this way, the opportunity to heal what hurts is presented many times during life. Until these patterns are healed, they act like a horse’s blinders that can keep baby (us) traveling in the same emotional rut as she grows. Eventually they demand attention. Conscious intent, understanding and compassion will sever their hold.

Absolutely everything that happens in the presence of the baby creates this template. (For reasons of space, only the example of inter-relationship will be used yet all unmet needs create issues of self-esteem, food, time, gender, being wanted, belonging, etc. for baby.) During bonding, this first meeting with others forms the template for all relationships. How mother and father, midwife, nurse and doctor receive baby is how baby will experience being received all her life. Is she greeted with warmth, love, and celebration or with emotions that do not feel good? Our methods of birthing have been responsible for our lack of relating to others and our perceived separation from God.

"In bringing birth back in accord with Natural Law, it is intended that all influences are eliminated that have sabotaged human relationships and your deepest connections to Source, for they are one and the same.”(1)

Most of us born after 1940 intimately understand what life is like with an opaque template that calls for lots of healing. In this country, we had (have) the type of birth that inflicted pain and fear and disallowed bonding. Our births included forceps, drugs, unconscious mothers, absent fathers, long separation in a nursery, and the assumption that infants could not feel pain or remember it - hence were treated that way. Because of these procedures, babies were kept apart from the only ones who could truly comfort them. Bonding did not happen. We bonded instead with our ‘walls’, our incubator and crib and the attitude of ‘I’ll do it myself.’ These birthing practices produced templates of emotional patterns of withdrawing, overwhelm, connecting fear with stress, fear with excitement, fear with abandonment.

**Healing the template**

Unless born enlightened, we are born with templates of varying densities. It is the base level of our reality, for health or otherwise, out of which we live our lives, create our sense of self, trust and relationship. It is time to heal the trauma from our birth and therefore, our experience of life. It is time to heal the template. That is not to say that this era of emotional healing was inappropriate. Far from it. It was perfect in its time and allowed intimate understanding of the uncharted territory of the emotional realm. It has created an epidemic of separation that is now asking to heal. Large numbers of people are healing by remembering their births, their womb life and conceptions from either dreams, spontaneous recall, with the help of circular breathing as in
Rebirthing or from hypnosis or therapy. This is a new kind of cutting edge ‘technology’, a softer birth technology from the feminine perspective that addresses what is outmoded. I call it birth-spirit-technology, or Sacred Birthing.

The healing of birth trauma is no longer new. Stanislav Grof, psychiatrist, spoke of newborn memories in the early seventies. Dr. David Chamberlain tells us inThe Mind of the Newborn that everything matters, for the fetus and the newborn remembers it all. Santa Barbara Graduate Institute offers the first MA and Ph.D. degree programs that focus on prenatal and perinatal psychology. They teach the relationship of the perinatal period to the development of a healthy authentic self, family and societyand offer this training as self-healing and for clinical licensure (see www.sbgi.edu.). Also available to midwives, birth practitioners, parents and therapists is consultation relating to optimal birth and healing of perinatal trauma in infants and children. See Wondrous Beginnings,www.wondrousbeginnings.com. There are those in this new field who help resolve birth trauma by working with the newborn and her parents. (see Birthing Evolution, Birthing Awareness, BEBaray@aol.com.) The Association for Pre and Perinatal Psychology and Health (APPPAH) dedicated to in-depth exploration and education of the pre and perinatal time and the affects of the psychological, emotional and social development of babies and parents.

“Womb ecology becomes world ecology” (see www.birthpsychology.com).

These are some of the professions that offer ways to heal the template. They can help us relieve our misunderstood psyches that we were led to believe were only the product of our genes and environment and not too, our birth experience. As the understanding of the birth template is spread to parents, and consciousness continues to rise on the planet, the choice to heal will call many.

**Blooming or Recoiling?**

To the baby, birthing is about being received. We unfold to the world and know our value once received with love and acceptance, in our own perfect timing. If someone yanks us out of a place intrusively, we naturally recall and go within, in order to maintain balance against this outside force. The difference of being received compared to being forced, results in opening to this world or shielding ourselves from it. These actions create a different personality in a baby. The personality exhibits baby’s template.

If we constric at birth from fear, inflicted pain or trauma other than from birth’s natural process, our nervous system constricts and imprints our template. Our emotional body develops a personality to match the severity of our physical constriction. Our mental body takes on belief systems to reflect this stance. Our spiritual essence is overshadowed by the template and we shine a little less. The template forms from birth but lies in a somewhat dormant state until fully activated around the age of three, when an important event happens that triggers it. This event is often the content of our first memory. Our life becomes a mirror of birth’s tension and we discharge hurt throughout life until we heal.

The whole purpose of having an un-medicated, natural birth is to allow and support this experience of bonding. Bonding cannot happen when either baby or mom are fearful or in pain. The whole purpose of bonding is to fill the baby’s needs and NOT create an opaque template. The interventions of the modern birthing protocol require endless interruptions after birth, in the place where bonding should be. Specifically epidurals and the use of episiotomy in forceps and vacuum deliveries, which require extensive stitching afterward. For good reason the staff must oversee mother and baby until they are stable. Instead of the needs of this newborn life taking priority, this precious first two hours for bonding has been lost to the necessities of the hospital.

The less hindered a birth is, the more opportunity there is to bond. A natural birth results in an alert, pain free newborn. Mother too, is tired but not in pain. There is no need to be overly concerned after most natural birth for we can quickly, quietly and invisibly attend to necessities. The heart and energy fields of mother and father are open to their fullest. When mothers understand the soul-needs of their baby and wish to offer them a life of grace, they often find new inner strength to select a natural labor for their baby as well as this powerful and unlimited initiation available for themselves.

**What Can Be Done**

Self Examination: What would it be like if we as midwives, could receive a newborn in such a way as to create consistent smiles at birth? As midwives, we have already perfected the art of gentle birthing. We are good at that. What can we do beyond gentle birthing to preserve the full consciousness of the newborn?

Go inside first. As a midwife, I ask to be taught how I can clear my own obstacles in consciousness, my personality and belief systems in reaction to my birth template. I ask to release my own entire birth matrix so that my hands imprint this clarity upon the babies I receive. I ask to serve babies and parents whose births will exemplify the understandings I need to continue refining this path. I ask to learn to think ‘outside of the box’, from a spiritual perspective. Is there something else I can offer to help this baby be a loving, peaceful, balanced individual?

After each birth, don’t be too busy to ask searching questions. Be still long enough to receive the answers. Then, formulate what you need to learn and ask for it. Spirit midwives or ‘midwives on the other side’, are working with each of us. Ask them for their help. Often, little pockets of fear reside in us and take their toll at each birth. These are the fearful places still left in our template. We see by the births we attract, how much fear we still have lurking within us. Ask to participate in births with clients who will show you your next level of learning. Then, you can expect your next gift at each birth. Feel how this shifts your whole energy as you move towards a birth.

It can be very hard for us midwives to open to something new because we work on the cusp of life and death with precious little support. It is difficult enough just to hold this place without inviting in the unknown. However, the ‘midwives on the other side’ are not unknown to us, and we are never alone in our chosen work of midwifery. With their support we act as transducers of energy as Spirit comes into matter, as baby soul enters a body. We hold this place in the fullness of who we are and are constantly being asked to open ourselves to more. These Spirit midwives are reminding us of our essence, the authentic self and midwife we are, underneath our own template. They are offering us this path as yet another way to step into who we are with every birth we attend. Because it was no longer enough for me to simply receive babies gently and not introduce harm, I have had to make this jump and be courageous enough to ask Spirit to “teach me how to help create a birth for this baby’s soul that does not contain a template”. That is the kind of birth I intended and now work to create. This has opened a whole new ball game.
Sacred Birthing: Because of the rise in consciousness on the planet, some souls wanting to be born now are asking to birth in such a way as to retain all of their innate Divinity. The babies born in this way are boundless. Their full soul essence shines without the template’s overlay. Their unlimited soul-knowing is directly accessible in the body of the newborn. These enlightened babies are asking to birth as fully awake, sentient beings. These are babies that need no healing. They are vast, unbounded beings with full memory, in sync with creation. Families comfortable with this choice may offer this to their babies. Some of us will be called upon to support babies to birth without creating any template. This is truly the purpose of Sacred Birthing.

Sacred Birthing can also eliminate or drastically reduces the creation of the template for those desiring to conceive consciously and for those already pregnant. To do this requires the parents, the soul, the midwife and a birth team to work together. This work calls for the interaction of many layers of understanding that come as people work together with Spirit, for who but Spirit is able to shed light on these mysteries of life? There are birthing practices evolving to fulfill the needs of these babies birthing their essence in full consciousness. Sacred Birthing uses these birth practices to help the soul continue to hold its full Divinity in body. Unhindered souls are incarnating as a result. (www.sacredbirthing.com)

For The Doula: A doula can make sure bonding happens within the entire family by sitting with them and teaching them ways to be present with baby. They can help keep parents focused instead of hopping up. Point out how baby is communicating with her every move and tongue thrust; how telepathy is well developed in baby just as in pregnancy; and, how this is the time to pour our love into the baby and their future. Help them speak softly and slowly for the deepest connection. They will imitate you as you slowly speak from the heart and say to the baby what we all need to hear:

“We are so glad you are here. You are safe. You are perfect just the way you are. We honor your journey, whatever that may be.”

In doing this, you are wanting only to ‘jumpstart’ the parents. Make sure your words are absolutely genuine or parents will know it and be embarrassed to express their truth. Sometimes only 3 or 4 words are necessary.

When parents express their deepest truth, they find strength to commit to this soul. This promise lasts a lifetime and can transform layers of ancestral belief systems that we all carry forward from our parents’ lineage. Sometimes, the realization of all they are saying hits as they speak and they hear themselves as a parent, maybe for the first time.

During the first three days, clarity of their soul is available to every baby. Because this tiny baby is truly a soul of vast proportions, she is fully aware of her mission in life and why she chose to incarnate in this time. Baby also knows why she chose these parents/siblings and what gifts of strength this choice will develop in her. She knows how her choice will challenge her. Often, the baby inwardly recolls from the parent who will be her challenge. If this parent greets the newborn with a present heart, baby will experience the challenge and the deeper love out of which a challenge always comes. It will change their relationship for a lifetime. The challenger is the parent who hesitates or is not available physically or emotionally to speak their heart. Learn to see this and empower this parent with your encouragement and words.

For the Childbirth Educator Parents’ understanding, intention and support can eliminate the need for an opaque template in their baby’s life. This awareness can be taught early in pregnancy to allow for parents’ deepening responsibility. We can offer this overview so that it stimulates parents to ask questions of themselves, like, “Do you feel the baby’s need for emotional support changes, when in the belly, at birth, out of the belly?” “How does my mental/emotional state affect my baby in the creation of the template from conception?” “What response of my baby at birth, would indicate to me that my baby’s has little or no template? How do I plan on helping baby realize that response?”

At the childbirth classes, we can remind them again of the clarity that a template of least density would offer to their baby’s life. Few have ever heard of a birth template and this may not be the concern of every family for it is an option offered out of a holistic perspective that includes a spiritual overview. Those parents who recognize it as the way that feels right to them will be able to act on it. Trust your parents to always make the best decisions for their baby.

Spiritual Bonding and Evolution of Consciousness

In many traditions, it is the duty and honor of the father to welcome the newborn to Earth. In these traditions, the first sound and the very first impression that the baby hears is the voice of her Father. He will whisper in the left ear of his newborn, the most sacred word known. To the Hindu, this is a mantra, a most sacred name of God. To the Sufi, it is the words, “There is no God but God.” The Native American father touches his baby’s feet to the floor, symbolic of greeting the Great Mother Earth. Each culture offers what they feel to be highest.

At the final moment of our death, father’s original gift of welcoming his newborn into the world, again plays a significant part in the next stage of evolution. It is at this time that the entire life of the individual plays backwards from the most recent to the earliest experience. Your last memory is of your father at birth, whispering into your ear the name of God. The name of God is in your thoughts as your spirit separates from the body it joined so long ago. Being conscious of the name of God sends you on your way. Sacred Birthing, creates Sacred Living, creates Sacred Deathing, creates Sacred Birthing, creates.

Just as the evolution of the soul can be enhanced for subsequent lifetimes in the moment after birth, we are discovering many truths embedded in the fragment of time defined as bonding. The experience of birth determines the vibration of the life that this soul will live. This vibration becomes the template for life and filters the way we experience the world. Only by creating a birth of absolute safety, gentleness, warmth and acceptance, internal peace, love and a state of wonder can we have a baby who knows within herself as she grows, “I am all this. I am secure and loved.” Only by giving each baby a gentle, natural birth to allow the thinnest possible template or no template at all, will we have children who act out of an inner peace and interact with others in a balanced way. As these children grow up and those of us with wounded patterns heal, we will have jointly created society anew. As we take this step individually and as a group, it will be mirrored in the health of our world.

“Although attempting to bring about world peace through the internal transformation of individuals is difficult, it is the only way.” His Holiness The Dalai Lama (2)

1) Sacred Birthing, A Spiritual Perspective of Childbirth, Sunni Karll
2) Peace is in every Step, Thich Nhat Hanh
Safety of Birthing at Home

Over the last 80 years, modern maternity care has evolved from birthing at home to hospital maternity care. Midwives have been added to maternity wards in an effort to match the care traditionally received from them in home births. The benefit that hospital births are safer becomes one of the primary reasons for the shift.

The Data

Mortality data largely does not support the perceived benefit of safety when babies are delivered in hospitals. At best in one study, the death rate at home is equal to hospital mortality, a stretch when looking at this research with a small sample over a short period.

The larger and longer studies, show that home birth is 50% safer than hospital births as reported in a 15 year review of mortality data (abstract #1). The average mortality rate reported in the second abstract is 2.3/1000 for hospital maternity care. When compared to home births as described in abstracts three and four, hospital mortality rates are 48% (1.2) and 26% (1.7) higher than home birth.

In abstract #11, selected states in the US report a collection of various data. On the whole, midwives experience a lower mortality rate than physicians in hospitals. In 1991, Vermont, with the highest home birth rate, reports 5.8/1000 mortality rate versus the US average of 8.9/1000. In the state of Oregon from 1975-1979, there were approximately 3-4 neonatal deaths per 1000 births in homebirths attended by midwives, as opposed to approximately 9-10 deaths per 1000 births for all residents (footnote #6, Abstract#11).

The worldwide data corresponds to the experience in the US. According to an article published by Caroline Hall Otis, Utne Reader “In The five European countries with the lowest infant mortality rates, midwives preside at more than 70 percent of all births. More than half of all Dutch babies are born at home with midwives in attendance...” (footnote 9, abstract#11). A longer study by Kitzinger and Davies reported: “Records kept from 1969-73 in England and Wales indicate still birth rates of 4.5 per 1000 births for home deliveries as opposed to approximately 9-10 deaths per 1000 births in hospital deliveries.” (footnote 8, abstract#11).

In abstract #12, the Farm reports a 18 year summary of it’s midwife assisted births as being 25% lower than the national rate for 14,000 births in 1980 (1.00/1000 vs. 1.33/1000). Of course, if you use the infant mortality rate reported in 2000 of 6.9/1000, the difference is much more substantial.

Data Analysis

The examination of statistical data covering mortality rates requires additional comments. In the abstracts attached, positive perinatal results are often better with home births because the women are reported to be healthy, low risk pregnancies. The hospitals are given the tough cases, births that require transport from home due to prolonged labor and other complications.

Yet, it is clear from the data that the mother and baby injury increases in hospital births (abstract #9). Due to the perceived need to intervene, caesarean section, forceps, vacuum extraction, episiotomy, duration of labor, occurrence of severe perineal lesions, maternal blood loss creates trauma and lifelong complications for the child and mother (for more information on these affects see Sacred Birthing, Birthing A New Humanity by Sunni Karl at www.sacredbirthing.com).

Beyond physical damage of intervention, costs escalate when you enter the hospital to give birth. C-sections are increasing at an alarming rate worldwide as the medical profession attempts to supplement the natural birth process with the mechanical need to control it under the idea of either safety or efficiency. Not only does the C-section deprive the mother of a naturally holistic experience, the average cost of C-sections can be as high as $15,000 compared to a much lower home birth average of $1,600.

The other key factor in examining mortality data needs to include the idea of comprehensive primary care. The role of general practitioner and midwife are not limited to the place of birth; they cover the whole of pregnancy, delivery, and neonatal care. The examination of mortality data by itself does not adequately measure the total care available for the pregnant mother outside of the hospital environment. Simply questioning any mother who has experienced births in both environments quickly illustrates the extent of care given in the home as compared to the hospital.

Mothers are given longer prenatal appointments, the midwife blends into the family atmosphere and improvement of low risk, healthy pregnancies is the result of deeper care received at home.

Good prenatal care goes a long way toward ensuring a healthy birth experience for mother and baby. And birthing at home, along with other philosophical reasons, lessens the risk of some of the common complications. Baby has no risk of contracting an infection that is not present for instance. Also, baby has zero risk of injury from forceps at home. Most midwives do no force delivery of the placenta as is common in hospital, thus reducing the incidence of hemorrhage.

Other prenatal care considerations when considering care outside of hospitals can also be seen when looking at the rate of miscarriages, premature birth and infant mortality with the use of ultrasound commonly employed in hospital care. As reported in abstract #10, premature births increase when exposed to ultrasound treatment. The need to use hospitals with premature birth greatly increases thereby exposing the mother and child to higher risk as evidenced by the higher rate of infant mortality in these cases.

(This article was contributed by the Sacred Birthing Foundation, a US non-profit public foundation. For additional information about gentle birth and other related subjects, please see www.sacredbirthing.com)

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<th>Home Birth vs. Hospital Birth Infant Mortality</th>
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Birth Trauma Research

Rapid Release of Trauma
Research with QXCI Presented by:
Sacred Birthing Foundation

**Birth Trauma Methodology**
- **Weekend Workshops**
  - 1st day subspace work focused on trauma at birth
  - 2nd day subspace work focused on conception & forgiveness
- **Real time QX Measurement and Treatment with the workshop over two days with two QX systems**
- **Group Treatment during the workshop**
  - Pre & post measurement pre and post.
  - Pre & post measurement – individuals at the beginning and end of workshop
- **A total of 18 tests on 77 quantitatively measurable variables**
- **A total of over 3500 keyboard entries**

**QX Group Protocol – First Day**
- **Orgone field generator with an extensive prayer to ask for assistance and clearance from the Divine**
- **Tri-vector, Auto Varhope, Auto Frequency to stimulate electrical systems**
- **Disease Dictionary with added therapies with highest main matrix reactive items into “Add Therapy” button using nosodes, isodes, allersodes, symptoms and constitutional for nutrition.**
  - Super conscious selection of the treated areas
  - Vaccination, Shock, nutritional disturbances, spinal, toxicity, learning disability, pertussis, prineal disease

**QX Group Protocol – First Day**
- **Therapy with 66.7 Rife, 10k Scalar & Primary Disease:**
  - Birth trauma, Heart shock, Lymph stagnation, Allopathic drug overdose, Toxicity kidney liver spleen pancreas, Blood brain barrier dysfunction, Adrenal lymph exhaustion, Hypovolemic anaphylactic umbilical respiratory shock, Induction anesthetic drug toxicity, Poor breastfeeding coordination digestion bonding speech memory, Neural overload shock, Apeas, Brain necrosis concussion confusion, Crossed eyes, Heart pressure cardiac nerve destruction, Dissociated from body, Blood liver flukes, Brain face skull tissue dura neck spine palate eyes nerves forceps damage, Pituitary brain coherence, Brain hemispheres imbalance, Occipital frontal lobes brain damage, Autism, Addiction, Superimposition, Vitamin mineral deficiency, inability to focus

6 times
30 mins.
QX Protocols – First Day

**Therapy: Organ Relation**

**Therapy: Emotional Blockage**

QX Group Protocol – First Day

**Biofeedback w/piggyback as time allows. Always check unconscious choice for priority – top 2-3**
- Baby skull, Stimulate Oxygen, Shock, Brain, Endocrine, Adrenal & Immune Stim, Throat, Attention Deficit, ADD, Autism, Eyes, Lungs
- Liver, Female, Pancreas, Spleen, Release Karmic Bonds, Adjust Cranial bones, Endocrine system, Reduce Spinal Stress
- Release 2nd Brain wave, release spiritual attack

QX Protocols – First Day

**Invert Selected Birth Trauma items**
- Bupivacain – Epidural Anesthetic
- Anaphalactic & Hypovolemic Shock
- Ether & Morphine

**Invert list of Sin Allopaths**

**Brain Trauma Protocol**
- Delta, Immature, Theta with area(s) above Normal
- Treat Yellow box as it shows
- Theta with General Asymmetry
- Delta with Deep Brain
- Alpha with Cerebellar
- Keep doing until Normal is bigger than all other waves

QX Group Protocol – First Day

**NLP**
- Unconscious Reactivity – Treat all Physical, Emotional, Pervasive Energy and Gestation trauma.
- Note where groups trauma: Drugs, parents, lack of love, abandonment, not getting needs met, fear & pain:
- Mental & Emotional – Balance Love index, top/bottom emotional & neurotransmitter balance, Neural net stabilization & stimulation.
- Dissipate Karma, Higher Purpose alignment, Unconscious Choice, Stim Insight, Open Mind Therapy, Ascension Stim

**Timed Therapy – Original Sarcodes**
- Skin, Sin, Lymph, Kidney, Pancreas, Thyroid, Heart, other unconscious choice of therapy
- Piggyback all main matrix items taken from disease dictionary

**Timed Therapy**
- Degeneration, Auto Neurological Repair, Recommended and Feel Good Therapy
QX Group Protocol – First Day

- SuperConscious Reduction Panel
  - Clear Conception, neonatal & birth
  - Trauma, hormotox for allopathic suppression
  - Detox allopathic drugs
- Short Sarcodes
  - TMJ, digestion
- Long Term Therapies with piggyback flower and Bach essences
- Biofeedback for Spiritual Oppression and Dispel 2nd Brain Wave
- Ask Archangel Michael and his legions to return all hitch-hikers & other entities to Source on the count of three
- Qualitative Measurements: Survival Awareness Form-NLP; Emotional and Biological Flow-NLP

QX Group Protocol – Second Day

- Repeat first day Orgone Field prayer, Disease Dictionary, NLP, Unconscious Therapy and Therapy Protocols
- Repeat Qualitative Treatments: Survival Awareness, Emotional & Biological Flow
- Time Space Travel to Conception
  - Change Forgiveness of Self, Parents & God
- Auto Zap Plasms, Vaccines
- NLP Brain Scan
  - Medulla, whole brain stem, Hypothalamus, Pons, Corpus Callosum, All
- Repeat EEG, ECG Brain Wave treatment

Biofeedback additions
- Unconscious Interaction, Reprogram Karma, WBC Immunity, Endocrine
- Timed Therapy
  - Injured Tissue Repair, Feel Good
- Biofeedback – Another Round
  - Restore Myelin to Nerves, Heart, Release Karmic Bonds
- Sports therapy
  - Select Whole Organ Health balance after checking all red hormones, setting time-start
- Spinal – Lymph
  - Set 3 minutes, rectify, takes 5-6 times easy
  - Tick emotional pain, electro chelation

QX Group Protocol – Second Day

- Body Scan
  - Note large chakra’s, usually well balanced after two days of treatments along with an large box with a red circle in the middle – spirit helpers present
  - Go skin – Divine Light for 15-30 minutes depending upon the time available
- QX at workshop location
  - Cardiac & spinal nerves
  - Stem cells, dark field
  - White Blood Cells, Leukemia
Research Results - Quantitative

Strong Indicators of Change
- Personal Evolution – Survival Awareness
- Individuals cleared 87% of entries
- Unconscious Reactivity
- Both individuals and workshop cleared an average of 5 trauma, emotional, perverse energy areas.
- Sarcodes – Endocrine System – Top 3
  - Workshops decreased reactivity by 25% on average
  - Individuals decreased reactivity by 20% on average
- Sarcodes – Chakra’s – Top 2
  - Workshops reduced reactivity by 30% on average
  - Individuals reduced reactivity by 16% on average

NLP – Top 3 emotions
- Workshops decreased reactivity 40% on average
- Individuals decreased reactivity 30% on average
- Risk Profile – Top 4 categories
- Workshops & individuals reduced reactivity 10% on average
- Harmonics
  - Both the workshop and individual post evaluations showed improvement in the harmonics as measured during calibration (+1370 to 1630)
- Ratio’s of Love-Frustration
  - The workshop shifted positively with a 19% increase in Love over frustration while individuals went unchanged

Mixed VARHOPE Results
- Scores in both measurements against the total population were not impacted.
- With one exception, average resonant frequency over the individual tests did increase by 7918.
- Neurotransmitters/Amino acids were varied in response
  - Pain assistance: Endorphins lessened in the overall group by 29% but the need increased for individuals by 18%.
  - Emotional assistance: Dopamine increased in both measurements by 32% for the workshop and 18% for individuals. Tyrosine also increased in the overall workshop by 35%, unchanged for individuals.
  - The need for Love & Bonding: Oxytocin increased in the overall workshop by 27% but decreased slightly by 7% for individual responses

Neurotransmitters/Amino acids were varied in response
- The need for Joy and happiness inducement, as indicated by Seratonin, decreased in both segments. Total workshop went down 19% and individual results were down 35%.
- Cortisol needs were unchanged in both groups.
- Iso-Leucine for alertness and AD/HD remained unchanged.
- Need for Taurine, heart support, increased for the workshop by 27% but decreased for individuals by 9%.
- Tryptophan for relaxation decreased in the overall group by 11% and remained unchanged for individuals.
- An exact opposite result for Glutamine that calms the mind. The workshop needs increased (16%) while individuals were largely unchanged (1%)
Research Results - Quantitative

- Trauma Indicators with the need for frequencies that heal trauma showed varied results:
  - Fistula reactivity, incomplete birth closures, went down 4% and 6% for respective workshop and individuals
  - Reactivity of the epidural Bupivacain shifted down for the overall group by -20% and increased by 6% in for individuals.
  - Ether reactivity shifted by both groups by 14% for overall and 1% for individuals.
  - Morphine reactivity increased for both groups by 7% and 8% for total workshop and individuals, respectively.

- Anaphalactic Shock went down by 11% for the group and up by 7% for individuals.
- Hypovolemic shock went up for the group by 7% and down for the individuals by 4%.
- Injury went up for over both segments, 13% and 11% respectively.
- Africum Flower, inability to recognize past trauma, went up by 3% and 12% respectively.
- Awapuhi Melemele, release buried memories, went down for the group and up for the individuals, -26% and 7% respectively.

Miasms were varied, however, they were valuable directional indicators of significant shifts:

- Psora went down for both groups (-12%, -5%) indicating the need for struggle in life was lessened.
- Sycois went down for both groups (-8%, -6%) indicating that fear lessened and attention and mental capability increased.
- TB went down for both groups (-7%, -10%) indicating that people could loosen up their breathing and feel more unencumbered as well as calmer.
- Vaccination went down (-18%) for the workshop and remained the same for individuals suggesting that the clearing of vaccinations was quite successful on individuals not in our sample.

Brain Wave indicators showed much total all workshop improvement on a majority of indicators:

- Attention Deficit was hugely impacted with a 84% decrease
- Local Slow Waves improved by 70%
- Epileptic improved by 25%
- Deep Brain and General Asymmetry improved by 23% and 14%, respectively.
- Injury improved by 4%
- Theta waves improved by 25% as an indicator of the shift in consciousness during the workshop, while worry indicated by Beta waves went down 7%.

Stress went up by 10% indicating that bringing these deeply held memories to the surface challenged all participants.
Research Results - Qualitatively

- Questionnaires from all workshops have not been received and compiled at this time. Yet, testimonial emails from participants report:
  - Profound understanding of their life
  - Acceptance of why they came into the body in view of the difficulties that they had experienced in life
  - Deep peace from the new revelations
  - Forgiveness of self and parents releasing life long resistance
  - A deeper spiritual awareness of life and the non-physical forces that are available to help them

Well, the game of Reality Monopoly is still being played all over the world. One percent of the world’s population is winning and no controls over 80% of the wealth. The law allows the game to continue till we will see one winner and 6 billion plus losers.

Big Tobacco, Big Sugar, Big Pharma, Big Oil, and Big War Industry are exempt from lay and they kill and injure, maim and cripple in the name of profit. They seek to control and dominate medicine to further build their profits.

Their money controls governments, regulators, and the small minded media. The Ultra Rich Master Echelon Computer now sees and hears all the things we say, write, and do. Rights of privacy are gone worldwide. They have taken away our rights of free speech. The Ultra Rich control the media and refuse to tell stories that expose or offend the Ultra Rich Power. They control every movie that gets distribution, every song that hits the radio, everything that is put on the world news. They use science and psychology to control and manipulate the minds of the masses.

But medicine is controlled by Universities that teach medicine. There is now one university starting to defend Natural Medicine. IMUNE has a new 12 month home study course that can be bought with Karma and you can learn how to do natural medicine and how to break free from the Ultra Rich control.

Go to www.imune.org to learn and to get your course materials. You could get a Doctorate in Wellness and an international or accredited European professional qualification in neurophysiological bioresonance and biofeedback.
Healing Our Birth

A Proposal for Additions to the QXCI Clasp32 Program

Healing Birth Heals Life

- **Birth is the First Stress in Life**
  - Elimination of physical, emotional and spiritual trauma produced during labor and birth for infants/children, and adults is the ultimate healing opportunity

- **Holds the Keys to the disease layering**
  - Simple definition: If it’s not natural, it depletes the life force which lowers vibration making it possible for disease

- **Maximize healing by getting to the Core**
  - No need to peel the onion
  - By addressing Core Stress, the heart, trauma of all levels can be cleared. Nerves, detox & shock re-printing after
  - Birth trauma is more emotional and physical and is able to be repaired by the QX

QXCI Birth Trauma Program

- **Heal what Nature had perfected prior to the medical model of birth**
  - Spot on for 3 million years

- **In 3 generations, added influences that have drastically altered the human body**
  - Women have not lost their ability to birth, they have lost their birth wisdom and stopped trusting their abilities
  - Women’s fear interrupts nature, creates due dates, drugs that medical profession has invented to respond to fear

- **Trauma stored in cellular memory for life**
  - Anesthesia lowers the vibration in baby and mother and this low frequency creates a physically exhausted and emotionally fearful experience
  - Nerves hold the deepest trauma from birth. When constricted at birth, delicate receptors are damaged even before they are perfected. Areas of the heart, brain and spine are most affected
QXCI Birth Trauma Program

- New Panels and buttons for the Clasp32 program
  - The new panels are designed to eliminate low frequencies associated with mother's trauma at birth caused by a variety of conditions
  - New panels are NEEDED to be used for elimination of anesthetics from the brain, spine and dura caused by the epidural anesthetics

- Signs of birth trauma in babies – demographics
  - Sleep deficiency
  - Eye contact-ability to bond
  - Weight gain and feeding irregularities
  - Nervous reactions-frequent crying, fussiness

- Signs of birth trauma in adults - demographics
  - Sequential trauma in areas of life, trauma attracts more trauma
  - Birth trauma recapitulates and becomes a time bomb at different stages of life:
    - Rejection in relationships as a result of abandonment at birth, no bonding with mother.
    - Memory loss and stress can all be traced to birth trauma

QXCI Birth Trauma Program

- Energetic medicine can repair and re-grow cardiac and cranial nerves
  - Trauma, once repaired, stop the calls of distress from the brain like Hamer Herd’s and releases energetic imprinting from birth

- Frequencies relating to "time bombs" need to be eliminated
  - Variations of drugs, trauma's and other birth damage identified

- Healing the Heart is necessary

Impact of Drugs

- Drugs overwhelm the baby’s nervous system and locks in any feelings of emotional abandonment
  - Minute a drug is administered, dance between baby & mom ends
  - Creates exhaustion in mom that lasts for years, usually blaming the baby and birth, not aware of the true culprit

- Whether a baby is open emotionally, or is hurt and scared, determines the primal decision of the newborn within moments of birth:
  - My world is friendly vs. my world is hostile
  - Anesthesia has an affinity for nerve & brain tissue and placed in spinal fluid, it bypasses the blood brain barrier

- Combined with other toxins, the brain psycho magnetizes the anesthesia, as a result:
  - Neuro messages are affected & they no longer send their messages in purity because toxins accumulate in the brain
Impact of Shock

- Because of the babies lower vibration, an environment is created suitable for parasites of the same frequency e.g. flukes
  - Where there is lower vibration, there are parasites, and where there are parasites, there are entities. Entities influence the growing child to eat and act in ways out of harmony.
  - This creates habits at early ages and the child is upon a path of less support. Clearing parasites is difficult in these small bodies, therefore, they stay influenced and have few options, perhaps, for an entire lifetime
  - Baby grows up spaced out, disassociated, not in body
- Flukes, then, travel through the blood to other organs

Results of Birth Trauma

- Forceps: Severe Mental difficulties from the intense pressure as a result of forceps at birth. Also, cross-eyed, orthodontics, major cranial-sacral work needed.
- "Anesthesia fog": cycles through us every few minutes.
  - Clear one moment, and then uncertain, as if a veil comes down over us
- Sabotage: the interference of energies drawn to the environment and frequency created by spinal-epidural anesthetics at our own birth
- Emotional upheaval: Undermining of our Divine nature created out of the discrepancy between what the soul planned and what anesthesia dictated through its lower frequency
- "Time Bomb": Trauma held in the brain, that vibrates our distress, causes all the drama in our lives and later years disease
  - Disruption to the cardiac and cranial nerves from pain and fear at birth

Treatment Stipulations

- Types of Shock
  - Nerve shock – disconnect from unseen feedback and feelings of well-being
  - Umbilical shock – respiratory distress from immediate cord cutting
  - Liver shock – overload of unfiltered containments from an exhausted placenta
  - Hypovolemic shock – baby is accustomed to all his blood and stem cells, not reduced from cutting the cord immediately.
  - Kidney shock – filtering the overdose is too great so its delicate filtering teams to allow it to circulate.
- Systematic Protocols
  - Lymphatic system cleanse from overload of anesthesia, pain and induction drugs.
  - Brain, Spine and Liver detox-overload of drugs is stored there.
  - Baby is not able to be alert with all this going on within him. He is overcome with sensations and feelings that take all his attention. There is distress, overwhelm physically and emotionally, great stress loads on the body, and great detox is needed
- Blood cleansing to re-vitalize
  - Lymphatic cleanse again and stimulation, as mop-up.
  - Energetic healing and the inclusion of stem cells there can be repair and re-growth of nerve tissue. Hours of this can stimulate the nerve to grow.

Program Indicators - Infants

- Interrupted or poor sleeping habits
- Poor feeding
- Lack of eye contact
- Jerky flailing arms and legs
- Crying that can’t be soothed
- Crying for no obvious reasons
- Failure to thrive/gain weight
- Unhappy, fearful or nervous baby
- Mother doesn’t trust herself from drugs used at birth that lowers her vitality/vibration
**Program Indicators - Adults**
- No or little childhood memory
- Behavioral patterns that become exacerbated instead of lessened with age
- Patterns of interpersonal relationship difficulties
- Food, time gender issues
- Chronic illness that do not resolve
- Stress patterns that become more & more crystallized

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**Group Protocols**
- Work on individuals can happen more deeply when clustered in groups of similar trauma. Place people with similar healing needs in groups or rooms
  - 3rd world countries like Africa with the AIDS epidemic
  - The potential is to do more faster than treating individuals
- Many opportunities to affect large scale change and spread broader QxCI awareness
  - Cooperating with health professional who teach healing practices in group settings
  - Working with church's to affect forgiveness
  - Assisting earth healings similar to the Auckland conference healing of the Tsunami area with Dr. Debbie Drake

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**A Well Born Baby**
- **Awake baby looks like:**
  - Physical: Wide eyed, alert, interested in life around them; long periods of direct eye contact. Smooth movements
  - Emotional: Acts and responds to everything, nurses with ease, sleeps deeply, curious, gains weight, thrives
  - Spirit: Qualities found in elders, peace & calm & happy.
- **Nerves inside and outside body**
  - Baby's nervous system is of the finest matter
  - A baby consciousness when NOT traumatized has spiritual senses operating on an energetic level, and physical counterparts, nerves, which take in sense impressions. Baby's consciousness finds itself immersed in life's activity and is hungry for more and more.
  - Nerves and senses are acutely aware of bringing the outer impressions into the inner world of the body. Consciousness reaches out, perfectly interrelating with the inner nervous system.

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**A Well Born Baby**
- **Nerves inside and outside the body**
  - Energetic continuation of filaments
  - If seen, it looks like each hair follicle in the skin grew a very fine nerve hair that reaches across the room when needed, or dissipates when baby sleeps
  - Baby has an innate, felt-connection with the unseen world as well as the seen world
  - Another field of connection that acts as “all sense” beyond newly available normal senses
  - Additional mode of receiving is like a sensitive radiance that spreads out like streams of colored bio-filaments slowly waving in the air, reaching out to what attracts his attention
A Well Born Baby

- Nerves insides and outside the body
  - Like a sense that has no boundaries, it is based solely on baby’s curiosity, and is active whenever his interest is peaked, and wherever it is directed
  - Without moving, the baby can taste someone across the room, or touch their emotion, or smell a new color or shape. It is all data.
  - It also lets him know there are unseen others around, and that he is safe and well. It keeps him connected to his vastness and his soul purpose.

Why Trauma Happens

- Major trauma impact – Drugs
  - Baby’s nervous system cannot tolerate the overdose of birth drugs given to mother appropriate to her weight.
  - As anesthesia from mom’s blood goes into the baby, it enters through the umbilical cord and goes straight to the heart then to the lungs, and then within half a minute, the whole body. The Heart recoils from this unknown impact, and its sound is quieted.
  - When this happens, the heart’s song is out of sync with the song of the Soul.
  - When baby is so overwhelmed by anesthetic, both baby and mother lose their ‘felt sense’ and emotional contact with each other.
  - Both baby’s bonding to mother, and mother’s attachment to baby are destroyed.
  - If a baby feels abandoned from anesthesia, he perceives himself not being received and therefore loses his own innate Soul connection. Lack of Self-love comes from not being loved or not being able to feel the love that is there.
  - With this loss, baby feels abandoned, no similar resonance with which to tune, and suddenly there is less direction, less stability of inner peace. Leaving the heart’s original distress allows symptoms to continue to express themselves in a myriad of forms.

- Newborn’s nerves receive the core trauma.
  - In recoiling from physical or emotional pain, they pull back their innate connection with the universe.
  - Emotional disconnect from the Oneness is the core of all emotional and physical dis-ease.
  - When the physical nerve pathways no longer coherently mesh with the energetic configuration that links baby with the unseen, feedback stops and baby’s perception is one of abandonment.
  - Sensations of abandonment comes from the anesthetics as nerve functions are disabled.
Conception Trauma

- Womb life healing
  - Not only the trauma of birth, but too, trauma from conception and womb life are recorded by the heart.
  - The Soul who will be this baby knows how challenging this journey through life will be long before conception. He knows of the difficulties with the parent who will challenge him. When he is little more than a thought in mother’s mind, he knows why he has chosen this family, what his challenges will be, what he will learn and how this will strengthen him.

Mother Mary Speaks

- Mother Mary: “The inner groupings of the cells that make up the heart are different than cells that create any other part of the body. These cells are Creation Cells, full of memory and strong intention for the future. With this help, the baby/child/adult is constantly guided to recognize pieces that cross his path and support his life mission. This guidance system is in place when a heart is protected from harm. When hurt, the guidance is hit or miss and is soon ignored. Imagine ignoring your inner guidance! This is the predicament of much of humanity.”
Vibrational Excellence of Natural Birth

And Vibration Derailed
Sunni Karl 2006©

Synopsis: Supporting, and not hindering the innate vibrational excellence of birth allows newborn radiance. What creates high and low vibrations of birth? Three common birth interventions reduce baby’s vibrational excellence and affect baby’s consciousness. (Baby is ‘he’ since mother is ‘she’. “Your” refers to parents along with mother.

An enormous scope of birth wisdom has been lost through time. Giving birth is the highest degree of honor, for it is our act of co-creation and is our personal gift to our baby. Not only is it an honor to create and nurture another being within, but to release and offer this baby in gratitude for our life and nurturing from the Earth and cosmos is a fulfillment of the cycle of life. For generations, we women have let ourselves miss the opportunity to give birth to align with our true self. We have, on some level, agreed to be anesthetized in birth to highlight this forgetting. To give birth to a baby is an honor. In the world, there is nothing else like it, and women have this honor. If we look to our baby’s birth as our gift to and from the Divine, we will most likely choose to be in a state of heightened consciousness and choose wakefulness of body, mind and heart. Conscious presence and joyful expectation is a state commensurate with this grand opportunity.

Birthing is a dance of consciousness and matter as a soul is fully received into a body. When the newborn is gently received, with holistic soft practices, and without haste and interference, babies are born at their highest chosen vibration in order to shine forth their essence without overlays of limiting emotional patterning. Humanity, Nature, Spirit, Earth and planetary energies all coalesce for the good of this individual.

What creates vibrational excellence in pregnancy and birth? Many soft ways support parents to welcome their baby gently. The one that starts first is creating a ‘field of birth’. This is an energy field made up of both parents’ thoughts, feelings and actions toward the birth of their baby from pre-conception onward. Everything is part of the field, and becomes the energy that surrounds, protects and later, carries you into birth. Water birth is another gentle practice that better supports both mother and baby; another is honoring your baby by allowing him to determine his own labor and birth time, instead of inducing or scheduling; and another is giving birth naturally.

One new mother said, “As a women, I want to know this passage, to remember it, to feel each part, to have the memory of being in the ancient lineage of all birthing women. I want to feel the baby move down the birth canal, to crown, to be half in and half out of me, to be of me but not mine, and then to slither out. To have him curled up on my soft hollow belly, to see him look around wide-eyed at his new world, alert, gazing into my eyes. I want him to speak to us of his essence, and to remember our promises. I want to know it all.”

If there is only one thing you can do for your baby, let it be the continual offering of love. Love affects all parts of the process and therefore the goal. Love creates every step of devotion and every one of your caring actions. Love becomes your field of birth. It gives you the discernment needed to sift what feels good, from that which is not for your baby. It pulls you toward a birth of aligned and heightened circumstances. It infuses the field around you, within you, and therefore, baby’s physical body. It attracts more of this same delicious vibration to you in outer occurrences.

Building on your love, nature has the implicit ability to raise this vibration in a natural birth - if we do not interfere. As the birth energy flows into mother, the vibration of mother, and therefore baby naturally raises through the hours of contractions. In early labor, our energy is in the lower energy centers, the pelvis and belly, spiraling slowly back and forth from root to navel chakra. As a contraction builds, our feminine energy spirals predominantly from the root chakra up to the navel chakra. If mother welcomes the rushes as that which will help her give birth, her intention draws to it a powerful supplemental energy gifted by The Great Mother. As the rush starts to recede, our masculine energy pulls the birth energy down to the root again, releasing its intensity. The Mother soothes and strengthens each mother between contractions.
As labor progresses, the birth energy builds and moves into higher chakras, purifying our holding patterns from the limiting emotional decisions we hold. Our heart, the seat of our true being, becomes better cleansed as this great surge of energy opens us to vibrational places not reachable in everyday life. As labor peaks, we are immersed in this vibration, bathing us in this higher octave. Creativity held captive at our throat chakra is activated and we discover deeper parts of ourselves that we have forgotten, parts we have unknowingly denied. We surrender these obstacles, and move into more alignment with our essence. When a mother takes part in a non-medicated birth and welcomes the help of The Great Mother, who served birth through time, she clears many limiting patterns that ask for healing so that she may more closely match her soul design.

When feminine energy rises up mother’s spine to her crown, the intensity of the rush builds. As her energy moves down returning to the root chakra, she rests into a new energetic clarity of who she is. She welcomes new integrity within. When mother’s intention is empowered by The Mother, this is the full spiral of birth. We are breathed by an energy greater than ourselves during our initiation of birth. The spiral of birth is the same as the spiral of love. Parent’s love deepens mother’s intention to more closely match that of The Great Mystery, and sends up the next birth wave with renewed momentum.

Suzanna said, “...Giving birth turned me inside out. The swirling driving power of nature swept through my body with an amazing force. What a big baby! Huge! How did you come out of me? My body really worked hard - a storm of change, of transformation. I became a woman.”

Vibration Derailed
In much of the last century, birth has been loosing its magnificence little by little and becoming addressed as its components. In the western world, society places its attention on the intellectual and physical aspect of birth, with its emphasis on pain foremost: the epidural is the dominant request and mothers doze through one of the most transformative opportunities of life: one grand purpose of giving birth as nature perfected is ignored. The emotional aspect of birth is tolerated but not revered. Father is a guest instead of an integral part, and the needs and desires of mother, father and baby are still less important than hospital protocol. Modern birthing prides itself on its technology, allowing its tools to determine decisions rather than its patients. Science dissects birth in order to analyze it, pharmaceutical research ‘forgets’ to watch the behavior of babies as they mature, and match it with the drugs of their birth histories. When a mother takes part in a non-medicated birth and welcomes the help of The Great Mother, who served birth through time, she clears many limiting patterns that ask for healing so that she may more closely match her soul design.

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However, the deepest level of harm in the newborn may in fact be due to the actual energetic effects of the medication. Picture this: as mother is learning to work with labor and opening to the ever-increasing flow of Divine energy moving thru her body, the vibration of mother’s body is rising. The baby’s body within mother also experiences this. As labor progresses, mother incorporates greater amounts of this refined energy and her vibration is rising more quickly. When a pain medication is given, the vibration of mother and therefore baby’s body suddenly plummet in response, yet the vibration of the baby’s soul remains high and constant. The impact of an epidural causes a great energetic discrepancy between the baby’s body and soul, that previously were more coherently aligned before medication was given.

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So what exactly lowers vibration at birth? There are many practices in modern birth that interfere with natural birth’s vibrational excellence. When drugs are involved in birth, consciousness is affected: consciousness and awareness in the mother, and also consciousness and awareness in the baby.

The truth must be stated: drugs harm babies, in the womb and out. Every step we take toward a more natural paradigm in conception, pregnancy and birth deeply affects the soul, the emotions and body of our baby. Nature has perfected a process that has birthed babies safely through eons. When we interfere with nature’s masterpiece by adding drugs, there can be far-reaching consequences, often not easily acknowledged because of the lag time.

Anesthesia lowers the vibration in a newborn and mother. The amount of medication in an epidural is determined by mother’s weight: yet, what mom receives, baby receives. This means that the baby will receive 15 to 20 times the amount appropriate for baby’s body weight. At birth, baby will not be alert as in a natural birth. Anesthesia and drugs keep a baby from participating emotionally in his transition from the womb to the world. He is less aware and has less innate curiosity. Physically, he is more disconnected from his surroundings, more passive and often glassy-eyed. The use of drugs in birth does not only have a momentary impact. With an overdose of this size, the nerve structure of this pristine little body may be dulled permanently. The low vibration determines the place at which baby starts life.

With the administration of any birth drug, mother loses the vital inner communication with baby that she has felt throughout pregnancy. Baby loses all feeling of connection to mother because medication has overwhelmed her delicate nervous system and dulled her receptivity. Mother loses her innate connection for baby’s well-being. Her sense of tracking her baby is dramatically diminished or disappears altogether. She is no longer focused on working together with baby to give birth. When there is no feedback linking them, birth is reduced to the mechanics of muscular contractions. When mother loses contact with baby, the birthday turns into a day like any other.

With an epidural,

- mother is not visibly working to give birth,
- she starts talking or sleeping,
- father’s heart does not open for her work done,
- those around reflect the parents’ level of involvement,
- the love does not flow,
- the sacred atmosphere of birth is lost,
- the baby feels abandoned.

However, the deepest level of harm in the newborn may in fact be due to the actual energetic effects of the medication. Picture this: as mother is learning to work with labor and opening to the ever-increasing flow of Divine energy moving thru her body, the vibration of mother’s body is rising. The baby’s body within mother also experiences this. As labor progresses, mother incorporates greater amounts of this refined energy and her vibration is rising more quickly. When a pain medication is given, the vibration of mother and therefore baby’s body suddenly plummet in response, yet the vibration of the baby’s soul remains high and constant. The impact of an epidural causes a great energetic discrepancy between the baby’s body and soul, that previously were more coherently aligned before medication was given.
A further step in the gentleness of birth is to not cut the umbilical cord. To allow the cord to stop pulsing before cutting it gently encourages baby to breathe on her own, as mother feeds progressively less oxygen to her. It allows baby to take the first breaths without the panic of suffocation, and this alleviates shock to the baby’s heart and respiratory system. It is not necessary for the scream, so commonly heard on television, to accompany a first breath when the cord is not cut. Often within thirty seconds breathing begins, sometimes imperceptibly at first. Baby may become pink even before you see the ribs expanding, indicating her tentative breathing.

When the cord remains intact and is not cut, the baby holds the vibration of birth and is not susceptible to the energetic depletion and its common baby illnesses. Baby’s vitality can be used instead to gain weight, thrive and discover her world. Protecting the umbilical cord upholds the energy field and protects baby’s immune system. This is called Lotus Birth.

The “harvesting” of stem cells is another detrimental intervention as it is practiced. The protocol is now to harvest stem cells within 15 seconds of birth, significantly reducing the baby’s blood volume and taking the very substance that baby needs for a healthy life. An alarming increase in autism is being seen in Canadian babies because of this practice stemming from greed. Stem cells belong to this baby. If in fact it is necessary to borrow some, the best practice is to extract what remains, after the baby’s breathing is well established and the cord has naturally stopped pulsing.

These are just three of the many interventions that degrade vibrational excellence available in all drug-free birth. Since a newborn’s physical and emotional stance cannot remain open if life-depleting procedures are performed, instead, let’s honor the whole being of the baby. To retain his innate wholeness, may his whole being be cared for: by doing your best in pregnancy, by receiving a baby with gentle hands, by lovingly welcoming your baby. These moments are his first impressions and you have set the stage for a magnificent human.

“"The patterns baby carried into conception, and the experience from conception through birth creates a blueprint that the child will be called to heal."

-Sacred Birthing, Birthing a New Humanity-

Sunni Karli is a birth therapist and a midwife. Author of Sacred Birthing, Birthing A New Humanity, she is guides international ‘birthshops’ to help eliminate birth trauma. She teaches parents and birth helpers how to offer a baby a ‘softbirth’, in order to protect the consciousness of the newborn and support these awakened children. She is a grandmother living and can be found at www.sacredbirthing.com.