ISSUE 18

SQUAT BIRTH JOURNAL

EXERCISE YOUR RIGHTS!

LETTER FROM THE EDITOR

Fall 2014

Photo by Jade Beall

This month I appeared naked on the internet, and I couldn't be more proud. I had the great joy to be part of photographer Jade Beall's Beautiful Body Project, which we've featured before in the pages of SQUAT. What was even more special was posing with very good friends of mine, friends with whom I have shared the trials and joys of parenting, women who make up a vital part of my village.

SQUAT functions very much like a village as well – we are a community of volunteers who come together to make each issue happen, supporting one another and our larger work in with our own gifts. In the last year we've had a new baby, sent an Editor abroad to complete her midwifery training, and gotten pregnant with another baby; we continue to ramp our work up and down as we need to support the changes in one another's lives. We've added incredible folks to our editorial and design teams, and have started reaching out to the larger community to plan SQUATfest, coming to New Orleans in May.

We are a family that leans on one another, and that family includes our readers and contributors -- in short, it includes you! Thank you for being part of this village, and please continue to get to know and support us, whether it's through participating in conversations with us on social media, submitting to the magazine, or volunteering with our organization. If you want to be more involved with our work or lend a hand planning SQUATfest, get in touch with us at squattingbirth@gmail.com.

With love and appreciation,
Sarah Tarver-Wahlquist
Managing Editor

Next submission deadline is November 15th, 2014!

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About Us

SQUAT is a quarterly publication that is put together by just a few people who dedicate their time to create a magazine to support healthy and empowering birthing practices. We hope to expand our magazine's readership and content as we continue to produce new issues every season.

Our Mission

We strive to provide a forum where radical, often unheard voices can share their message. It is our goal to promote safe and healthy birth options for all. We celebrate the transformative power of birth in all its varied forms. We acknowledge the need for the midwifery movement to expand its consciousness, scope of practice, and accessibility. We seek to provide a safe space of expression and community for those who wish to shift current birth culture as an essential part of the midwifery and birth movement.

Submit Your Work

We are always looking for articles, stories, artwork, poetry, and photography. Articles can be on a range of birth, midwifery, or parenting topics, including academic articles and cultural critiques.

Submissions Guidelines

We welcome articles that are between 500 and 3000 words. We reserve the right to edit for length, and do our very best to not edit your content or voice. We welcome the submission of birth stories that are 2000 words or less. Please submit all articles with a short bio, between 50-100 words and any relevant bio images if possible.

Send submissions to:
SubmissionsToSquat@Gmail.com

Contact Us
SquattingBirth@gmail.com

SQUATFEST 2015

New Orleans

MAY 22ND - 24TH SQUATBIRTHJOURNAL.ORG/SQUATFEST

Call for Workshop Proposals

Due October 30th

SQUATFest is a conference for birth workers, students, parents, and advocates, organized by the folks that bring you SQUAT Birth Journal. SQUATfest is like walking into the pages of our quarterly birth journal, with a focus on reproductive justice, evidence-based practice, full-spectrum care, and much more. SQUATfest 2015 will be held May 22-24 in New Orleans.

We are currently accepting proposals for speakers and workshops for SQUATFest 2015. We are looking for workshops that represent that great breadth and diversity of birth work, pushing the boundaries of how we think and talk about birth work, reproductive justice, and parenting, while offering practical knowledge and skills.

For more information go to:

squatbirthjournal.org/squatfest/squatfest-call-for-workshop-proposals/

REQUEST FOR RESEARCH PARTICIPANTS

Screening for Alcohol Use During Pregnancy

Who is conducting the study? What is this study about?
Researchers from the College of Nursing at the University of Massachusetts, Amherst, are recruiting participants for a study evaluating midwife/nurse prenatal alcohol screening practice as well as knowledge about the effects of prenatal alcohol use and Fetal Alcohol Spectrum Disorders.

Who can join this study?
Midwives and nurses who currently provide prenatal care.

Why should I join this study?
Although you will not directly benefit from this research, your participation will assist in improving pregnancy alcohol use screening practices, allowing for important intervention.

What will I be asked to do?
The anonymous survey asks about your current alcohol use screening practice and knowledge about the effects of prenatal alcohol use. The survey is available online and will take approximately 20 minutes to complete.

How do I join this study?
Please visit http://bit.ly/prenatal-alcohol-study to learn more and access the survey

PLEASE CONTACT US FOR MORE INFORMATION

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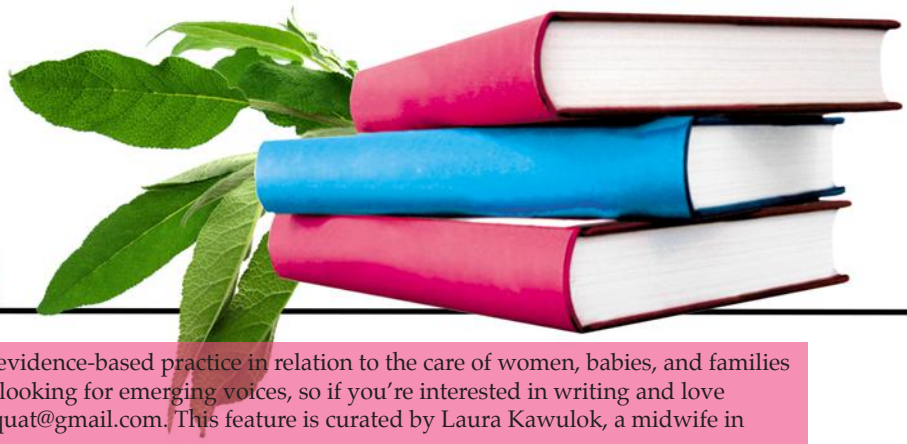

Sage Science

Sage Science is a quarterly article focused on evidence-based practice in relation to the care of women, babies, and families during the childbearing cycle. We are always looking for emerging voices, so if you're interested in writing and love research, please contact us at submissionstosquat@gmail.com. This feature is curated by Laura Kawulok, a midwife in Colorado.

Oral Vitamin K: Reflections on Use

by Jen Anderson-Tarver

Administering oral vitamin K to a newborn has a long history in the midwifery community and in many countries as an alternative to giving vitamin K through injection. When vitamin K supplementation began in the mid-1940s, babies were supplemented orally. However, by the mid-1950's this method fell out of favor due to the fact that the version given at the time caused hemolytic anemia and jaundice at high dosages. By the 1960-1970s, injectable vitamin K was the standard route (Hey 2003). Oral vitamin K came back into greater use in the 1990's when a study linked injectable vitamin K as a potential factor in childhood leukemia or other cancers. As a result, alternative oral protocols were developed and entire countries switched to giving predominately oral vitamin K (Hey 2003). During the leukemia scare, the US still recommended injectable vitamin K, but consumers in the US began to look for alternatives. Oral vitamin K offered a middle ground for many in this debate, being that it was less invasive yet still protected babies against Vitamin K Deficiency Bleeding (VKDB). The oral route was more in line with natural families' and midwives' desires to help create a trauma-free birth and postpartum for baby, a deeper recognition of baby's awareness, and understanding that babies feel pain. While the leukemia scare has largely been disproven, as there is a lack of convincing evidence (Lippi and Franchini 2011, Shearer 2009), and injectable remains standard, several countries and many US midwifery practices still offer oral vitamin K or use it exclusively.

Vitamin K is given to newborns to prevent Vitamin K Deficiency Bleeding (VKDB) or Hemorrhagic Disease of the Newborn as it was called prior to 1999. VKDB is defined as bleeding from any source stopped by vitamin K administration. Vitamin K is a fat-soluble group of vitamins that are essential in the production of the factors needed to clot blood. There are two naturally occurring types of Vitamin K: K1 and K2. Vitamin K1, or Phylloquinone, is found in food sources including dark leafy greens, broccoli, some whole grains, asparagus, kiwi, nuts, olive oil, soybean oil and others. We get most of our vitamin K from our diet in the form of Vitamin K1. More vitamin K is absorbed when eaten with a fat. Cooking does not destroy vitamin K. Vitamin K1 absorption is affected by the process of digestion, through bile salts in the small intestine. Vitamin K2, or Menaquinone, is synthesized from many bacteria that colonize the intestinal tract. Liver and some fermented products are thought to be the only food sources contributing to K2 (Frye 2007). K2 is the primary group stored in the body, mostly in the liver. As K2 is not very bioavailable and thus not a significant source for human use, adults rely on oral intake of vitamin K1 rather than through gut synthesis (See Lippi and Franchini 2011, Van Winckel 2008).

Studies have shown that newborns are born with low levels of vitamin K1, limited stores in their liver as compared to adults and no K2. The placenta does not transfer vitamin K in high amounts even if supplemented. In one recent study of 683 mothers in Thailand, babies born with "potential clinically relevant vitamin K insufficiency" were likely to have had high risk births (forceps, vacuum, c-section, prematurity and low birth weight of <2500g). There was also a trend noted for mothers who had low vitamin K status to deliver a baby with low vitamin K status. In light of the outcome of this study, the author questioned if 90 mcg should be the recommended daily amount (RDA) for pregnant women or if it should be raised (Chuansumrit et al 2010).

Milk from mothers who do not supplement with vitamin K is low in vitamin K, averaging around 2 ug/l with colostrum, and 1 ug/l with mature milk (Shearer 2009) and up to double according a study by Greer (2004). Based on a few small studies, we know that if the mother supplements vitamin K in high doses it goes through breastmilk in substantially higher amounts (See Greer 1997, Nishiguchi et al 1996). We know that limiting feedings, delayed or poor feeding in the first week is linked to low vitamin K (Hey 2003). Generally, newborns do not initially assimilate and synthesize K2 until after the first week due to low bacteria counts in their gut. The newborn clotting system is considered immature until 6 months (Shearer 2009).

There are three types of VKDB: early, classic, and late. Early onset occurs within the first 24 hours and is linked almost exclusively to maternal drug intake, particularly seizure, antituberculosis drugs, or anti-coagulant medications. Vitamin K given at birth does not necessarily prevent this type of onset as bleeding may have already occurred.

Classic onset VKDB occurs between 2 to 7 days of life. This is the most common type, thought to occur in 0-.44% (0-4.4/1000 births) in recent reviews and is generally less severe than late onset (Luppi and Franchini 2011). Bleeding can occur and occasionally be significant from: the umbilicus, gut, nose, circumcision site, or exhibit as bruises (Luppi and Franchini 2011).

Late onset VKDB is the focus for prevention and key reason for vitamin K supplementation. It appears from 8 days up to 6 months, with typical presentation at week 2-8 (Shearer 2009). Late onset, while rare, is often fatal (20%) or leaves serious morbidity (40%) due to intracranial hemorrhage, which characterizes late onset VKDB in 50% of cases. (Lippi and Franchini 2011 and Shearer 2009). During late onset, bleeding in the brain is often the first sign of VKDB; 30% of cases have a warning bleed (Shearer 2009). Prolonged jaundice after 14- 21 days may be linked to late onset (Busfield et al 2013). In up 60% of cases, there was undiagnosed liver disease (cholestasis, biliary atresia, 1-antitrypsin etc.) or another disorder causing malabsorption (cystic fibrosis, impaired secretion of bile salts, repeated antibiotics, etc.) (Shearer 2009). Recent

data indicates that the rate of late VKDB is about 1/15,000 to 1/20,000 without any vitamin K given (Luppi and Franchini 2011). If an infant has a single oral dose of 1-2 milligrams at birth, their risk is 1/25,000 to 1/70,000 (Enkin 2000). The rates of late VKDB for an infant given a 1.0 mg IM injection at birth is 0.1/100,000 and for an infant given an oral 2mg dose at birth followed by a 1 mg dose weekly through 12 weeks there was a similar rate of 0-0.9/100,000 (Van Hasselt 2008). Higher rates, up to ten fold, for late onset VKDB occur in Asia (Thailand, Japan and Vietnam) possibly due to genetic or environmental factors (Chuansumrit et al 2010).

The standard recommendation by the American Academy of Pediatrics is to give all term newborns injectable Vitamin K1 1 mg/ 0.5mL within the first six hours of birth regardless of route of delivery, intent to breastfeed or formula feed, or lack of trauma at birth. Developed countries recommend injectable vitamin K to be given to newborns or at least "at risk newborns" (ie: premature, low-birth weight babies, or mothers on certain vitamin K depleting medications and instrument delivery, vacuum or c-section) (Van Hasselt et al 2008). However, many countries recognize oral vitamin K as an alternative option, especially if parents decline the injection and are low risk. The Netherlands still exclusively gives oral vitamin K (Busfield et al 2013). Other countries like the UK, Australia, many EU countries, New Zealand, and Canada offer oral as an alternative, but prefer injection.

Many oral protocols have been used, from using only one 1-2 mg bolus dose at birth, to adding two additional doses-typically one at day 7-8 and one at 4-6 weeks, to weekly and daily dosing. Currently, there is no unified cross-country oral protocol or recommendation. Those countries that continue to give oral vitamin K do so with a more effective multi-dose regimen rather than giving oral once at birth. The most effective protocol appears to be the Danish protocol of a 2 mg drop at birth, followed by a 1 mg dose weekly for 12 weeks; this protocol showed a similar efficacy for low risk infant to the IM injection prophylaxis for classic and late onset VKDB, especially for babies with cholestasis (Van Hasselt et al 2008). The Netherlands continues to prefer and recommend oral vitamin K, dosing initially with 1 mg and then daily from day 8 through 12 weeks with 125mcg, recently increased to be in line with the Denmark evidence from 25 mcg (Busfield et al 2013).

The evidence is clear that a single dose of oral vitamin and the three dose regimen are not as effective compared to IM injection in the prevention of late onset VKDB (Busfield et al 2013). It is important to ensure baby has indeed gotten the oral dose; therefore, if baby throws up within 60 minutes after the dose is given, it is suggested to repeat the dose. Some breastfeeding advocates have argued that oral vitamin K has the potential to disrupt the sealing of the gut lining that occurs in a breastfed baby. Research has not been focused on this issue, but we do know that IM injection is a direct and sustained route as the muscle acts as a reservoir for the medication and works faster in the body rather than having to navigate the gut (Shearer 2009). Concern has been raised around compliance of parents with oral vitamin K multi-dosing, as missing a dose could be critical, but one study in Denmark showed 94% completion (Hansen et al 2003).

There are two common options sold in the US for oral vitamin K. Scientific Botanicals, a naturopath-run company in business for over 30 years, sells K-Quinone. It is an extract of Vitamin K1 and contains 2 mg per drop made from alfalfa, nettles and green tea in an olive oil suspension. This product is sold directly by Scientific Botanicals to a few small midwifery birth supply sites for around $32. Mephyton Vitamin K1 by Aton Pharma, a division of Valeant Pharmaceuticals, is sold in 5 mg tablets/100 tablets a bottle and is sold for roughly $1650 or more for 100 tablets, or $25-60 per child depending on protocol. It contains inactive ingredients: acacia, calcium phosphate, colloidal silicon dioxide, lactose, magnesium stenrate, starch and talc. It is sold by major medical companies like Henry Schein and carried by Cascade. One regimen is to divide in half and crush and mix with breastmilk and give via syringe immediately in a three-dose schedule (Frye 2007). This would give a 2.5mg of vitamin K at each dosing. Hypothetically the tablet could be cut in fourths to simulate a weekly dose of 1.25 mg, roughly simulating the Danish protocol. It can be formulated by a compounding pharmacy by taking 5 tablets, crushing them and mixing with methylcellulose and sorbitol. This second suspension is only stable refrigerated for three days (Drug Information Group, University of Illinois at Chicago, FAQ).

Injectable Vitamin K1 by contrast comes in many forms, but the most natural option is called Phytonadione by Amphastar Pharmaceuticals, which comes in a prefilled syringe of 1mg/.5mL. It costs around $10, thus significantly cheaper than oral vitamin K. It contains 10 mg polysorbate 80, 10.4 mg propylene glycol, sodium acetate anhydrous, and glacial acetic acid. It must be protected from light and kept at room temperature (50-86 degrees) as with all oral vitamin K. Both polysorbate 80 and propylene glycol are generally classified as not expected to be harmful but are considered mild non-reproductive toxins, rated a 3 on the Environmental Working Group database (www.ewg.com).

No oral vitamin K in the US is FDA-approved for use with newborns. The FDA has no reason to recommend its use, as injection is the recognized form of vitamin K for newborns in the US. Mephyton is FDA approved at a 2.5mg dose (half tablet) for use in adults and the dosage is confirmed and consistent. None of the oral vitamin K products that have been used in Europe and in the majority of studies are available in the US. Europe uses phytomenadione; however, it's unclear from what source it is derived and the additives/ stabilizers are different than those used in phytomenadione available in the US. Neokay, an oral vitamin K used in Europe, is phytomenadione in coconut oil and other preservatives, thus showing a move towards more natural additives (Busfield 2013).

One might argue that all the studies that have been done on vitamin K have been done using the synthetic version, so a botanical extraction like K-Quinone might not be as effective. However, arguments have been made around the body's ability to absorb vitamins from food and food based sources more readily than those of synthetic nature, although we lack the evidence to both prove or disprove this postulation.

Since the AAP does not recommend oral vitamin K, providers are at the mercy of the products available by pharmaceutical companies for clinical use, as it is costly to research and assemble evidence for efficacy to obtain FDA approval, especially for newborns. We find ourselves in a situation where evidence cannot fully be carried out by the consumer or provider, therefore limiting the real-life options. This is not a new conundrum, as researcher Hey points out, "policies for giving babies Vitamin K prophylactically at birth have been dictated, over the last 60 years, more by what manufacturers decided on commercial grounds to put on the market, than by any informed understanding of what babies actually need or how it can most easily be given" (Hey 2003: F80). For example, the Roche Company inexplicably pulled Kondikion Cremophor, the oral vitamin K used in the Denmark study, forcing the country to switch to a recommendation of injectable vitamin K given that no oral was available (Shearer 2009). Hey's point might be expanded to include public health advisory institutions. For example, the UK National Institute of Health and Clinical Excellence (NICE) recommended in 2006 that all newborns receive an injection of vitamin K. NICE guidelines significantly influence UK practice, moving many countries to use injectable vitamin K. It is argued that their recommendations might change to at least equally recommend oral proto-

cols if current oral products were reviewed (Busfield et al 2013). At the time of the NICE review only one oral vitamin K product, Kondikion MM, was available in the UK. It was expensive and required administration by a medical professional therefore limiting its practicality from a public health perspective (Busfield et al 2013).

Further research into the implications for mother's milk based on maternal diet and supplementation postpartum is needed to build on the trend that was shown in Thai study. Of the fat-soluble vitamins and their relation to newborns and maternal intake, vitamin D is the one in the spotlight of late, and thus receiving the funding. For vitamin D, one pilot-study showed that when nursing mothers' levels of Vitamin D are high enough or when nursing mothers supplemented Vitamin D in high levels, newborn's levels were equivalent to those who had received vitamin D drops directly (Wagner et al 2006). Vitamin D and Vitamin K may have some similarities, as they are fat soluble in the body and transported through our lymph breast tissue. If research could look at high levels of maternal supplementation and it's impact on VKDB, and results were positive, the debated issue of oral vitamin K in regards to newborn gut health could potentially be eliminated.

While late onset VKDB is the most risky, it has been identified that it is higher in certain populations, as well as in those with underlying liver/malabsorption issues, and connections with maternal drug use. Even injectable vitamin K cannot eliminate bleeding in these groups entirely (Busfield 2013). As research has progressed, more underlying disorders have surfaced in connection to late VKDB that were once thought of unknown origin and many idiopathic cases have been linked to self-correcting disorders of the liver function (Shearer 2009). One wonders if there are other disorders that might not have been discovered as the cause of the other 40% and late VKDB is rather a sign of those cumulative diseases rather than a separate issue, but maybe there are truly idiopathic cases. There is still much that we do not have clear evidence about. But as we know, classic VKDB is rare and late VKDB is rarer, thus this would be very difficult to conclusively identify without whole countries adopting this protocol. While several thousands to hundreds of thousands must be treated to prevent one case of VKDB, we know supplementing either with the shot or oral have relatively small drawbacks. Midwives have few early signs to know when to transfer care. We cannot always identify which babies will have a difficult time nursing, and there are few clear signs of liver disorders in a newborn. If one compares known pros and cons to giving some form of Vitamin K to a baby after birth to dynamics such as repeated early antibiotic use and its lifelong impact on our microbiome, the issues with vitamin K supplementation seem trivial. The modern midwife has emerged, and evidence-based research has taken a firm hold as the standard and goal of obstetric care. As we move away from many practices that have been historically not rooted in evidence, the other side of the coin is that every practice is substandard until evidence has proven it. Many standard protocols cannot be proven in a double blind randomized trial for mother-baby dyads because they are unethical or too large to capture, or they are alternative strategies that cannot reach funding.

To date, the oral protocol from Denmark or the current daily 125 mcg dosing of the Netherlands offers midwives a comparable protective protocol to injectable vitamin K against late VKDB. While the products available in the US have not been approved for newborns, reason stands to argue they offer a reasonable alternative while we wait on research and pharmaceutical companies to demonstrate efficacy. In light of all the arguments, parents and midwives must walk of fine line of both continuing to understand the medical model, navigating research, understand risk and gaps in knowledge and give the best informed consent we can while looking for bias. This is a difficult task given all these dynamics.

Jen Anderson-Tarver is a Certified Professional Midwife in Denver, Colorado. Her home birth practice, New Leaf Midwifery, is an integrated woman-centered practice that is informed by research, mindful of tradition and sensitive to intuition. Jen is a graduate of National Midwifery Institute, a MEAC accredited academic program, accompanied by 3 1/2 years of training in home birth apprenticeships. Before deciding upon the road to midwifery, Jen worked as a Doula privately in Chicago and then on-staff at a public hospital in Minneapolis.

References

Busfield, A., Samuel, R., Mcninch, A., & Tripp, J. H. (2012). Vitamin K deficiency bleeding after NICE guidance and withdrawal of Konakion Neonatal: British Paediatric Surveillance Unit study, 2006-2008. *Archives of Disease in Childhood*, 98(1), 41-47.

Chuansumrit, A., Plueksacheeva, T., Hanpinitsak, S., Sangwarn, S., Chatvutinun, S., Suthutvoravut, U., et al. (2010). Prevalence of subclinical vitamin K deficiency in Thai newborns: relationship to maternal phylloquinone intakes and delivery risk. *Archives of Disease in Childhood - Fetal and Neonatal Edition*, 95(2), F104-F108.

Dekker, R. (2014, March 18). Evidence for the vitamin K shot in newborns. *Evidence Based Birth*. Retrieved September 28, 2014, from http://evidencebasedbirth.com/evidence-for-the-vitamin-k-shot-in-newborns/

Enkin, M. (2000). *A guide to effective care in pregnancy and childbirth* (3rd ed.). Oxford: Oxford University Press.

Fr, G. (2004). Vitamin K in human milk--still not enough. *Acta Paediatrica*, 93(4), 449-450.

Frequently asked questions. (n.d.). *UIC Drug Information Center. Retrieved September 29, 2014*, from http://dig.pharm.uic.edu/faq/2011/dec/faq1.aspx

Frye, A. (2007). *Understanding diagnostic tests in the childbearing year: a holistic guide to evaluating the health of mother and baby* (7th ed.). Portland, Or.: Labrys Press.

Greer, F. R., Marshall, S. P., Foley, A. L., & Suttie, J. W. (1997). Improving the vitamin K status of breastfeeding infants with maternal vitamin K supplements. Pediatrics, 99(1), 88-92.

Hansen, K., Minousis, M., & Ebbesen, F. (2003). Weekly oral vitamin K prophylaxis in Denmark. *Acta Paediatrica*, 92(7), 802-805.

Hasselt, P. M., Jorgensen, M. H., Houwen, R. H., Kimpen, J. L., Berger, R., Lundin, C. R., et al. (2008). Prevention of vitamin K deficiency bleeding in breastfed infants: Lessons from the Dutch and Danish biliary atresia registries. *Pediatrics*, 121(4), e857-e863.

Hey, E. (2003). Vitamin K--what, why, and when. *Archives of Disease in Childhood - Fetal and Neonatal Edition*, 88(2), 80F-83.

Lippi, G., & Franchini, M. (2011). Vitamin K in neonates: facts and myths. *Blood Transfusion* , 9(1), 4-9.

Nishiguchi, T., Saga, K., Sumimoto, K., Okada, K., & Terao, T. (1996). Vitamin K prophylaxis to prevent neonatal vitamin K deficient intracranial haemorrhage in Shizuoka prefecture. *BJOG: An International Journal of Obstetrics and Gynaecology*, 103(11), 1078-1084.

Shearer, M. J. (2009). Vitamin K deficiency bleeding (VKDB) in early infancy. *Blood Reviews*, 23(2), 49-59.

Vitamin K - the debate and the evidence. (2005). Bristol: MIDIRS.

Wagner, C. L., Hulsey, T. C., Fanning, D., Ebeling, M., & Hollis, B. W. (2006). High-dose vitamin D3 supplementation in a cohort of breastfeeding mothers and their infants: A 6-month follow-up pilot study. *Breastfeeding Medicine*, 1(2), 59-70.

Wickham, S. (2013). Revisiting vitamin K and the newborn: What have we learned in a decade?. *Essentially MIDIRS*, 4(7), ..

Winckel, M., Bruyne, R., Velde, S., & Biervliet, S. (2009). Vitamin K, an update for the paediatrician. *European Journal of Pediatrics,* 168(2), 127-134.

Winter, J. d., Joosten, K., Ijland, M., Verkade, H., Offringa, M., Dorrius, M., et al. (2011). New Dutch practice guideline for administration of vitamin K to full-term newborns. *Ned Tijdschr Geneeskd*, 155(18), A936.

The Other Side Of The Coin

Conversations with Full Spectrum Workers

The goal of this regular column is to shine a light on full spectrum work and how it affects our ability to make progress as radical birth workers. By interviewing folks who are at the forefront of supporting families in reclaiming the full span of their biological experiences (reproductive plus end of life care as well), we hope to create a vision of the national movement and the diverse approaches to supporting different sides of the same coin.

— Kelly Gray, birth worker, story collector, www.storiesfromthewomb.org

This quarter I wanted to look at one of the darker forces that affects women's biological experiences; rape and the stigma that is attached to it. With an estimated more than 200,000 sexual assaults happening each year in America alone, we have either been the victims of rape or sexual assault or know someone who has. We carry these horrors in our bones and our bodies, often quietly for years, often passing on the stigma and trauma from one generation to the next. The cultural impact should not be underestimated. As birth workers, we often see these experiences rise in women during birth and affect a person's ability to birth and to parent from a place of autonomy. As birth workers it behooves our work to ask ourselves the question, when and where does the healing begin?

I was able to catch up with Jollene Levid to talk about the impact of her grandmother's story on her political life and work, and the impact of sharing her grandmother's story within the transnational feminist movement. Jollene Levid is the National Chairperson of AF3IRM, an anti-imperialist transnational feminist women's organization that combats trafficking, militarism, and fights for im/migrant women's rights. She has been a part of the organization for 12 years, previously serving as the Secretary-General, Organizing Director, and Coordinator of the Orange County chapter. She received her BA in Political Science with a minor in Asian American Studies at UC Irvine and got her Masters in Social Work from USC. She is currently a union organizer and contract negotiator for public sector nurses in Los Angeles County. Jollene recently returned from doing anti-sexual violence work in the typhoon and military disaster areas in the Philippines. Jollene tries to live by AF3IRM's belief: A woman's place is at the head of the struggle for the liberation of all humanity!

Kelly: *Can you tell me what a comfort woman is and how you came to do the work that you do around comfort women?*
Jollene: Comfort women were sex slaves of the Japanese imperial army during World War II. Untold thousands of women were captured, raped, and shamed by the soldiers in places like Korea, Okinawa, and the Philippines.

I learned about the comfort women in college as a student activist. By the time I joined the women's movement, I had seen documentaries, read articles on campus about them. A year later, in 2004, I was in the Philippines working with the Philippine women's movement --- living with trade unionists and organizing, and also I met the "lolas" - the grandmothers - our name for the comfort women/survivors. I was truly honored.

Kelly: *Recently, you learned more of your lola's (grandma's) story during WWII. What happened to her?*
Jollene: I learned last year that my grandmother, Gertrudes Bernabe, had been raped repeatedly by several Japanese soldiers during WWII. She lived in a place south of Manila, called Bataan. The place had fallen to Japanese invading forces and she became what people say of those raped nowadays in Afghanistan, Syria … "collateral damage" of war. She lived in shame about this, carrying it with her until her death in 2000.

Kelly: *From my perspective, there is a heavy and purposeful shroud of stigma around rape and even talking about rape. What type of feedback have you received from differently gendered people after sharing your grandmother's story with them?*
Jollene: I consciously chose to tell the women in my family first. I first told my mother and then she organized her sisters (my aunts) and our first cousins who are women so that I could tell them her story. Their first response was grief --- the women mourned her/our trauma and then agreed we should tell her story when it's time. I decided that this year was the first year to do it.

The men I have told, even the progressive ones, usually are very uncomfortable (quite rightly) about the topic. The unfortunate thing about sexual violence is that we are not given words to describe what happens to us. Most men are and were unable to articulate what happened. For us women, most of us are survivors --- so our empathy comes from a shared trauma.

Kelly: *Can you tell me about the significance of women healers in the Philippines?*
Jollene: My grandmother took a plant called the makabuhay plant to induce an abortion after she was raped and became impregnated. Filipina women have always relied on what the land and ocean has given us to meet our needs. We have a strong tradition of women healers --- they were/are called babaylans. When the Spanish first invaded the Philippines, they were outraged that these babaylans, these women, had so much power in their communities. They held the same esteem as the chiefs of their villages. Women were revered as healers and for their power to give life/birth. The Spaniards, with their patriarchal ideas and practices, ensured that these babaylans were the first to die. They conducted a witch-hunt to kill them off. Some babaylans survived --- you can see them and their all-women communities in places today like Mt. Banahaw. They are also still alive in the everyday healers in communities - called "hilots." I wasn't surprised to learn that my grandmother used a plant to induce an abortion. It was not a magical or uncommon practice, not taboo before the Spaniards. Only her religion (Catholicism, brought by the Spaniards) taught her/us that this was sinful.

Kelly: *Are there babaylans or hilots practicing the healing arts in America? How do young Filipina or Filipina-American women get introduced to this calling? Are these practices currently under threat?*
Jollene: There are babaylans and hilots practicing in America. The thing is, many of them don't call themselves this. Babaylans can be practicing because they are clairvoyant, or because they know home herbal medicinal practices passed down to them, or because they practice other healing arts like reiki. Just like any and all women's practices, they are constantly being threatened or looked down upon, or erased.

Kelly: *How do you think sharing your lola's story benefits your political work and the lives of the*

women that you work with?
Jollene: I think that it's our generation's responsibility to both demand justice in the streets for comfort women --- they deserve recognition, reparations. It's also our responsibility to heal the trauma of this mass rape and erasure of comfort women's stories. Scientific studies have shown that trauma alters our DNA. For women, this alteration is passed on to their children when they give birth to them. I have no doubt that I have inherited my Lola's trauma, her grief. I also know that I have inherited generations, thousands of years of Filipina women's ability to survive. I want to make sure that we do more than that though. I want to tell her story, heal our historical trauma, and fight for the kind of world that following generations of girls and women deserve.

Kelly: *You work for and alongside women who have survived sexual, economic and personal violence. When women participate in radical political work, how might it affect their future reproductive experiences such as puberty, birth, abortion, and menopause?*
Jollene: As a survivor of domestic and sexual violence, I know that the first thing that is robbed of you is your autonomy over your body. As a woman of color who must also contend with racism, classism, and other forms of oppression in addition to patriarchy, I know that all these things are tied. I think that participating in comprehensive political work affects my future experiences in that I am simultaneously healing as an individual - being attentive to and understanding myself physiologically, emotionally. I am also doing work that addresses the oppressions that allowed the violence to occur to me, to the women around me, to future generations of women.

Photo by Kelly Gray.
Jollene at Comfort Women Memorial.

In Discussion with Christine Morton

Author of *Birth Ambassadors: Doulas and the Re-Emergence of Women-Supported Birth in America*

"The world turns to women for mothering, and this fact silently attaches itself to many a job description." - *Arlie Russell Hochschild*

By Elise Rose

This quote opens Chapter Three of Christine Morton's comprehensive book on the history and current practice of doulaing in the United States, *Birth Ambassadors*. In this chapter, Morton discusses the separation between viewing doulas as "caring women," and viewing them as "trained professionals," — one of the essential dilemmas that can lead to a compensation and cultural valuation conundrum for doulas. While doulas may, in fact, be natural maternal-figures, providing a soothing touch or gentle words, they are also trained advocates and advisors.

In *Birth Ambassadors*, Morton adds one more role to the doula repertoire: doula-as-observer. Through this addition, she allows the experience of the doula to be a lens into the world of birth — sharing stories of variation, successes and flaws in maternity care through the observations of the doulas present during labor. Through this method Morton includes "day-in-the-life," details that will fascinate readers considering doula training, offering social commentary on current birthing practices for readers already immersed in the field.

Morton covers an impressive depth and breadth of birth-related topics in the pages of Birth Ambassadors. Recently, SQUAT was able to speak with Morton about her research, her writing and her thoughts on the future of doulaing.

SQUAT: Tell me a little about yourself and your background— how did you become interested in the issues surrounding childbirth and doulas?

Christine Morton: I seem to have always been interested in any/all facets of the reproductive experience. As a sociologist in grad school I wanted to study something that had to do with reproduction. As I was working toward my PhD I was all set to do my dissertation on another topic when I discovered the doula role. I went to a doula training in LA and I thought "wow, how did this role escape my attention?!" Here are women who are able to be present in hospitals when birth happens (which is something I had wanted to do as a sociologist, but couldn't figure out how) and they're using science as a way to justify their role at birth! Even more than that, doulas are challenging the mainstream care of women as they go through institutionalized birth.

So, I became really fascinated with the role and I subsequently moved to Seattle where I was very fortunate to become involved with Pacific Association of Labor Support (PALS) doulas and I got to know many of the people there including leaders in the field, such as Penny Simkin, Annie Kennedy, Sheila Capestany and others.

SQUAT: In *Birth Ambassadors*, you frequently mention that more research on doulas is needed. What are some research projects that you'd love to see done?

"Doulas, for me, were also an ethnographic window into birth. Social scientists haven't done a lot of research asking people who are present at birth about their perceptions and experiences working in the field. So I felt like the doula perspective was able to give me a snapshot of the varying practices that they saw firsthand. The doulas were telling me stories indicative of the variability of practice and policy."

CM: That's a great question! I would refer you to the Birth Ambassadors blog— we posted very recently with some great ideas about future directions in doula research. (*Editor's note — Examples from the blog include: "How has the sexual element of birth been incorporated and/or transformed in the medical setting?" and "How do community based doula programs work? What are their outcomes? How is doula ideology transformed and shaped in cultural contexts beyond white middle class frameworks?")*[1]

There were a lot of things that came to my mind as I studied doulas from a social science perspective. Most of the research prior to my study had researched the outcomes of doula care, but I was really interested in the experience of the women who were doing this work, the doulas themselves. I wanted to know how they grappled with what I came to see as some inherent contradictions in the doula role— how they dealt with the disjuncture between their philosophy of birth and what they saw happening in hospitals

Doulas, for me, were also an ethnographic window into birth. Social scientists haven't done a lot of research asking people who are present at birth about their perceptions and experiences working in the field. So I felt like the doula perspective was able to give me a snapshot of the varying practices that they saw firsthand. The doulas were telling me stories indicative of the variability of practice and policy.

In the last few years, I have also been a co-investigator of a cross-national survey of doulas, childbirth educators and labor & delivery nurses in the US & Canada, called the Maternity Support Survey[2]. A team of eight of us have been working together over the last four years and we have collected over 3,000 responses. We are in the process of analyzing that data and getting that out in conferences and publications. We will be presenting our research findings at the Lamaze/DONA 2014 Confluence in Kansas City this September.

SQUAT: What is the biggest change or advancement that you'd like to see made in the doula community?

CM: I have observed what I called "organizational diversity," in the birth world in general— this is true of doulas, childbirth educators, midwives to some extent, and now even maternity advocacy. I have concerns that this diversity can work against the interest of people in these organizations, especially when it comes to representing their members in policy decisions.

This is especially poignant as doulas are becoming incorporated into the Affordable Care Act and potentially being reimbursed by state Medicaid programs. Who speaks for the doulas who are going to be incorporated into the state-based policy? Is it DONA? Is it CAPPA? Is it BirthWorks? Is it HealthConnect One? Or an independent group of dedicated volunteers in each state?

Further, I've learned from working in my current role how effective people can be if they come together as a unified organization, even if there are differences among the members about tactics/strategies. The organization presents a united front. I know there have been many attempts in the birth world to provide that overarching voice, but it seems as though it's hard to coordinate, especially when there are not a lot of resources to go around.

There's also a work-justice angle there, with community-health doulas being incorporated into programs that realize the cost-savings possible by doulas leading to a decrease in c-sections/other costly interventions.

In the end, I think that there's always going to be a tension between our cultural idea that being a doula should be a "labor of love," doula services freely given, because it's a "natural thing that certain women just do," vs. it's a skilled, valuable service, essential to the ongoing reproduction of society.

SQUAT: Do you think that the doula role changes when the birth is attended by a midwife rather than by an OBGYN?

CM: I think that regardless of the provider, doulas are always necessary to fill a patient-advocate role. In other words, a woman can never have too much emotional support. If her partner or family members are providing that or the clinical staff is providing that, great! But it's always nice for the woman to have somebody there to step up if she needs it. Women giving birth have a lot of needs that may or may not be readily apparent or visible, but having someone in her corner as an objective advocate is, unfortunately, what we need right now in our healthcare system.

SQUAT: What are your thoughts on training women as abortion doulas?

CM: When I was looking around in the early stages of my research for an analogous position to the role of the doula, the only one I could find was the abortion clinic counselor. So it's interesting that now the abortion doula role has sort of superseded that.

Also, now that the option of a chemical abortion has become possible, things have changed. A chemical abortion is a procedure that isn't going to happen in the clinic. So, abortion doulas who are present with women in the home, waiting for the abortion to take place, could be very valuable. I can definitely see the need for someone like that. In general, I think that the idea of reproductive justice and the role of the doula in the whole reproductive continuum is a really innovative model.

"So, abortion doulas who are present with women in the home, waiting for the abortion to take place, could be very valuable. I can definitely see the need for someone like that. In general, I think that the idea of reproductive justice and the role of the doula in the whole reproductive continuum is a really innovative model."

In retrospect, one thing I regretted not asking the doulas about in my study was their attitude toward abortion. So, in this most recent research project (Maternity Support Survey) we've asked doulas about their attitude toward abortion. We will be looking at this in more detail, but so far we've seen in our responses that doulas are more likely to think that abortion should never be legal, as compared to the responses of childbirth educators and nurses. We can't claim that our sample is wholly representative, but we did have over 3,000 responses. So, I think that this will be an interesting follow-up.

SQUAT: What do you hope readers will take-away from *Birth Ambassadors*?

CM: I want readers to understand that women who are undergoing labor need as much support as they could ever want. Also, I want readers to understand the depth of commitment/passion that goes into becoming and practicing as a doula. Hopefully we'll provide a space for doulas to be recognized.

Also, I think that there are some concerns that doulas are just making women happy with hospital birth and they're not going to change the status quo. But actually, to me, doulas are the ambassadors of the midwifery model of care. By being out there in the hospitals and on the internet, the idea of a different way of birth is becoming more pervasive in the public discourse. My final hope is that doulas will open up that midwifery model to more women.

CHRISTINE H. MORTON, PHD is a medical sociologist whose research has focused on women's reproductive experiences and maternity care roles. Since 2008, she has been at Stanford University's California Maternal Quality Care Collaborative, focusing on maternal mortality and morbidity and maternal quality improvement.

ELISE ROSE is a SQUAT contributor currently working toward becoming a Certified Nurse-Midwife. She graduated from University of Michigan with a bachelor's in English in 2008 and has spent the last several years living in Niger, New Orleans, Thailand, Nicaragua, New York City, Alaska, and rural Colorado.

[1]www.birthambassadors.com/2014/04/13/future-directions-in-doula-research

[2]www.maternitysupportsurvey.com

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Four quarterly issues of SQUAT delivered to your door! Available for readers in the United States and Canada. See our website for more information.

SQUATBirthJournal.org

SQUAT Spotlight on Education

SQUAT Birth Journal is pleased to bring back its popular column, Spotlight on Education! This column explores all types of educational options available in the United States for those interested in birth work. This column is intended to support the educational opportunities and awareness of every person who dreams of becoming a midwife, and all the various types of education that might include, serving as a platform for introducing varied educational options to our readers in each issue. We'll be featuring a wide variety of paths, programs, schooling, and unschooling. We aim to provide factual information about programs and trainings, as well as student reviews about their experiences.

The path to midwifery is an uphill one, full of familial, financial, physical, and spiritual challenges (to name a few), and also deep meaning, joy, and profound learning. A balance between institutionalized training and intuitive undisturbed birth must be found for our work to reach its highest potential.

We encourage you to share your experiences with us so we can feature your program/path and words from students in the coming issues. We look forward to hearing from our readers how they went about their midwifery education and what they thought of it! Please e-mail us at submissionstosquat@gmail.com.

National Midwifery Institute, Inc.

Bristol, VT

The National Midwifery Institute, Inc. is a distance program dedicated to the preservation of community-based midwifery training and education. Our curriculum supports woman-centered birth and prepares graduates to meet national standards as described by the North American Registry of Midwives (NARM), the Midwives Alliance of North America (MANA), and the California Midwifery Practice Act.
nationalmidwiferyinstitute.com

School Contact:
nmioffice@nationalmidwiferyinstitute.com. 802/453-3332
Class Locations: Community-based education (distance-learning program)
Accreditation: MEAC-Accredited
Cost: Total tuition and fees $17,000
Financial Aid/Payment Plans: Minimum down payment $5,000, monthly payments months 1-12 $500, monthly payments months 12-36 $250. If alternate agreement is made with preceptor, $3,400 preceptor fee may be refunded.
Prerequisites:
High School Diploma or GED.
Academic Structure: First complete Heart and Hands (in-person workshops in CA, or distance options available), then complete Study Group (52 modules) along with community apprenticeship and clinical experience documentation. Student Support: Staff available by phone and e-mail, student Yahoo group. Many students form in-person or online study groups.
Length of Program: Average of three years. Once enrolled, you have seven years to complete.
Acceptance Rate: Unspecified
Certification or Degree offered: No degree offered: students meet requirements to sit for NARM exam.
In what type of environment do your graduates practice?: Primarily out of hospital midwifery settings.

Student Reviews

First Name: Anonymous
Length of time enrolled in program: 13 months
Why you chose the program over others: I chose NMI for its distance option and module organization.
What you love about the program: I love that I can work from anywhere on my modules and see an outline of the entire program clearly.
What you find challenging about the program: Working alone can be difficult. I have not connected with the study groups that I know are available in my area, due to my busy schedule. I'm sure this would be a great benefit, but is unfortunately not an option for me at this moment. I hope to make those connections in the future and be able to work alongside local midwives.
Do you think you will stick with this program until you complete your studies?: I will continue this program through completion. I am concurrently getting my nursing prerequisites done. This program allows me to set the time frame so that I can continue both routes.
Would you recommend it to other midwifery students? Why/Why not?: I would recommend this program to midwifery students with a less flexible schedule, but who are eager to enter the field nonetheless. It is a great way to immerse yourself in studies while preparing for your apprenticeship. It definitely requires a ton of self motivation and would not be ideal for those who require more structured learning. The modules are well organized and I find it quite satisfying to know exactly what lies ahead of you in the program. While the program is incredibly affordable, it does have drawbacks of not being eligible for financial aid. I have had to postpone my apprenticeship and clinical training due to financial constraints, and am only working on my book studies at the moment (which I do not believe is ideal). However, I intend to combine my NMI studies by finishing with my clinical work at Maternidad la Luz. While this may not make the most sense for all midwifery students, I have found it is the answer for me. It financially opens a door so that I may begin working locally and practicing midwifery skills within my community, without having to take out huge loans in order to complete what may be at least a year long apprenticeship. For me, this will allow me to continue on my path to becoming a midwife, without a gigantic financial burden and without having to take extended breaks during my schooling.

First Name: Molly
Length of time enrolled in program: One year completed
Why you chose the program over others: I took Elizabeth Davis' Heart and Hands workshops in CA while I was thinking about enrolling in midwifery school. I was moved by the balanced blend of academic, clinical, and intuitive/spiritual approaches to the art of midwifery and knew I wanted my program to be rooted in all this. Plus, NMI was affordable and I anticipated moving a lot during my education, so distance-learning was a must.
What you love about the program: I love the challenging content of study group, and the encouraged independence. They have been flexible and understanding in my variety of clinical experience and apprenticeships.
What you find challenging about the program: It's my understanding that the majority of NMI students are in CA. I haven't been in CA the whole time I've been enrolled (first I was in WA, then abroad, now in New England) so it has been difficult to connect with other students and it has at times felt isolating and lonely. At times, it can be hard to get a hold of staff, but they always write back eventually.
Do you think you will stick with this program until you complete your studies?: Yes. I think I've invested enough in it that it makes sense to finish, and I'm enjoying the modular format. I plan to pursue my CPM, and going to a MEAC-accredited school has helped me streamline that process.
Would you recommend it to other midwifery students? Why/Why not?: Absolutely. If you are very independent and self-motivated, it can be a very enriching and substantial program, at a relatively affordable price. It's flexible, manageable, and encouraging.

First Name: Lauren

I am a third-year midwifery student at The National Midwifery Institute. I took both the beginning and advanced Heart and Hands courses and then enrolled as a full-time midwifery student in the Spring of 2011. I acquired a midwifery apprenticeship with a San Francisco-based homebirth midwife.

It was a dream come true to begin my apprenticeship with Sue Baelen. NMI advised me to start my clinic work with my preceptor as soon as I enrolled in the program. Sue had me attend a few births during the first four months of my apprenticeship, but as time went on I was taking on 100% of her client load which was two to three homebirth clients per month.

I had to fully support myself while enrolled in NMI. It was always a challenge to balance my work life with my apprenticeship, but after two and a half years I am happy to say that I have a roof over my head, plenty of food to eat, and clean clothes on my back.

Throughout my full-time apprenticeship I worked as a massage therapist and a birth doula. Both of these professions blended nicely with my studies in midwifery.

I have really enjoyed the NMI program and have nothing but good things to say about it. It is affordable, the course load is manageable, and I love working on my education at my own pace.

I feel so fortunate to have found this program. I love midwifery for it is a profession that promotes continual education. It is important to never stop learning and NMI creates a wonderful educational platform.

WomanCraft MidwiferyEducation Program

Amherst, MA
"Birth is a sacred and natural process. Women already have the wisdom within them to give birth." womancraft.org

School Contact: Beth Anne Moonstone, Midwife, CPM, Director, beth@womancraft.org. 413/230-3918.

Facebook page: facebook.com/womancraftmidwiferyeducation.
Founded: 2001
Class Locations: One-year local course in Midwifery Studies held in Amherst, MA, March-December (includes doula and childbirth educator (CBE) certification). Requires once-a-month classes in Amherst, MA.
One-year online distance course in Midwifery Studies (includes doula certification).
Three-day Beginning Midwifery Retreat Weekend held every spring and fall in Amherst, MA.
Accreditation: None
Cost: One-year local midwifery program is $2,500 (includes doula training and CBE training). One-year online distance course in midwifery is $1,750 (with doula training) or $1,500 (without the doula training).
Financial Aid/Payment Plans: Each year we offer several work scholarships for students with financial need for both the local and distance programs. Students pay their deposit to register for the program and then use a ten-month payment plan for the remainder of their tuition. One full scholarship is given out each year for a student with financial need who plans to serve in a community where there is a high need for midwives.
Prerequisites: High School Diploma or GED, CPR certification (can be completed during the course year).
Student Support: Students have access to the instructor via e-mail, telephone, and Facebook for questions or assistance throughout the course year. We have regular study group times for students to connect and work on their studies together. These happen both in-person and online via tools such as VoiceThread and GoogleHangout. In addition, our program has an active and thriving Facebook student and alumni list to keep students connected, and help them network and ask questions.
Length of Program: One-year
Acceptance Rate: 98%
Certification or Degree offered: Certification of Completion.
In what type of environment do your graduates practice?: Private homebirth practice, group homebirth practice, birth centers. Some graduates have also gone on to become CNM's and practice in the hospital.

Student Reviews

First Name: Krystin
Length of time enrolled in program: One year
Why you chose the program over others: I wanted a less expensive local option

that would allow me to dip my toes into midwifery in order to get a sense of whether it is something I want to pursue professionally. It was also important to me to be in a room with other women, and not online.

What you love about the program: Beth Moonstone is an incredible teacher. In addition to her own extensive professional experience, she is well-versed in the political issues at stake in global midwifery today and is able to easily translate often complex contexts to a room of green students without telling us what to think. Her lectures are fantastic and her experience with homeschooling pedagogy means that she knows both how to teach and how people learn, making her classes and assignments dynamic and never a chore.

What you find challenging about the program: There's a lot of reading, but that's to be expected. It can be tough balancing it with my full time job, doula business and childbirth classes, other coursework, and relationships, but that's a choice I willingly made. While we do receive excellent hands-on training in practical skills (palpation, blood drawing, visual cervical examination, etc.), I don't think I feel fully equipped to serve as an apprentice without taking the advanced class, neonatal resuscitation, and so on, although I suspect that much of what would be expected of me as an apprentice would be acquired through on-the-job training. I suspect I'll feel better prepared after taking the advanced second year course, which I plan to do.

Do you think you will stick with this program until you complete your studies?: Yes, at least for this step along the way. I may choose to enroll in a MEAC program later on, depending on where I practice.

Would you recommend it to other midwifery students? Why/Why not?: I would recommend it to students who are curious about midwifery, especially to those already working as doulas. The classes have definitely improved my knowledge of the process of birth and tools that I can use during childbirth (mental and emotional as well as physical), and those have certainly made me a better doula. I would also recommend it to students who aren't interested in the CPM route, as it's affordable and provides the foundations for what an aspiring midwife would need to know before entering an apprenticeship. I truly appreciate that Beth has made it affordable; so many of the other programs out there are simply out of reach for so many, and Beth takes great effort to meet people where they are.

First Name: Anonymous

Length of time enrolled in program: Three-day program

Why you chose the program over others: I was referred to it by a colleague who had taken it as part of early midwifery studies. It sounded like an excellent opportunity to learn in a small environment with a seasoned homebirth midwife.

What you love about the program: The small group size; hands-on, comprehensive, learning started as soon as we arrived up until the minute we left; opportunity to build community.

What you find challenging about the program: Learning new skills such as checking vitals.

Do you think you will stick with this program until you complete your studies?: I took this program to help me become a better doula. I wanted to be able to understand the process of prenatal care better so that I could be a better resource for my clients as a doula and childbirth educator. I also wanted to determine if midwifery was something I should pursue. It helped my growth and I learned that I am better suited to work with moms in a way that supports midwifery care instead of providing it.

Would you recommend it to other midwifery students? Why/Why not?: I would recommend this course for aspiring midwives, those considering the field and other birth professionals. It's a great introduction and no matter what your ultimate decision you will come away more knowledgeable.

Why We Cannot Have Reproductive Justice Without Fighting Police Brutality

"Some problems we share as women, some we do not. You fear your children will grow up to join the patriarchy and testify against you, we fear our children will be dragged from a car and shot down in the street, and you will turn your backs upon the reasons they are dying."

Audre Lorde, "Age, Race, Class, and Sex," *Sister Outsider*

My younger brother is 16-years-old. He is six feet, four inches of gentle, timid, and awkward. He loves baseball and breakfast food, family and faith. He is quiet and complex, an introvert who often laughs with me about our frustrations with growing up in a small home with six people. But in our Orange County hometown, he is feared. A Black teen with a physical presence that far eclipses his white and East Asian peers, he bears the psychic toll of being seen as a walking threat before being seen as a boy. He knows the police are not on his side. He is right; every 28 hours a black person is killed extra-judicially by law enforcement or vigilantes. And that terrifies me.

My body freezes when I think about the possibility of his name joining the ranks of Trayvon Martin, Jordan Davis, Kimani Gray, Kendrec McDade, Ervin Jefferson, Victor Steen, and the countless other unarmed Black teens shot down by police in the prime of their youth. When I heard Sunday night that 18-year-old Michael Brown was shot dead by police in Ferguson, Missouri, my heart sank. My skin pulled tight around my hands, my stomach churned itself into knots. My mind raced, visions of my brothers' faces collaged into the painfully familiar sight of yet another innocent Black boy breathing — and bleeding — for the last time.

That kind of fear is immobilizing; it is unproductive and unending. It wakes you up at night, claws its way out of the pits of your stomach and into every memory of the precious child you love. It is a fear Black women know intimately, a fear that slips easily into our dreams because it is grounded in realities we want to turn away from during daylight hours.

A mess of anxious energy and terror, I took to Tumblr to share my deep panic about the debilitating prospect of ever feeling this disemboweling Black grief over my own child. Over 2,500 people shared my post. On both Tumblr and Twitter, Black women have expressed their constant fear that bringing another child into a world that seeks to exterminate them is "a fool's errand."

And yet, I do not hear this aspect of Black parenting — this wholly rational fear that babies will be snatched from our arms and this world before their own limbs are fully grown — addressed by white advocates in gender equality and reproductive justice. Is it not an assault on Black people's reproductive rights to brutally and systematically deny us the opportunity to raise children who will grow to adulthood, who can experience the world with childlike wonder? Is it not an assault on Black people's reproductive rights to tell us we give birth to future criminals and not innocent children, to murder one of us every 28 hours and leave a family in mourning?

Those victims are not just statistics; they are people, with bodies and families and future generations who will never see them smile again. They are children, mothers, fathers, aunts, uncles, sisters, brothers, and chosen family members. They are integral parts of communities that raise children. As RH Reality Check senior legal analyst Imani Gandy tweeted, we cannot ignore the truth that "police violence against black and brown people is a reproductive justice issue."

> Tumblr | 10 Aug 14 - How do you bring a black child into a world that plots their destruction before they leave the womb? how do you explain to a black child that their life is a crime, that they will be hated for existing? how do you weight your own love heavily enough to stand up to every force that tells a black child they are unlovable by definition? how do you bring a black child into this world?

Women of color bear a relationship to reproduction that is fraught with trauma and state control, a perpetual tightrope that stretches beyond the simple paradigm of "pro-choice" organizing. Police violence against our children is a continuation of the same culture that lynched pregnant Black women, that forcibly sterilized cisgender women of color well into 2010, that has required mandatory sterilization for trans people, that paints reproductive rights as an issue only affecting cisgender women. The unifying message is simple: Black bodies, trans bodies, disabled bodies are not worthy of defending. We do not need to continue existing, to further our legacies.

But our lives matter. We deserve to exist and to thrive. And those of us who fight alongside reproductive justice advocates deserve to have our children's fates be considered in our work, not simply paid lip service by pro-life campaigns more concerned with pathologizing Black motherhood than supporting Black children. We deserve to see coverage of Michael Brown in feminist outlets without fearing a parade of racist vitriol in the comments section from white women who turn around and beg us to stand in solidarity with them.

We deserve to have our co-strugglers in the fight for reproductive rights remember that our children are babies, too — and also fight against the police brutality that denies them a chance to see adulthood. Any force that systematically and unapologetically turns unconsenting Black wombs into graveyards is a reproductive justice issue. We deserve better.

Hannah Giorgis is a black feminist writer and organizer based in New York City. The daughter of two Ethiopian and Eritrean immigrants, she is a product of bittersweet diaspora and transnational resistance. You can follow her on Twitter @ethiopiennesays or on her website, ethiopienne.com. This post originally appeared in TheFrisky.com.

Community and Hope:
Reflections from a Weekend at Yonifest

Aboriginal grandmothers take care of festival babes in their traditional swing

Photos by Valerie Poul

A workshop inside the red t

"There were many moments during Yonifest where community midwives, unlegislated midwives and university-trained midwives held hands and expressed respect and love for each other. These moments give me hope that something else is possible and that we can move forward together."

When seven midwives and student midwives travelled to San Francisco last year for the first SQUATFest, they never dreamed that they would come back so transformed. Nor could they predict that the seeds planted there would grow into a wild and juicy project – **Yonifest 2014** – a radical birth festival in the Eastern Townships of Quebec Canada.

The festival was held outdoors by a river, which was the perfect setting to dive into the heart of the issues that were presented. Over 40 speakers came to share their ideas and research around birth. Amonst them were Kathleen Fahy, presenting on thirdstage physiology; Carla Hartley addressing how we can better trust birth; Trevor Macdonald, who shared on how birth workers can support trans people in pregnancy and birth; Katsi Cook, who led us through an exploration of ecogenetics; Sandra Demontigny speaking on using observation to reduce intervention; Ina May Gaskin, who spoke about sustaining midwifery in a changing world, and many, many more.

Aside from the speakers, the festival was also an opportunity to connect with other people who share a similar passion for birth. We put our heads together to see how collaboration can bring changes to our practices and to the ways that we view birth.

As I sit here and reflect on what **Yonifest 2014** was for me, two words come to mind: ***community*** and ***hope***.

We created a festival, and promoted it as a safe space in which we would encourage people to ask real questions (the ones which aren't often asked), about birth politics, about the future of birth and birth workers everywhere; about privilege, about wounds and healing and about the direction we'd like to take in order to protect that which we consider essential about birth – choices, reproductive freedom, body sovereignty and what birthing people tell us is important, to them and to their families.

Before this summer we were only a group of 15 organizers, hoping that through these convictions and a need to dig deeper, we would meet you – kindred spirits, seekers, those who also yearn for the magic of undisturbed birth, courageous and determined to "go there."

400 people showed up. From this point, a community was born.

So many questions were raised by the speakers and participants of the Fest:

- Which models of care best serve the needs of pregnant people?
- How can midwifery remain autonomous and sovereign?
- How can midwifery care remain accessible to everyone?
- In Canada, how can we preserve a PUBLIC health system, all the while retaining autonomy for midwives and birthing women?
- What can unassisted childbirth teach midwives?
- How can we work together to heal the wounds in our communities, to speak more honestly and to look at the fears that have been ingrained in our birth culture?

For me, these questions bring much hope. Although conscious of the work before us, I also witnessed an incredible willingness to examine these questions, and a true desire to come together as a community. Midwives need women to guide them, and midwives need to be able to count on each other for support. All midwives, regardless of their background, studies or path, need to be acknowledged and respected in what they do. There were many moments during **Yonifest** where community midwives, unlegislated midwives and university-trained midwives held hands and expressed respect and love for each other. These moments give me hope that something else is possible and that we can move forward together.

Where do we go from here? Many people have asked if there will be another **Yonifest** and our answer is ….***yes***! The seeds have been planted for a 2016 edition, but we'll need your help, to determine what issues are important to you and who you'd like to hear! Until then, our goal is simple - keep the dialogue going!

Sara-Michelle Bresee studied anthropology and women's studies before embarking on the adventure of becoming a midwife. She is a doula, yoga teacher and an activist. She is passionate about deepening human relationships and building community by seeking out the heart of compassion.

Mothering Yourself Through Miscarriage

By Falan Storm

The spotting. I knew it wasn't good, even with the attempted reassurance that it could be normal. This was my first miscarriage, following the journey of two ideal, planned pregnancies, births, and additions to our family. It was shocking, confusing, and accepted all at the same time.

Spotting again. A certainty flowed through me, as my body recognized this already traversed territory. My second miscarriage, following the journey of my third ideal pregnancy, birth, and addition to our family, was grief ridden, heart bruising, raw, and even beautiful in so many ways.

Miscarriage is like many other experiences in life, in the sense that when it is happening to you it feels like you are the only one. And worse than that, it can often feel like it's something that reveals that you may have fallen short. It's birth without a baby. Confusion and chaos of the heart. Hope reabsorbed. It seems to matter so little that miscarriages are way more common than we realize, because that common thread amongst women seems so thin when you are in the midst of your own miscarriage.

The experience of miscarriage is yours.

It is your loss and your story.

"It seems to matter so little that miscarriages are way more common than we realize, because that common thread amongst women seems so thin when you are in the midst of your own miscarriage."

It is handled and healed differently by each woman; yet, the following are 23 things I think can nurture most miscarried hearts:

You are enough. Period.

Miscarriage is birth and death at the same time. Sometimes it can be a birth and death of parts of yourself too.

Everyone will move on before you. You may feel like you are living under water while the world exists despite your pain.

Treat yourself as though you've just given birth. Because you have.

Welcome support. **Allow those who love you to help.**

There will be sadness and grief. There will be anger and disappointment. **It is all okay.**

You may want to judge your body. **Remember you are whole. You are beautiful.**

Trade the "why" or "how" for as much trust as you can muster.

Ask for help. With other children, with housekeeping, with meals.

Rest more than you think you need.

Share your story with someone you trust. Sharing heals.

Journal it all out. Release it as it comes. **Access the buried emotions.**

You are whole. Even when you feel like your body is broken.

Drink lots of tea. Hot cups of lemon balm. Red raspberry leaf infusions.

You may feel like you need to get over it faster than you are ready. Don't. **Take all the time you need.**

Give yourself what you need.

Write a love letter to yourself. Read it every morning when you wake and every night before you sleep.

Allow your body and heart to heal.

Enjoy warm, simple, and nourishing foods; ideally made by someone who loves you.

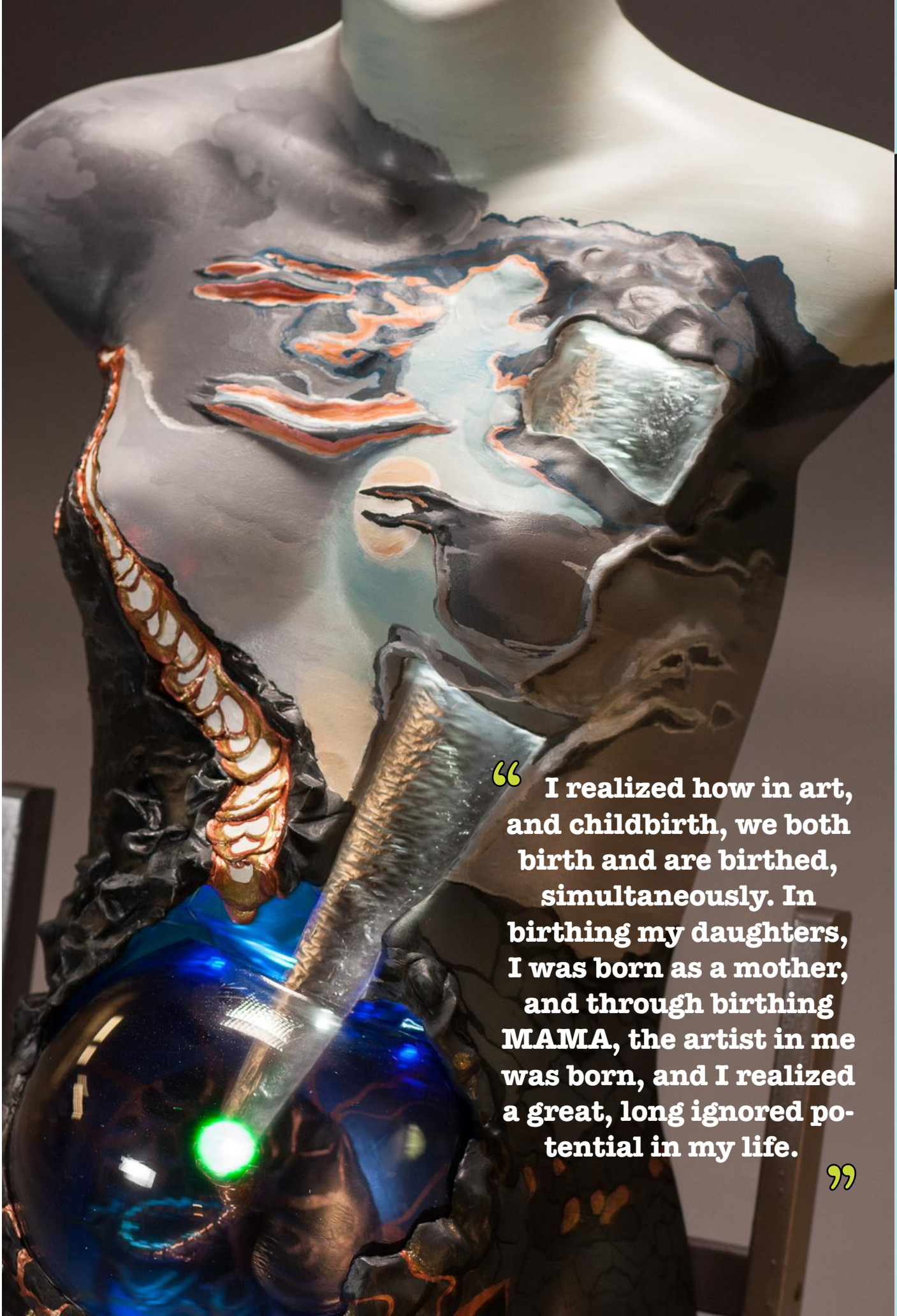
Cry your own river. Make it as long and as deep as it needs to be. Crying heals.

Take everything off your calendar and to-do list that is not absolutely essential.

Connect with spirit. The spirit of nature. The spirit of your baby. The spirit of yourself.

Give yourself all the time you need.

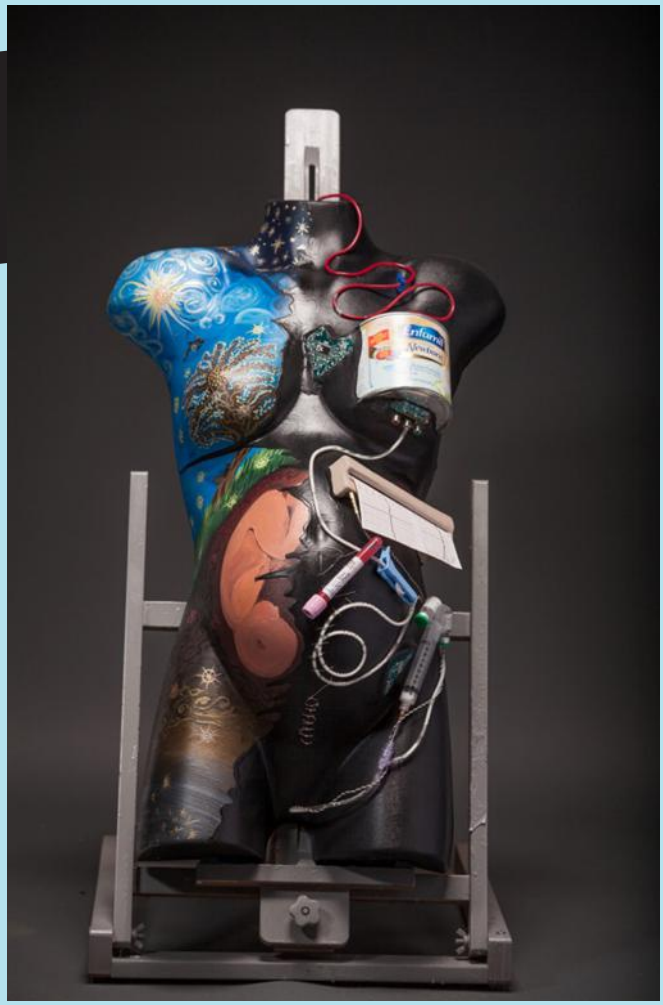
Falan Storm is a devoted Mama to three, a loving wife, and a writer who shares ways to live a meaningful, free, and feminine life at falanstorm.com. She is the creator of She Cycles (falanstorm.com/she-cycles), an E-course helping women to eliminate the inconvenience and illuminate the wisdom of their menstrual cycles. She can also be found on Instagram (followgram.me/falanstorm).



> I realized how in art, and childbirth, we both birth and are birthed, simultaneously. In birthing my daughters, I was born as a mother, and through birthing MAMA, the artist in me was born, and I realized a great, long ignored potential in my life.

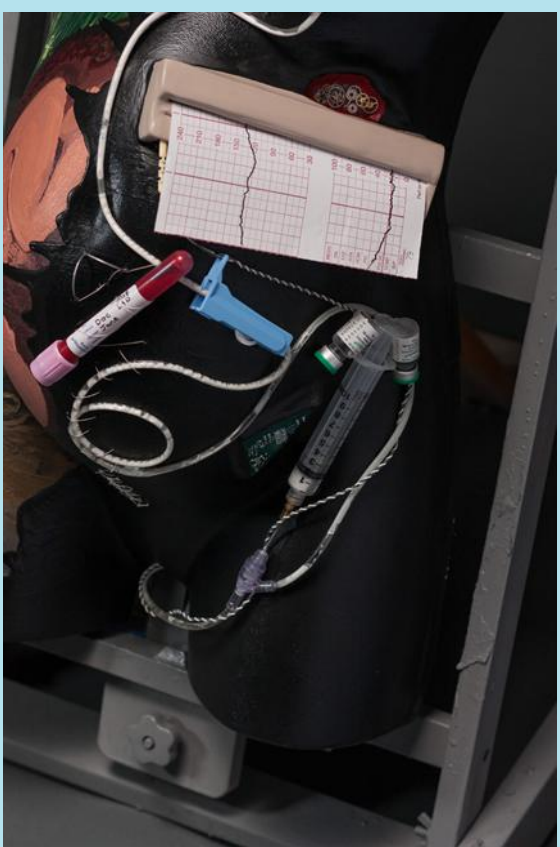
A Creative Approach

"MAMA" Mixed Media by Erin Zaffis



I was barely 17 when I got my first taste of the maternity care system in America. It was hard enough to be in the predicament I got myself into, and I felt all the same things an average mom-to-be feels: discomfort, insomnia, anxiety, stress, anticipation, worrying over whether I was ready and if I would know what to do. In addition was a sense of failure, shame, grave financial insecurity, and lost opportunity. It felt like wearing the scarlet letter; I sensed people looking at me with disgust and pity. Being naive, I thought doctors, nurses, and other medical personnel were among the people in society required to put their own biases and personal beliefs aside to provide a certain standard of care for their patients. They are professionals whose job is to care for you as kindly, safely and effectively as possible, right? Imagine my shock when I was treated way worse by the staff inside a hospital than I was by anyone on the outside.

I was looking forward to my birth. I was in awe of all women who had done it before; they were like superwomen to me, and soon it would be my turn to become a superwoman. I had taken a class offered by the hospital and had been reading all the material my doctor gave me. I felt prepared. I thought when I arrived at the hospital in labor, a nurse would help me through it, and maybe I would get something to calm me if I needed it, but I did not want an epidural. Unfortunately, when I arrived at the hospital I was immediately made to sit in a wheelchair, which I tried to refuse, as I felt better up on my feet. After enduring my wheelchair ride to the maternity floor, I was put in a bed and strapped to a fetal monitor and IV, which confined me to said bed, and...I was just left there. The only thing my nurse suggested (after she suggested that I "be quiet") was pain medication, and so eventually I ended up with the epidural, which I hadn't wanted. The entire experience ended up being way more scary and traumatic than the arduous but exciting rite of passage I had imagined it would be.



"When I finally landed a position on the maternity floor at the same hospital I was overjoyed. I couldn't wait to attend to women in this most vulnerable, exciting, and spiritual time in their lives. I was going to be their nurse in shining armor! Alas, I was very disappointed to find that the management and culture of a hospital maternity floor does not support this ideal."

Less than a year later, at the suggestion of my high school guidance counselor, I decided to apply to nursing school. I looked forward to becoming a maternity floor nurse; obviously they were in need of good ones. Nursing school was hard. My first year as a new grad on a Medical Oncology floor was harder. When I finally landed a position on the maternity floor at the same hospital I was overjoyed. I couldn't wait to attend to women in this most vulnerable, exciting, and spiritual time in their lives. I was going to be their nurse in shining armor! Alas, I was very disappointed to find that the management and culture of a hospital maternity floor does not support this ideal.

I did, however, notice a difference between the births I attended with midwives and the ones I assisted with the OBs. The midwives were more attentive to their patients — staying with

them, encouraging them, making suggestions for assuming different positions or other ways of coping besides drugs. They often used intermittent auscultation rather than strapping their patients down with the continuous monitor, they didn't hurry to break the bag of water or start pitocin and didn't even require moms to have an IV if they wanted to birth naturally. Their deliveries were more "no frills" and required less fuss and setting up of medical equipment, creating a more peaceful vibe and allowing me to stay at the patients side, focused on them and the amazing moment that was unfolding.

"Not only has MAMA been helpful for me in opening up dialogue on the issues of women's rights and autonomy in childbirth, but I feel the images are a striking tribute to the intimate experience of motherhood and the inherent creative potential of all women, whether they choose to become mothers or not."

I became pregnant with my second daughter only 6 months after I began my job on the maternity floor. I chose to receive care from the midwives I worked with, and deliver at the in-hospital, natural birthing center down the hall. My second birth, all natural, was the arduous yet exciting rite of passage I had imagined, and made me feel like a superwoman. I started reading all the books about natural birth and the maternity care system I could get my hands on. It was after reading the book Born in the USA by Marsden Wagner that I realized my experiences as both a patient and an L&D nurse in the hospital setting were not unique. Since my first birth I had an intuitive sense that there was something wrong with the system, something wrong with our culture's approach to childbirth, and now I had confirmation that those feelings were right. It became clear to me that the lack of childbirth options in this country and blatant disregard by OBs and hospitals of the evidence supporting minimal intervention birth practices is not only a health care issue, it is a women's rights issue.

I transferred from the maternity floor to a per-diem position in the birthing center where I delivered, which eventually became a full-time position that I enjoyed and felt immense purpose in for nine years. While I loved my job, and was proud of the care I was able to provide the birth center clients, I didn't feel I was making an impact on the bigger picture; the culture at large. I knew right down the hall, on the maternity floor, it was business as usual. The midwives I worked with often complained about the overuse of pitocin and cesarean sections by the OBs, and how they were taking their private patients away because of financial cutbacks.

I decided to enroll in a Master of Arts in Holistic Health program, in hopes a Master's degree might help me score a teaching job at a university. I thought that maybe I could make an impact by teaching the next generation of nurses the truth about childbirth. The program required me to attend one full weekend per month in which we learned about, and experienced, different alternative health modalities. After a weekend at the school exploring Expressive Arts Therapy, I was inspired to embark on a project that would end up serving as my Master's Thesis. I began with a simple, plastic maternity mannequin, which a friend of mine had acquired from a local maternity store that was going out of business. A year later I had 10 of them; all turned into multimedia sculptures, an exhibit I named MAMA.

MAMA began as a way of expressing my feelings about motherhood and our relationship to our mother earth, but it ended up embodying much more than that. As I worked tirelessly on the sculptures, preparing for my thesis presentation and a gallery show, I used my experience with birth as a metaphor to guide me through the creative process. I compared my work on the project in terms of the stages of labor: the making of sculptures 1-10 was the dilating process, and the efforts to promote and execute my show was the hard work of pushing. I realized how in art, and childbirth, we both birth and are birthed, simultaneously. In birthing my daughters, I was born as a mother, and through birthing MAMA, the artist in me was born, and I realized a great, long ignored potential in my life. In one year I went from a mother and nurse with no art training whatsoever (other than some classes I took in high school) to an artist with a gallery exhibit. Anything seemed possible. What is unknown can be known, what is dreamed can become

reality if we are willing to labor.

Birth is more than just having a baby, it is an opportunity for women to realize their strength, resilience and infinite potential — all things needed to endure the challenges of motherhood. Modern maternity care has dehumanized birth and has robbed women of this opportunity, convincing them they cannot birth on their own. It keeps women believing they are weak and powerless. As a culture we need to ask ourselves: Does it benefit humanity to keep half the population, the same half that are primarily rearing the entire population, weakened and oppressed? The problems with our maternity care system are far more destructive than what the current statistics on childbirth outcomes can express.

Not only has MAMA been helpful for me in opening up dialogue on the issues of women's rights and autonomy in childbirth, but I feel the images are a striking tribute to the intimate experience of motherhood and the inherent creative potential of all women, whether they choose to become mothers or not. I did not take a job as a nursing instructor; instead I continue to work part-time at a free-standing birth center and create art, taking opportunities to talk publicly about MAMA and my experiences as a birth nurse. I have found my approach to changing the culture surrounding childbirth, is to simply continue doing what birth taught me.

Erin Zaffis is a mother of 3, Registered Nurse, Birthing From Within Childbirth Mentor and artist. She has worked in childbirth for over 14 years in both the hospital and natural/free standing birth center settings. "MAMA", her 11 piece multimedia sculpture exhibit, continues to be available for display at colleges, birth centers and community centers and accompanied by Erin's lecture, "Birth as a Creative Process". For more information, and to view the MAMA exhibit, please visit mamamore.co/mama/ and erinzaffis.com.

Mandala Journey

Artwork by Amy Haderer

Sheela Na Gig, 2012

Alchemy, 2012

Rumina, 2014

Yemaya, 2010

The Balance of Three, 2011

Brief Yet Everlasting, 2011

Solstice Babe, 2011

This is Why, 2011

Amy Haderer lives in Denver, CO USA with her three beautiful daughters. She is a fine artist and doula who began making mandalas to prepare for the home birth of her third daughter, Seren. Creating these pieces helped her envision (and ultimately create) her ideal birth as well as meditate to prepare for labor. Since her daughter's arrival the mandala project has broadened to draw from other women's experiences of their births. Through her art she hopes to change the climate of birth from fear to empowerment and convey feminine energy.

Website: themandalajourney.com
Etsy Shop - jewelry, gifts, and more: etsy.com/shop/mandalajourneyamy
Facebook Page: facebook.com/mandalajourney
Email: mandala.mama3@gmail.com

Triskele, 2011

Stuff We Love: Social Media

For many of us, Social Media continues to be a way to stay connected with one another and learn about all the crazy, awesome, and cool things happening happening in our larger communities. Here are some of our favorite Facebook feeds, Twitter handles, and other social media folks to follow.

Black Women Do Breastfeed

If you love to see beautiful and inspiring photos of babies getting their fill of breastmilk, you've got to follow Black Women Do Breastfeed on Facebook. Started to support black women who breastfeed and create a virtual community for support, information, and visibility, the page now has 40,000 followers. Posts include proud photos from nursing mothers and questions from readers for the group,
www.facebook.com/pages/Black-Women-Do-Breastfeed

-Sarah Tarver-Wahlquist

A Mighty Girl

Are you a new parent or soon to be parent who is tired of all of the monochromatic pink + prince saves the day fluff that is often marketed towards girls? Don't fret! There is great media out there for your family too! A Mighty Girl has one of the largest, if not the largest databases of books, toys and movies for those who want to raise "smart, confident, and courageous girls". Their Facebook page is an active source for today's role models and events to pay attention to for your mighty girl. Along with the current news they share, they link to media in their database if you're interested in further exploration of a certain person or topic.
https://www.facebook.com/amightygirl/info
http://www.amightygirl.com/

-Willow Rosen

Offbeat Family

This is part of what's called the "Offbeat Empire" - it's a group of websites revelling in the funky. Offbeat Family is not currently publishing new stories, but they reshare those published from 2009-2013 on their Facebook page and new discussion is available. I love this page because it talks about things that are either stigmatized on other mainstream parenting boards - or just not talked about at all. There are cutesy "geeky" and "nerdy" postings, but a lot of it talks about how different types of families do what they do. Their moderators are on top of it and I have yet to see a troll take over a discussion. It remains a positive space to share and ask questions for those families that feel more on the fringe of the norm.
facebook.com/offbeatfamilies
offbeatfamilies.com/

-Willow Rosen

Founder of Black Women Do Breastfeed, Shlonda Brown Smith
Credit: Blue Sky photography

Black Girl Dangerous

I can't describe it any better, so let's let BGD do the talking: "Black Girl Dangerous is the brainchild of writer Mia McKenzie. What started out as a scream of anguish has evolved into a multi-faceted forum for expression. Black Girl Dangerous seeks to, in as many ways possible, amplify the voices, experiences and expressions of queer and trans* people of color. Black Girl Dangerous is a place where we can make our voices heard on the issues that interest us and affect us, where we can showcase our literary and artistic talents, where we can cry it out, and where we can explore and express our "dangerous" sides: our biggest, boldest, craziest, weirdest, wildest selves."

blackgirldangerous.org/

-Shannon Hanks-Mackey

Southerners on New Ground

This organization and its media feeds give me some good feelings about the social justice, reproductive health and LGBTQ movement in my adopted Southern home, and it's no wonder. The vision statement of the group, organizing across the South since 1993: "SONG is visionary, not reactionary. SONG organizes for hope, not in response to fear. We build, connect, and sustain a kind of organizing that is not limited by the boundaries of race, class, culture, gender and sexuality; an organizing that amplifies hopes and dreams of transformation to a better world. We organize to build the world we really want to live in."

Their focus on intersectionality is profound: "We envision a multi-issue southern justice movement that unites us across class, age, race, ability, gender, immigration status, and sexuality; a movement in which LGBTQ people – poor and working class, immigrant, people of color, rural – take our rightful place as leaders shaping our region's legacy and future." At the moment their major campaign is #QueerTransRelief for Undocumented Immigrants and the combination of online and in-person organizing around intersecting issues that matter can really make a difference for those of us in Alabama, North Carolina, South Carolina, Virginia and especially folks in Southern small towns who otherwise might feel alone.

facebook.com/ignitekindred
southernersonnewground.org/

-Gwendolyn Roberts

HEATHCARE PROFILE: Young Women United

by Sarah Tarver-Wahlquist

This summer, public buses drove through the streets of Albuquerque, New Mexico, wrapped in beautiful and eye-grabbing art, inspired by the words and stories of mothers and parents who face addiction and who are now speaking up to end the stigma surrounding this issue.

The campaign was organized by Young Women United (YWU), a community organizing project by and for young women of color in New Mexico. YWU has been on the forefront of social and reproductive justice for 15 years, launching successful organizing projects and policy initiatives that have made an impact on the lives of women and families throughout New Mexico.

YWU runs several programs and campaigns for young women of color (and they invite all those who identify as women, be they queer or trans*), including discussion and support circles on sexuality, leadership, and political change, and a collective of women offering pregnancy and breastfeeding support to women in their communities. YWU has also been involved in political campaigns to maintain access to safe abortions, protest institutional racism and police brutality, and support incarcerated women in their efforts to breastfeed their children.

But for all of the organizers of YWU, the issue of substance use has always been close to home.

"For generations, New Mexican families have been deeply impacted by addiction in the lives of people we love." says Denicia Cadena, Communications and Cultural Strategy Director at YWU. "We have known and carried this struggle for a long time."

YWU's initial strategy was a political one—to support legislation that called for treatment of addiction instead of incarceration. This effort meant emphasizing that addiction is a healthcare issue and not, as Cadena says it is often framed, as a "moral failure." The legislation passed through the state legislature; however, it was vetoed by New Mexico's governor. Realizing that the political climate in their state was not conducive to passing laws based in public health, YWU organizers decided to address the cultural stigmas that women, particularly pregnant women, face in regards to substance use.

"In our organizing, we center the expertise of those most impacted by an issue." says Cadena. "The women we organize with have been highly criminalized, moved in and out of the criminal justice system and stigmatized in both healthcare settings and in greater communities."

Over the last three years, YWU put together a series of working groups with women who had experienced substance use and pregnancy at the same time to explore the social stigmas they faced as well as their experiences pursuing and getting prenatal care.

Women shared that they often heard hurtful messages, like they must love doing drugs more than they love their own children, or that if they really loved their children they would stop using drugs.

"These kind of judgemental comments only serve to shame women struggling with addiction and do nothing to actually help their families." says Cadena. "When substance use in pregnancy is framed as a selfish and irresponsible act instead of a healthcare issue, families are pushed farther away from the resources they need to thrive."

Conversations with these families revealed that most did not look for prenatal care out of fear of losing their children, and that when they did seek out care it was late in their pregnancies.

Organizers at YWU have also reached out to a variety of care providers to take part in conversations about how to better serve pregnant women with a history of substance use. They have brought together midwives and doctors across the state to form collaborations to better serve families. YWU also holds a close working relationship with the University of New Mexico Milagro Clinic which provides quality prenatal care and treatment for women that are substance using and pregnant, including incarcerated pregnant women.

But while a handful of collaborative resources exist for these women, there is an overwhelming sense of fear.

"These women described being pregnant and using drugs as the worst experience of their lives," says Cadena. "They weren't scared of going to jail, they were terrified of losing their children, specifically their baby they were carrying, but other children as well."

Conversations with YWU's working groups resulted in their 2013 report, "Everyday Struggles, Everyday Strength," which documents the experiences of substance-using pregnant women. The group then went on to work more in depth with 12 women through a five-week art and organizing institute. Some of the work to emerge from this program was displayed in YWU's Campaign, "We are More Than Addiction," on Mother's Day 2014.

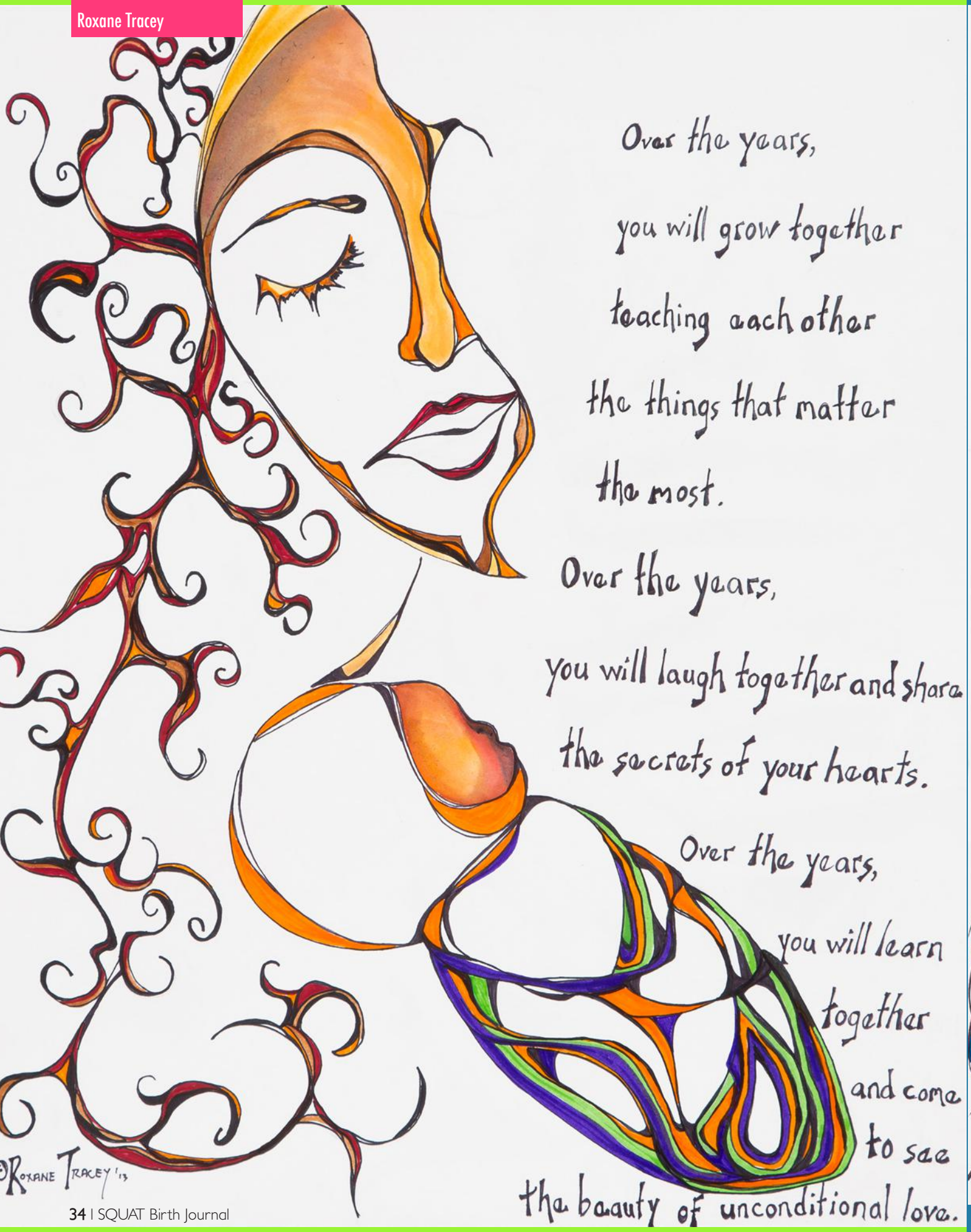
"Many of these women have known each other for years, but had never had conversations with each other about their pregnancies," says Cadena. Together they were able to create new and meaningful community out of shared lived experiences."

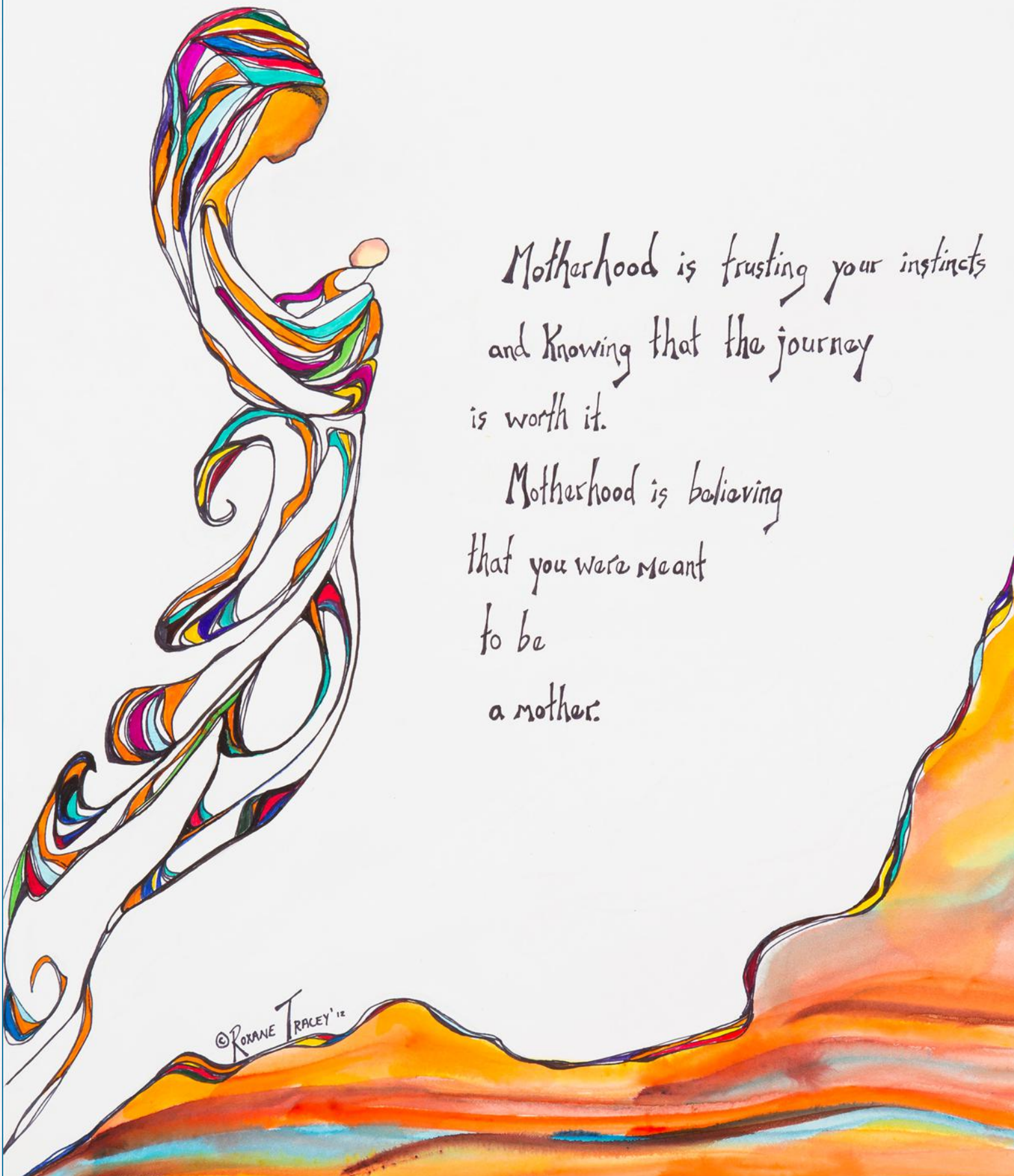
The launch of the "We Are More Than Addiction," campaign included public information campaigns in New Mexico and in social media, and the public display of artwork on city buses. There was also community art show and performance at the YWU offices, where participants' poetry, photography, and other visual art were displayed, and others engaged in pieces of performance art.

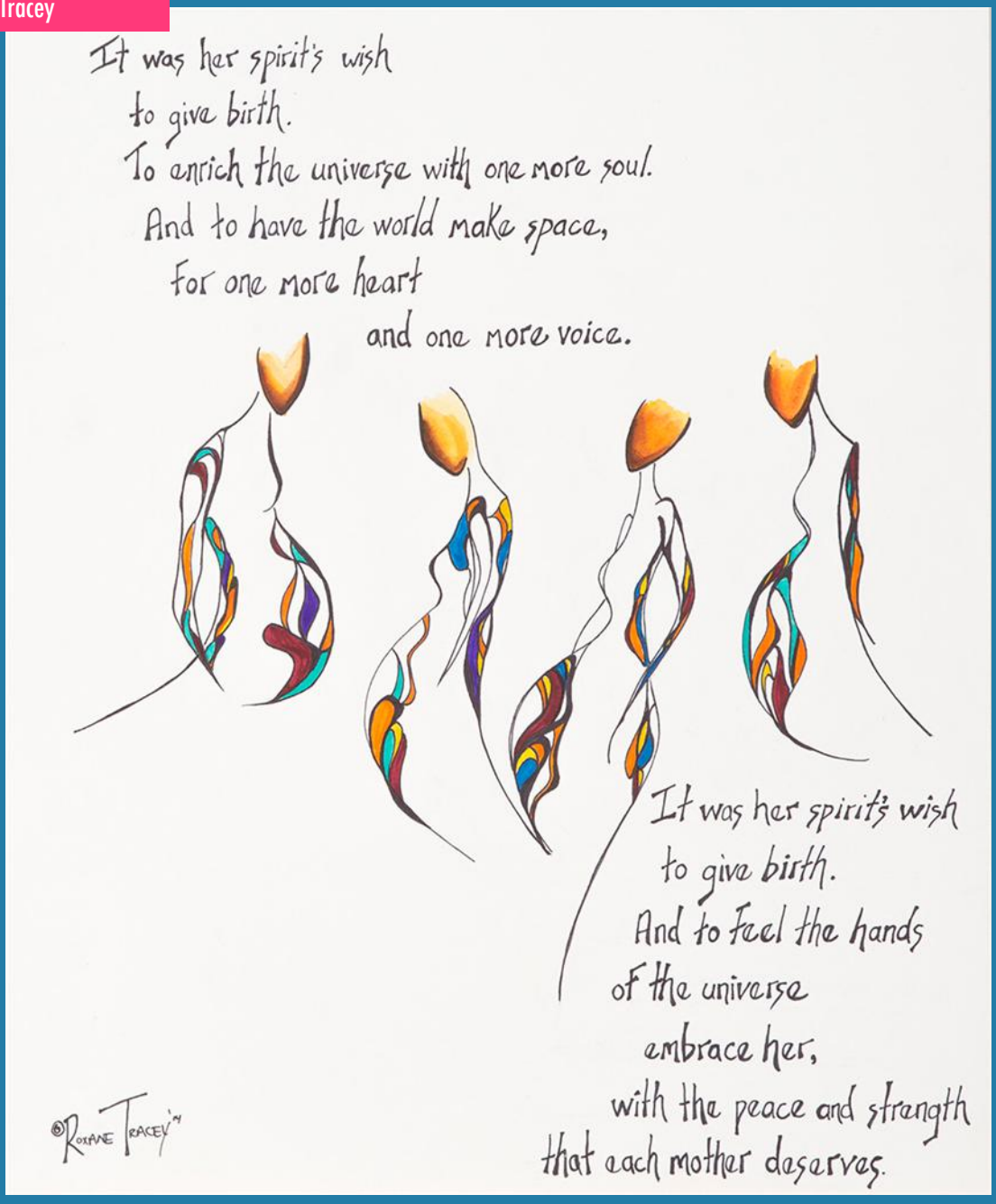
"Many people in attendance that night said the community art show had changed the way they thought about the issue," says Cadena," and for YWU the capacity to change people's hearts and minds is critical. We've had the honor and privilege of organizing with women and people who struggle with addiction through pregnancies and parenting. Together we are building a more just and loving New Mexico."

Read more about Young Women United, and download their reports on substance use and pregnancy, at youngwomenunited.org.

Sarah Tarver-Wahlquist is Managing Editor at SQUAT.


Over the years,
you will grow together
teaching each other
the things that matter
the most.
Over the years,
you will laugh together and share
the secrets of your hearts.
Over the years,
you will learn
together
and come
to see
the beauty of unconditional love.
©Roxane Tracey '13


Motherhood is trusting your instincts
and knowing that the journey
is worth it.
Motherhood is believing
that you were meant
to be
a mother.
©Roxane Tracey '12



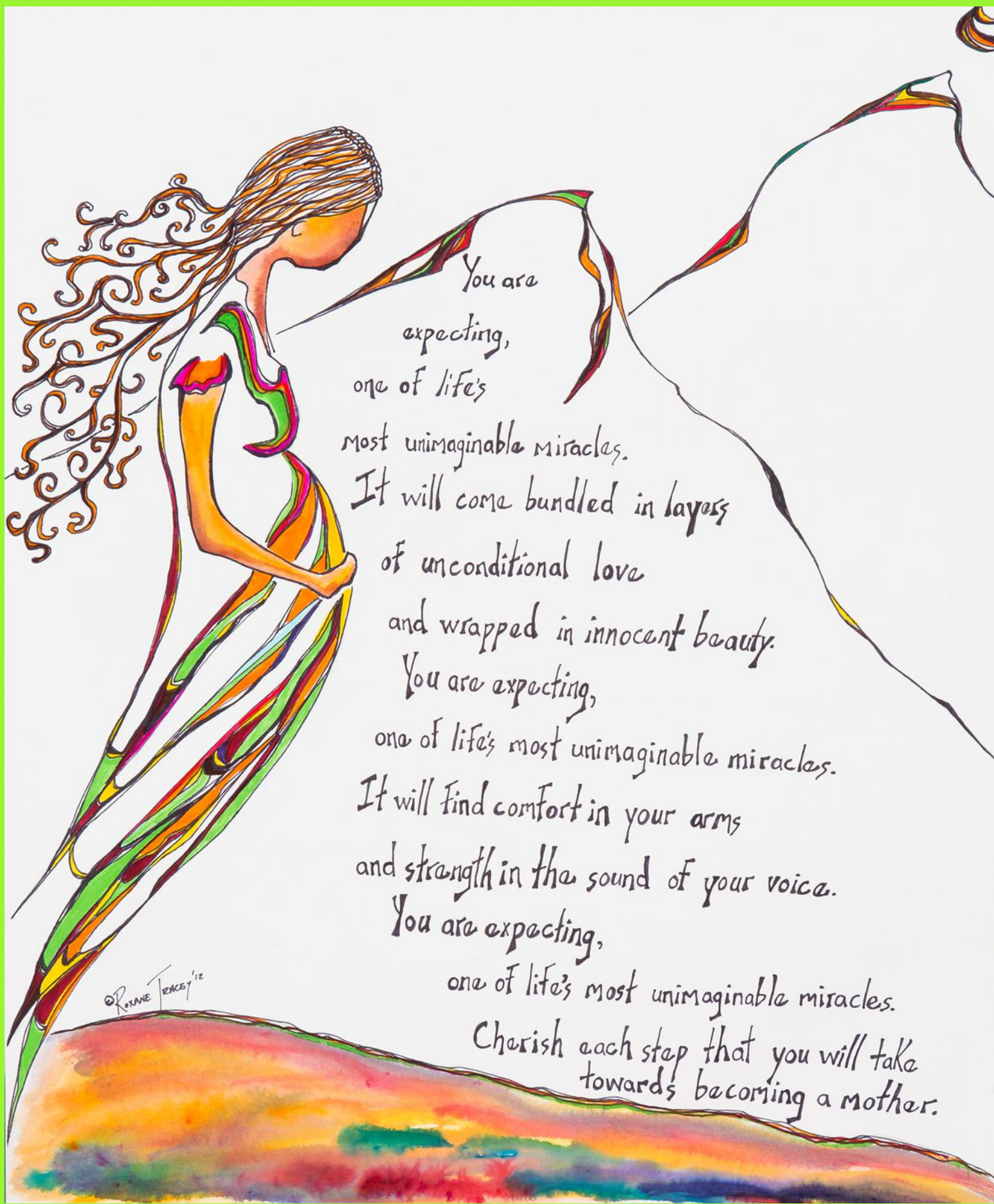
Roxane Tracey

Visual artist and poet Roxane A. Tracey is the owner of Poetic Art Studio located in Toronto. She has exhibited her artwork and engaged audiences throughout Canada and the US.

Roxane's work is currently reproduced as vibrant originals, prints, greeting cards, books and jackets. Her inspirational line of greeting cards and prints are currently distributed throughout the US and Canada and can be found in various gift stores, bookstores and other commercial outlets.

When Roxane is not creating she can be found facilitating art and poetry workshops for groups of youth and adults in local schools, community centres, and at her Studio.

poeticartgallery.com


You are
expecting,
one of life's
most unimaginable miracles.
It will come bundled in layers
of unconditional love
and wrapped in innocent beauty.
You are expecting,
one of life's most unimaginable miracles.
It will find comfort in your arms
and strength in the sound of your voice.
You are expecting,
one of life's most unimaginable miracles.
Cherish each step that you will take
towards becoming a mother.
©Roxane Tracey '12

Birthing a Midwife

Student Diary
by Tanya Smith-Johnson

Tanya, a student midwife in California, started sharing her diary with us in our last issue. She is currently a midwifery student doing the distance learning program through the Utah College of Midwives, and is also apprenticing the Community Birth Center in Los Angeles. Tanya is also a military veteran, military wife, and mom to four homeschooled kids. Each issue will feature excerpts from Tanya's diary as she travels through the journey of becoming a midwife. Tanya will begin a PhD program in the Fall at California Institute of Integral Studies in Human Sexuality with an emphasis in women's health, sexual and reproductive policy with the hopes of changing the trajectory of reproductive rights and birth justice on a larger scale. In the time encompassed in this set of entries, Tanya's husband returned home after a 6 month deployment that began a month before she started midwifery school and her apprenticeship.

Training and Putting it into Practice

I finally completed my CPR and neonatal resuscitation classes. I had scheduled them and cancelled three times already. Without fail there has been a birth every single time I was meant to go. But I am finally done. It was a lot of info. But I feel pretty confident that if need be I am ready and able to resuscitate a baby if I had to. Everyone in the class was from a hospital setting so lots of scenarios did not apply to me since I will not be at a hospital working if I need to resuscitate. The instructors were good about changing scenarios for me and they said they always love it when CPMs come to their class. They had lots of questions and threw in some curveballs, but I managed them pretty well and feel good. Hopefully I won't ever have to use it, but if I do I now feel prepared.

Three weeks later

OMG...I just had my first resuscitation. I kept saying that I needed to do the certification ASAP before the next birth I go to and sure enough the first birth I go to after completing the class I needed to put it into action — a real-life scenario just like the ones I went over and over in class. You never know what is going to happen in birth. And for me the moments right after baby is born are always the split second I kind of hold my breath — waiting, looking, assessing.

As soon as baby was out and I saw baby needs help and the midwife makes the call, I was on it. I felt prepared and ready. Of course, I was nervous, but I didn't realize until after the fact. In the moment, I was focused and recalling everything I just did weeks earlier. We had to work on baby for a few minutes and it was scary, but he was breathing, just not well. Everything turned out ok and he came around. But boy, once I got home and had a minute to process, my hands were shaking. But to hear the midwife say, "Great job in there!" made all the difference in the world.

Neonatal resuscitation test.

May 2014

I am constantly tweaking my schedule, my life. There is always fine tuning that even at my most meticulous and anal, still just isn't right. I feel like Goldilocks, "This course load is too light... oh no this course load is too heavy." I am still waiting on the "just right." There are only so many hours of the day. Any break I have, I am busting out some books and my iPad. But between being at the birth center, births, homeschooling, coursework, and everyday things like grocery shopping, meal preparation, and washing the ever-multiplying loads of laundry and the cloth diapers, I am struggling. I am still breastfeeding my toddler but that may soon have to come to an end because I am literally drained. Most days that

are light and I have a sitter, I will post up someplace outside of my house, like a coffee shop, because it is where I can get the most work done. When I am home with my kids, they get my undivided attention. I am away from them enough already, like I am working a full time job but without pay. Things are definitely much tighter around here. Thank goodness my husband is supportive, but he has even had moments where he gives me that look like, "This is crazy, what are you doing?"

Every minute I am away there is a cost. I have to have a nanny for the days I am away. I spend lots of money on gas since I commute three hours round trip to the birth center and most births I attend. I spend money on food since I have no time to cook like I used to. And it seems I am relieving my stress by eating.

I see why more women don't do this, especially women of color. How can this be sustainable? You have to have a partner bringing in good money to support you through school and the family while you are unable to work full time because if you have an apprenticeship and are trying to get it done in a timely manner you have to dedicate huge amounts of time. If you have children you need a sitter who can watch them any time of the day or night. You need reliable transportation and gas money. You have to pay tuition and books, and most midwifery schools don't have financial aid or scholarships so you are paying out of pocket. You may even need to move and uproot your family to find a school and/or apprenticeship.

So if you are the breadwinner and have to work to survive, how can you contemplate midwifery? This is a feat that requires lots of support. It is seemingly insurmountable. We need midwives who understand and empathize this struggle, who get it. Women of color need better prenatal care now. We need to see women who look like us. We need to be attended to by women who understand us. So when I am drowning, feeling like giving up, thinking about going back to my pretty comfy life as stay-at-home mom, I hold on to the faces, experiences, and journeys of the women who have come through The Community Birth Center's doors. They come from all walks of life, but they are all searching for the same thing. They come to be heard, nurtured, supported, cared for, and loved. When I see the gratitude, wipe away the blood, sweat, and tears, I am given strength. They have no idea that they help me on this journey just as much if not more than I have helped them on theirs.

Photo by Maggy Ehrig

June 2014

I can't believe I have had my first catch. OMG!!! What a feeling! It's hard to explain. In my mind I didn't think I'd be ready until much later. This is because the more I learn, the more aware I become of all the things I don't know. But I was poised and snapped into action. I wasn't scared or nervous like I thought I would be. Things happened too fast for that. But I had no idea at the time how fast things were going and of course I had no idea that today would be the day I would be pushed into the deep end, so to speak. Will I float and swim or panic and drown? I didn't freeze, stayed afloat. Thank goodness.

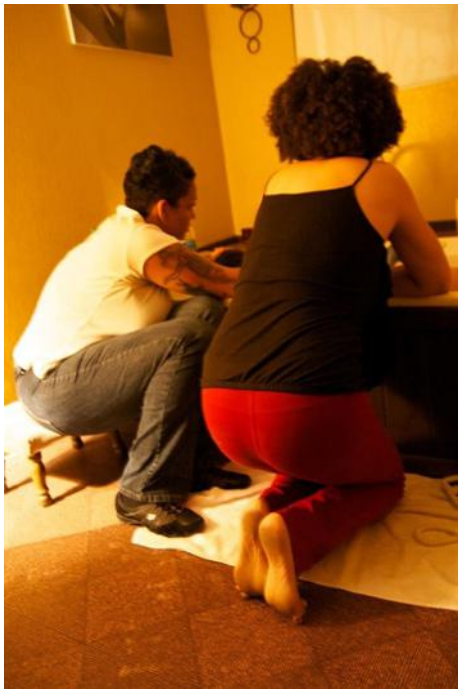
This became the moment I was handed the reins. A level of confidence was placed in me. I supported, monitored, reassured, and made decisions. Me!! My voice was the one speaking to a mother in a calm, confident, and reassuring voice. All the notecards, studying, and books weren't what came to mind. It was intuition, listening, and knowing. To think that at the same time she was listening to her body's inner knowing and voice, so was I. We were both giving birth, her to her baby and me to confidence and the realization that I am a midwife. Yes, I know I have more classes, coursework, tests, births, numbers and boxes to check before I will have those letters behind my name. I know I am a student and have a long way to go. But in that moment I was her midwife. And once mother and baby were all snuggled in bed, the midwife came to me and said, "Good job, student midwife, I knew you were ready. I am so proud!" with a huge smile on her face. I am proud of myself too.

"Women of color need better prenatal care now. We need to see women who look like us. We need to be attended to by women who understand us. So when I am drowning, feeling like giving up, thinking about going back to my pretty comfy life as stay-at-home mom, I hold on to the faces, experiences, and journeys of the women who have come through The Community Birth Center's doors."

Two weeks later...

I just had my second catch. This time labor was longer so I had more time to wrap my head around things. But what a beautiful waterbirth. This baby was born in its sac, or "in the caul." It is supposed to be a rare occurrence, so it was awesome to witness. I just sat there watching in disbelief. Everything was in slow motion it seemed, so you could see everything unfold. Since this was a slower labor I didn't know when or how soon I should get in there. Some midwives are more handsy than others. But my preceptor is perfectly comfortable letting labor and birth take its course, with hands off until needed. But for me as a student it is hard to know. I am still learning. But it feels good when you see a baby come out and look at her and know all is well.

Photo by Maggy Ehrig



July 2014

We just had our last birth center birth before we move to our new location. This was another beautiful waterbirth. This birth is not only a testament to the mother who was powerful and came into her own during this labor, but to the doula who attended her. I have seen many doulas, but none like this one. She has a strength and energy that is amazing. I think doulas are just wonderful and when there is one who truly holds space and can physically hold a mother up when she thinks she can no longer do it herself, it is truly something to behold. This stood out because I just completed doula training and learned so much. I didn't come into midwifery as a doula first like many midwives. It seems to be a natural progression for some. I came to midwifery as a former medical student, so I didn't have much knowledge of doulas until I had one in my own labor and birth of my fourth child. I just completed doula training with the wonderful Ana Paula Markel and it was life changing. It reaffirmed for me the idea of the triune of mother, midwife, and doula. It is a beautiful dynamic to behold, to be surrounded by women. After attending doula training at Bini Birth, I had a greater appreciation for all that doulas do. And after this birth, I know that doulas can make all the difference. I look forward to what's to come in the new and larger space, in a more central location. If my feeling is right, more women will have access to the birth of their dreams. We shall see!

Midwifery Internship Opportunity
Centro de Parto Natural, Guatemala

We have an amazing internship opportunity in Guatemala for graduate midwives. We are actively looking for interns from any country!

3-6 month paid internship for graduate midwives in Guatemala

We are accepting midwives with the following qualities:

- Graduate CPM or CNM
- Advanced Spanish skills
- Independent thinker
- Responsible, committed and flexible
- Women's health and rights activist
- Happy disposition

In your internship you will get to experience as primary care provider:

- Continuity of care
- Alternative approaches to women's health
- Natural birth in a supportive environment
- Wide range of women/couples
- Teaching
- Administration

You will get to assist an experienced midwife in:

- Routine and non-routine GYN care
- Water births and home births
- Family planning
- Use of alternative therapies
- Placentology

You will be supported in the following ways:

- Complete infrastructure
- One assistant
- 24/ 7 Telephone support
- Established medical back-up

Guatemala is a colorful, tropical country with Maya culture. Guatemala is full of travel destinations and fun weekend activities as well as lots of interesting people.

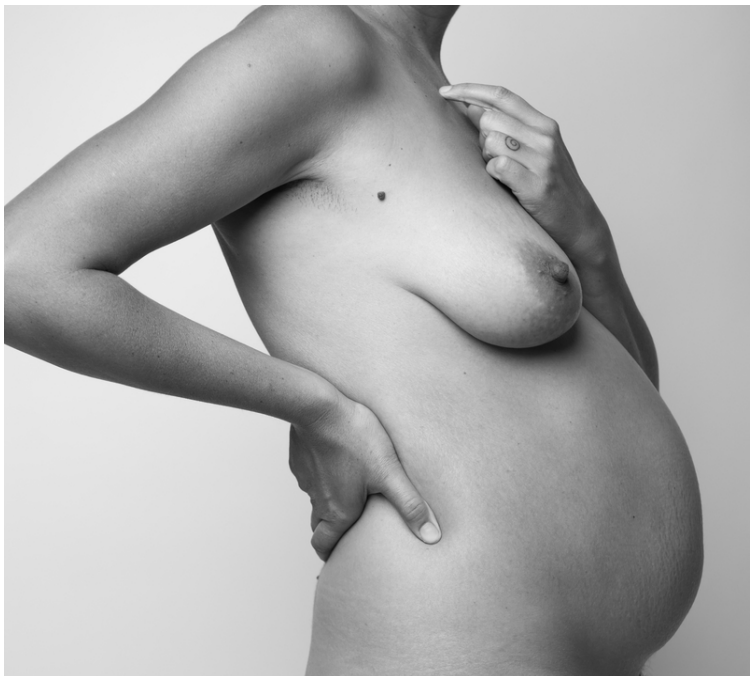
Please consider:

- Developing Country
- Irregular/ intense work schedule
- Cultural differences
- You will have to provide your own transportation
- Room at birth-center provided as accommodation
- You must have travel insurance

For more information on our birth center go to www.centro-departonatural.org and look us up on Facebook as 'Centro de Parto Natural'. For more information on the internship and to apply send us an email to dianiiz.freiwald@gmail.com introducing yourself.

Mothering Without Our Mothers

by Sarah Tarver-Wahlquist
Photography by Jade Beall



When I discovered I was pregnant with my third child, I went into a bit of a shock. I worried a lot. I worried about the age different between my other kids, who will be 5 and 7 when the baby comes; I worried about money; I worried that friends and family would think 3 kids was overboard; I worried about further delaying my re-entry in the workforce; I worried about how big our car was; I worried about how I would cultivate a winter garden; I worried about another round of stretching and birthing on my body. But all of these worries were a distraction -- at my core, I knew my real worry, my real pain. My mother died when my 2nd baby was 6 months old, which meant that I would have to go through this pregnancy and birth without her.

The thought of enduring a pregnancy, birth, and postpartum period without my own mother was so painful I lay awake at night wishing away the pregnancy. I did not wish for a miscarriage, but to travel back in time and prevent the conception, to stop this pain at its source. I sobbed by myself, thinking of the pep talks she would not give me, of the meals she would not cook for me, and the footrubs I would never get.

After a period of mourning I began to accept the pregnancy, to share in my family's excitement about it, to revel in my growing belly that was beginning to tell my secret to the world. We went on a vacation to a lake and I bought a bikini, embracing the belly and giving it room to grow. I was 13 weeks pregnant, finally feeling ready to be pregnant as my second trimester began.

That night I saw my mom in my dreams. I was grocery shopping and turned an aisle to see her there, smiling. She beckoned me over and said, "Don't forget this," then whispered something into my ear. I don't know what she said, and I woke with a deep yearning for her words, but also with the incredible comfort of having seen her face.

The next day as I sat on the dock and splashed my feet at the fish, I felt wetness beneath me and looked down to see myself sitting in a puddle of my own blood. My mother in law, who is a midwife, looked at the blood with a blanched face and called it "a considerable amount," and I assumed I was having a miscarriage. We drove 25 minutes to the nearest small town hospital, where an ultrasound showed, much to our surprise, that the fetus was viable and had a good heartbeat. I was actively bleeding in two places in my uterus, and was told that my chances of miscarrying were 50/50.

I'm not much of a mystical person, but I do believe I saw my mom in my dream the night before to prepare me for this day. To refill me with the sense of her presence, so I could hold it close to me as a trembled in a strange hospital bed wondering if my pregnancy was over.

I went back to our lake cabin and waited. Waited for the blood to start again, waited to lose the baby I had only just accepted. My pooching belly was no longer a round sign of a growing baby, but a constant reminder of a pregnancy in jeopardy. I tried an air of acceptance – I've known many friends who have miscarried, and my role editing a birth journal has brought me across many, many stories of pregnancy loss – but statistics mean nothing when you are waiting for it to happen to you. And I came to realize, for the first time, how much I wanted this pregnancy to make it, how much I wanted this baby to keep growing and stay with me. And when my son came up to my belly and said, "Hang in there, baby," I knew I could do it, if I had to, without my Mom.

We all need to be mothered, especially as we journey on the path of motherhood ourselves. We can only continue to nurture and love if our own vessels are being filled, if our own bodies and souls are being nourished. For some, that nourishment will come from our own mothers; for many of us, that nourishment will come from one another, from the village in which we find a home, from our partners and from our children. When my son places his hands on my belly and says, in awe, "Mom, you have two hearts beating in your body right now," I am filled. When my daughter falls asleep to the rhythm of baby kicks under her hand, I am filled. When I lean on my friends, when we laugh and cry together, we are nourished. We are mothered.

For more photos from Jade's Beautiful Body Project, visit **beautifulbodyproject.com**

Photo of Keira Langston,
@omg_ke on Instagram
Photos by Jori Thornes