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Michigan Birth Doula Training

Class Manual

by Patty Brennan

www.LifespanDoulas.com

This training is sponsored by:

The State of Michigan
Michigan Department of Health and Human Services (MDHHS)
Doula Initiative

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Birth Doula Workshop

June 21–23, 2024 (Friday–Sunday, 8:30am–5pm)
Includes a one-hour lunch break and two 15-minute breaks per day

Course Outline

Day 1: Doula Fundamentals
- Introductions
- Long-term impact of the birth experience
- Doula scope of practice
- What is trauma-informed care?
- Cultural humility, cultivating self-awareness
- Communication skills for doulas
- Ice exercise (pain coping)
- Professional boundaries

Day 2: The Role of the Birth Doula
- Hormones of labor
- Stages of labor overview
- Relaxation & breath awareness
- The doula's role in the first stage of labor
- Movement & positioning for labor & birth
- Doula certification
- U.P. Doula Networking—Visit from two birth doulas

Day 3: The Role of the Birth Doula (Continued)
- The doula's role prenatally
- Birth plans & promoting informed consent
- The doula's role in second & third stage of labor
- Immediate postpartum
- Support techniques for difficult & challenging births
- Hands-on comfort measures
- Cesarean birth & the doula's role
- The doula's role postpartum
- Creating a doula practice overview
- Closing

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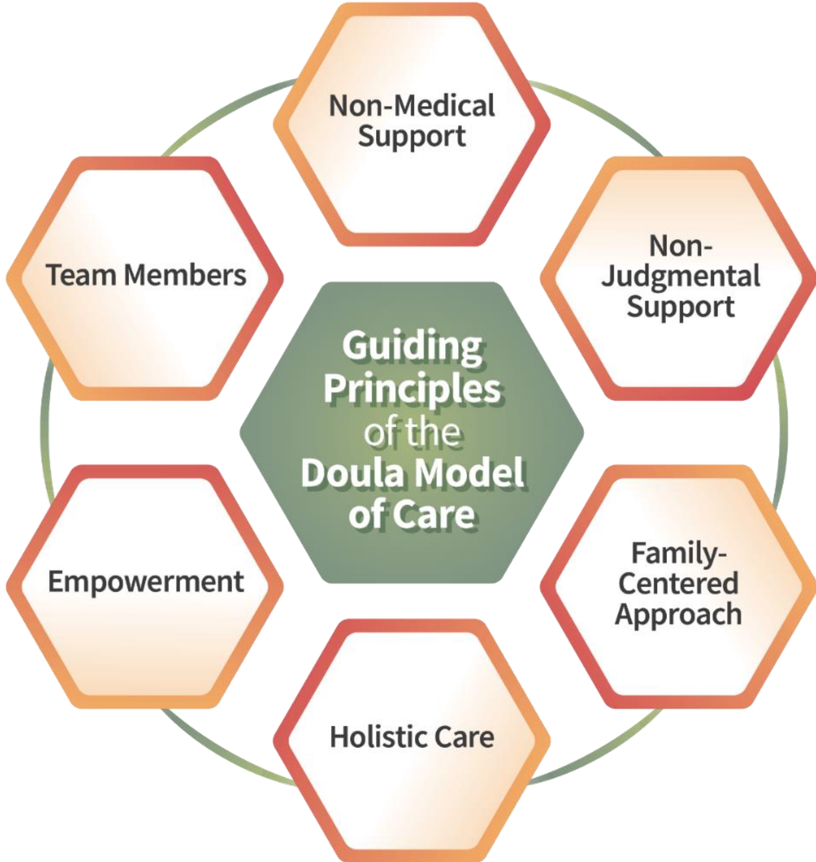
Doula Fundamentals



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What is Support?

Support is unconditional.

It is listening …
not judging, not telling your own story

It is not offering advice …
it is offering a tissue, a touch, a hug … caring.

We are here to help a woman discover what she is feeling …
not to make the feelings go away.

We are here to help a woman identify her options …
not to tell her which options to choose.

We are here to discuss steps with a woman …
not to take the steps for her.

We are here to help a woman discover her own strength …
not to rescue her and leave her still vulnerable.

We are here to help a woman discover she can help herself …
not to take that responsibility for her.

We are here to help a woman learn to choose …
not to make it unnecessary for her to make difficult choices.

Lifespan Doulas
Doula Scope of Practice

Standards of Practice

The Role of the Doula

- The essence of doula care is to provide non-medical, non-judgmental support and guidance to individuals and families through times of critical, transformative life change.
- Doulas nurture, inform, support, guide, empower and comfort.
- Doulas work in tandem with other caregivers and members of the medical or hospice teams.
- Doulas foster self-determination in their clients by assisting in the gathering of information and encouraging them to make informed choices that are right for them.
- For client needs outside of the doula's scope of practice, the doula makes referrals to appropriate professionals and community resources.
- Doula support is focused on, and adapted to, the unique needs and requirements of each person/family served.

Limitations to Practice

- As non-medical care providers, doulas do not perform clinical tasks (e.g., monitor vital signs, administer medication).
- The doula refrains from giving medical advice or from persuading clients to follow a specific course of action or treatment.
- The doula refrains from imposing his/her own values and beliefs on the client.
- Doulas do not undermine their clients' confidence in their caregiver(s). However, in cases where clients are initiating a discussion about a caregiver's advice or expressing dissatisfaction with a caregiver's practice or attitudes, the doula uses good listening skills to support clients to consider their options.
- Doulas do not usurp the role of other professionals and caregivers such as the doctor, midwife, lactation consultant or hospice team members.

Considerations Regarding Multi-Credentialed Doulas

- While understanding that doulas will draw from their full range of knowledge, skills and life experience, it is important to realize that offering enhanced or blended services may send a mixed message to the consumer regarding the role of the doula. The doula cannot, for example, be a non-clinical care provider and simultaneously "prescribe" an herbal regimen or assume responsibility for wound care.
- If a doula wears more than one professional hat and is seeking to leverage a blended skill set (e.g., nurse, social worker, pastor, herbalist, aromatherapist, massage therapist) while providing doula services, then she/he is obligated to make her/his additional roles and credentials transparent to the client.

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Continuing Education

- Doulas have a duty to maintain and update their knowledge in their chosen field. It is understood that professional doulas will engage in ongoing efforts (e.g., reading, podcasts, webinars, workshops, e-newsletters), from trusted sources, to ensure that they are always sharing the latest in evidence-based information with clients.

Code of Conduct

Ethical Duty to Clients

- In all professional interactions, the doula demonstrates the highest level of personal integrity by accurately representing her/his level of experience, training and credentials.
- Doulas should establish clear communication with clients, both verbally and in writing, regarding their availability, services included in their care, limitations to services, backup doula policies, and fees (including amount charged, retainers, terms of payment and refund policy).
- Non-abandonment. Doulas have a duty to complete services as promised, according to the terms of the agreement. If the doula is unable to complete services to a family (through personal choice, emergent need or unavoidable conflict), then she/he is obligated to: (1) give the family as much notice as possible; (2) help the family get their needs met by activating backup doula support in accordance with her/his stated backup doula policy; and (3) if backup support is unavailable, the doula should refund all client fees paid in advance for services not rendered. Volunteer doulas who agree to provide services for no cost or reduced cost have no less a duty to complete services to the client, as agreed.

Duty to Maintain Client Confidentiality

- While doulas do not fall under HIPAA mandates, they nevertheless should behave as though they are HIPAA-mandated to protect the confidentiality of their clients' private medical information.
- Doulas promise to maintain absolute confidentiality regarding the client's personal information, photos and story. If seeking to share client-related information for any purpose, including publishing photographs, or to share the client's story, the doula must obtain the client's permission and then abide by their wishes.
- The doula's promise of confidentiality also extends to family members and to other care providers involved in the client's care.
- When given permission to share personal information, all identifying demographic information should be omitted, unless the client has given express permission to be identified.
- Special care must be taken in the use of social media to protect client confidentiality.

Duty to the Doula Profession

- Each doula represents the doula profession and carries the duty to do so in a responsible, ethical, and professional manner.

- Doulas understand that they are part of a worldwide community of doulas and will treat one another with respect and kindness, regardless of affiliation.

Doula Scope of Practice Discussion Groups

Group A. Self-Determination & Client Empowerment

1. Discuss the difference between “advice” and “information” in relation to the doula’s role.
2. Identify doula actions/attitudes that do not foster self-determination but rather encourage dependency on the doula.
3. If the client asks the doula — “What would you do if you were me?” — what do you think are her motives for asking that question?
4. What can doulas say in place of saying, “I think you should …”? Brainstorm doula strategies for fostering self-determination (not giving advice or encouraging dependency on you for her decisions).

Group B. Client Confidentiality

This is the most frequently violated tenet of the Code of Ethics in my experience. Doulas are not HIPAA mandated because we are not medical care providers. However, since we are privy to private health information, we should behave as though we are HIPAA mandated.

1. List information, in addition to their name, that might reveal the identity of a client.
2. Explain precautions doulas should take online to protect client confidentiality.
3. What are some safe ways to seek support from sister doulas (e.g., process a challenging birth, problem-solve a client issue, vent, or identify needed resources) without violating client confidentiality?

Group C. Professionalism and Trustworthiness

1. List factors that could challenge or prevent doulas from reliably completing services to a client (consider both valid reasons and lame excuses).
2. Discuss how you might integrate a back-up doula (or two) into your doula practice.
3. Under what circumstances should you activate your back-up doula?
4. How much of the birth fee do you think is fair to pay your back-up doula?

Group D. Refund Policies for Doulas

Birth doulas generally charge one fee for a package of services that includes from 1–3 prenatal visits, on-call labor and birth support (2 weeks before and 2 weeks after the anticipated due date), and a minimum of one postpartum visit. I recommend that the doula collect half her fee when first hired as a “non-refundable deposit” to save space in her schedule, with the balance due at the last prenatal visit (before the “on-call” period starts).

1. Under what circumstances should a doula refund the client’s fee or a portion of the fee?
2. What about a missed birth?
3. What if the baby dies?
4. What if the client hired the doula to help her achieve a VBAC and she ended up with a cesarean?

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Group E. Advocacy or Mediation?

Both advocacy and mediation presume an adversarial situation is underway. The advocate doula speaks for the client. The mediator doula facilitates communication between parties.

Advocacy	Mediation
the act of pleading for, supporting, or recommending; active espousal	to settle disputes, or bring about an agreement, as an intermediary between parties, by means of compromise, reconciliation, removal of misunderstanding

1. Which is more appropriate to the doula's role—advocacy or mediation?
2. Brainstorm empowerment strategies doulas can use with clients to help them become their own best advocates.
3. What if mediation fails? Can you think of situations where stepping into the advocate role may be appropriate for doulas?

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Overview of Community Resources

Benefits of Compiling Community Resources

Doulas are generalists, not specialists (though they may have some areas of specialty). Becoming incredibly resourceful is central to becoming a good doula because you can't be all things to all people. Many families are simply too overwhelmed and stretched too thin to do the research on their own when help is needed. Compiling an up-to-date, vetted list of community resources will help doulas:

- ✓ Become knowledgeable about available services in your community.
- ✓ Have resources on hand for families and move more efficiently to resolve urgent needs.
- ✓ Stay within their scope of practice when faced with requests that are outside the doula's scope of practice. This demonstrates that you have anticipated needs that may arise and are ready to help them marshal needed resources.
- ✓ Maintain your boundaries with clients. You don't have to personally meet every identified need, but you can help clients get their needs met elsewhere. Having good resources on hand will help you avoid the temptation to become a "rescuer" and failing to honor your own boundaries.

How to Use the Worksheet

The accompanying worksheet contains a suggested list of potential services that individuals and families in your care might need. Feel free to add your own categories. You can include helpful/favorite websites as well. Whenever possible, include more than one potential referral source in each category. If that is not possible (e.g., your area doesn't have two acupuncturists), just do the best you can. Two to three choices in each category will empower your clients to make the choices that are right for them. One lone entry is more of an endorsement ("Use this person or agency") and therefore carries a bit more liability for the doula in the instance that a client acts on your referral and is not satisfied with the results. Your community resources list should always be a work in progress. Keep adding to it and updating over time.

Sharing Resources with Families

- ✓ Keep in mind that more is not necessarily better when someone is feeling overwhelmed. They need help and they need it now. So, while some choice is good, turning over your entire set of community resources to a family member to sift through is not recommended. Be more strategic.

- ✓ Look for that individual among family/friends who needs a bit more guidance regarding how to be helpful. Some folks are comfortable with direct “in the trenches” support while others may not be, but nevertheless be grateful to be given an errand to run or the chance to set up a Meal Train. Doing web searches and phone calls, vetting different service providers, agencies, etc., is also a way that a loved one who can’t be there in person can provide support.

Doula Business Tips

- ✓ Whenever possible, visit or reach out to the agencies, nonprofits, and service providers on your list. Learn as much as you can about who they serve and what they offer.

- ✓ It is not realistic to expect that you will know everyone on your list when you are just starting out. Over time, if you continue to engage this work and network with other doulas, you will develop a sense of the providers who are providing great value and the ones who may need to be removed from your list.

- ✓ Remember that generating good word of mouth about your services is all about providing great service and building relationships.

- ✓ Any business owner/practitioner to whom you might make a referral is also someone who is likely in a position to refer to you. Cultivate these reciprocal relationships, one at a time. Eventually, you will have your network.

- ✓ For service providers whom you trust in your area, see if they would be interested in swapping website links or sharing a particularly helpful blog you have written (with a link back to your site). This will help with your Search Engine Optimization (SEO) as the search engines like both outgoing and incoming links on your site.

- ✓ You may want to publish some resources on your website. These might include trusted local providers and/or your favorite online resources. A helpful webpage like this provides value to your clients and other visitors to your site. It gives them a reason to come back. However, you may want to include a disclaimer on directories or referral lists. For example, I publish a doula directory on my website. My disclaimer reads as follows:

  > *All service providers listed are independent from Lifespan Doulas, LLC and have paid to be listed in this directory. Inclusion of a practitioner or service on this list is not an endorsement of any one individual by Lifespan Doulas, LLC. Users are encouraged to investigate service providers by checking references and credentials.*

- ✓ An attorney I consulted advised caution in the use of referrals stating that people have been sued for referrals that resulted in a poor outcome. His recommended protection

involved listing at least three options in each referral category. While this strategy may not always be possible, it is a good general principle to keep in mind. At the same time, we want to focus on quality resources over quantity—just another one of those areas requiring the doula to take a balanced, thoughtful approach.

What is the doula's responsibility when making referrals?

- ✓ Keep resources up to date. Check in once per year to confirm they are still in business and whether they have anything new or different to share (again, building relationships here). If your resources are published, check your links from time to time.

- ✓ If clients are acting on referrals, follow up with them and see whether they got the help they needed. Ask for feedback.

- ✓ If the feedback is negative, don't assume the care provider is at fault. Some people are just difficult, and your client may be one of them. It's always good to hear both sides of the story before jumping to conclusions. On the other hand, multiple negative reports about the same service provider indicate a problem. In this case, I would remove that provider from my list.

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Community Resources Worksheet

Birthing Centers

Community-based

Hospital-based

Breastfeeding

Consultants/counselors

Support groups (La Leche League)

Products (pumps, including double electric hospital-grade breast pumps)

Classes

Breastfeeding

Childbirth Preparation

CPR (infant, child, adult)

Infant Massage

Newborn & Infant Care

Parenting

Pre-Postnatal Exercise/Yoga

Sibling Preparation

Community & Social Services

Abused women shelters & support groups

Addiction services & support groups

Child abuse/neglect protection agencies

Early intervention programs for babies with special needs

Public Health Department / Maternal-Infant Health programs

WIC (Women, Infants & Children) / food coupons for low-income pregnant women; lactation counselors

Complementary Therapies

Acupuncturists/Traditional Chinese Medicine practitioners

Aromatherapists

Chiropractors

Flower essence practitioners

Herbalists

Health Food Stores

Homeopaths

Massage therapists/body workers

Naturopaths

Osteopaths (neuro-muscular medicine)

Doulas

Birth doulas

Postpartum doulas

Doula agencies

Healthcare Providers

Clinics

Family practice doctors

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Midwives (CNMs and homebirth midwives)

OB/GYNs

Pediatricians

Household Help

CareFlash website, Meal Train, etc.

Childcare, nanny agencies

House cleaning services

Pet care (e.g., dog walkers)

Mental Health

Counselors/therapists

Grief/bereavement counselors/coaches

Perinatal Loss Support Groups

Perinatal Mood Disorders support groups

Support Groups

Mothers of Multiples

Mother-baby groups

Teen parents

VBAC

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How to Make a Referral for Mental Health Services

Adapted from an article by Melisa Schuster, MSW [MelisaSchuster.com]

Some of our clients/family members might benefit from mental health services. During pregnancy and postpartum, relationships can become very strained. Some new moms in the doula's care may be suffering from a postpartum mood disorder. And end-of-life doulas will routinely be supporting families facing the loss of a loved one. While not all people who are bereaved require mental health services, there are some who are not okay and need expert help. It can feel tricky to make these types of referrals. What are some signs that a person might benefit from a mental health referral?

Is a Mental Health Referral Appropriate?

- Repetitive story telling; there is no change in detail, focus or affect.
- Recall of an event (e.g., loss, previous birth experience, sexual assault) as if it were yesterday or with intense affect.
- Fear and anxiety that are high and/or unchanging.
- Ambivalence, confusion, or indecision that are intense or persistent.
- Lots of anger and blaming of others.
- Person is shut down with a blunt affect.
- Depression with a decrease in the ability for self-care, trouble fulfilling roles, feelings of hopelessness.
- Unrelenting guilt or shame.
- Failure of a plan for improving mood or functioning.
- Absence of support or little support in her/his everyday life.
- Multiple overwhelming problems, losses, etc.

How to Make a Referral for Mental Health Services

- Reflect what you see happening in the person's life. ("I've noticed that we talk about the same thing each appointment and things don't seem to be getting better for you." Or "You seem to be overwhelmed by many challenges right now.")
- Share how you are feeling. ("I can really feel how much pain you are in and I'm not sure how to help." Or "I'm really worried about you.")
- Relate your own experience, if true. ("When I had a similar problem, it really helped me to talk it out with someone objective.")

How to Frame Your Questions and Concern

- "Have you ever *consulted with*/considered *consulting with* a counselor or therapist?"
- "The healthiest person in the family is the one who seeks help."
- "It doesn't mean you're crazy."
- "Sometimes, we need an objective person to bounce ideas off, someone who isn't invested in the outcome or the decisions we make."

- "Why suffer longer than you have to?"
- "This problem usually doesn't get better without professional help" (e.g., substance abuse, family violence, posttraumatic stress disorder, complicated grief with intense emotions lasting longer than a year, postpartum depression).
- Use the analogy of a broken leg; it wouldn't be a sign of weakness to see a doctor (but minimize allusions to "illness").

If the Person is Reluctant to See a Counselor …

- Help her/him to establish a plan to determine when asking for help would be appropriate. How will she/he know when things are better ("I will feel better, like getting out of bed every morning.")?
- Set a time limit (two to six weeks, depending on the severity of the problem; postpartum depression lasting beyond eight weeks is cause for a referral).
- What is her/his plan for improving the situation? ("I will take a 30-minute walk every day." "I'll ask my mother to come over once a week for two hours so I can have some time to myself." "I'll ask for help when I need it.")
- Make an agreement that, if at the end of the predetermined time limit, the feelings or situation has not improved, the person will contact a therapist, doctor, etc.
- Work with partners or other family members to overcome reluctance to seek help so that they are not the barrier to the person seeking help. ("Would it help if I talked with your partner?")
- Have a source of referrals handy. ("I know someone good. Would you like me to introduce you?")
- Remember that sometimes people who need help withdraw from others. Don't let this stop you from following up. ("I'm just calling to see how you are doing.")

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The Doula as Educator

In the Doula Model of Care, every doula is an educator. We assist our clients to understand the process they are engaging in, help them to anticipate what may be happening next, identify questions for their medical care providers, share resources and support informed decision making. The education process can be overt, such as explaining how to judge progress in labor. Or the doula can share instructional videos on a wide range of topics (e.g., how to babywear, breastfeeding twins). Or, our approach may be subtler, such as simply modeling for a fearful dad how to hold a newborn. See the list below of key areas where families may need education.

- Role of the birth and postpartum doula
- Nutrition during pregnancy
- Prenatal/postnatal exercise
- Relaxation techniques for labor
- Optimal fetal positioning prior to labor
- Benefits, risks, and alternatives to medical interventions in labor
- The process of labor and birth
- Non-medical approaches to pain coping in labor
- How partners can support moms in labor
- Breastfeeding basics
- The value of skin-to-skin contact for newborns, Kangaroo care
- Healing the new mother, changing body, bleeding, comfort measures
- Visitor management, boundaries with friends and family
- Necessities / products
- Pet preparation & safety
- Parenting trends
- Household safety, baby proofing
- Adaptations for multiples (e.g., equipment, reconfiguring household)
- Newborn characteristics and behaviors
- Infant care (bathing, diapering, dressing baby, feeding, burping)
- Soothing, baby calming techniques, swaddling (how to, benefits)
- All things sleep-related
- Tummy time
- Return of fertility, contraception
- Babywearing (benefits, safety, how to)
- Postpartum adjustment, coping skills, self-care strategies
- Sibling preparation and adjustment
- Car seat safety
- Vaccines and informed choice
- Circumcision
- “Baby blues” and postpartum mood disorders

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Doulas Provide Evidence-Based Information
Consider the difference between information and advice.

Information	Advice
✓ Evidence-based, factual, up to date ✓ Unbiased ✓ Neutral in terms of choices; lays out different options ✓ Implies trust that people will make the choices that are right for them ✓ Always okay; within the doula scope of practice	✓ Opinion; may or may not be accurate ✓ Imposes own values and preferences on others ✓ Promotes a specific course of action ✓ Often uses the words "you should" ✓ To be avoided; outside the doula scope of practice

Learning Styles and Teaching Methods
We all have different styles of learning. In our role as educator, we might be tempted to be overly reliant on using our own preferred method. For example, I am a writer. That means I am a note taker. I need to write it down and see the written words. Then, I am much more likely to remember the information (even if I never refer to those notes). I could easily fall into the trap of assuming that if something is clearly spelled out on my website, all my site visitors will "get it." I have learned that they will not. Some of them will need to pick up the phone and call me, or engage in some other way, because they need to hear the information, process it, and have it confirmed. Doulas meet people where they are to be effective guides.

Percentage of Information Recall Based on Teaching Method Employed

Make your best guess matching up the teaching methods with the correct recall percentage and then check your answers using the Answer Key on the following page.

Teaching Method	Information Recall Percentage
Remembered from discussion	5%
Remembered from audio/visual	10%
Remembered from lecture	20%
Remembered from teaching others	50%
Remembered from reading	75%
Remembered when practice by doing	90%

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Answer Key
Adult learning research has discovered that the percentage of information recall based upon teaching method used is as follows: lecture 5%, reading 10%, audio/visual 20%, discussion 50%, practice by doing 75%, and teaching others 90%.

Methods
Make a conscious effort to pay attention to your clients' learning styles and how they respond to any efforts on your part to share information, and then adapt as needed. A variety of methods for sharing information/teaching can be used:

- Verbal information sharing, explanations, and reminders
- Online videos
- Written resources such as a hospice brochure or favorite website
- Demonstrating a skill, counterdemonstration, and feedback
- Modeling, showing by example
- Repetition

There is a "right" time for putting on our educator's hat. Let's not be that bull who just barges in and throws its weight around in a fragile environment. We need to be interested in the person/people we are attending. Meet them where they are and support their process. Cultivate an attitude of openness and curiosity and take your time to develop rapport and trust. It is not time to share information with clients until you have:

1. Explored what they already know and understand about their situation ("Tell me your understanding of …") and
2. Gained their permission to share ("Would you like more information about …?").

Resourcefulness is Key
One measure of our effectiveness as doulas is our resourcefulness. We do not need to know the answer to every question, but we do need to know how to help our clients get the answers they need. It is perfectly fine to say "I don't know" if, indeed, that is the case. However, it is not okay for "I don't know" to be your final answer to the question at hand. Rather, embrace this opportunity to expand your knowledge, to become more resourceful, and then share what you have learned. I guarantee this well-earned knowledge will then become a solid asset for your future clients (since 90% of learners—including you—remember best from teaching others).

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Communication Skills for Doulas

Communication = Conveying or sharing of ideas and feelings

Doulas are good communicators.

This means that we encourage and enable others to share through our attitudes, body language, behavior, and responses. There is no one perfect formula for successful communication. And, in fact, the more formulaic your approach (e.g., rigid adherence to "reflective listening" skills), the more likely you are to shut down communication. No one likes to feel that someone is using a "technique" on them. And a lack of authenticity on the doula's part will undermine trust, thereby limiting open sharing on the part of the client.

When we are acquiring new skills, we can feel a little clumsy and self-conscious. With practice, skills become integrated and more subtle. Keep in mind that you can begin by using the one or two techniques that feel natural to you, gradually adding more tools as you go. The whole point is to enhance communication, so let that be the measure of your success.

Avoid responses that tend to shut down communication:

- Order, command, direct
- Threat, warn
- Preach, moralize
- Advise, solve
- Lecture, logic
- Agree, praise
- Judge, criticize, blame, label, take sides
- Sympathize, reassure
- Analyze, diagnose
- Humor, sarcasm
- Distract, change subject, tell your own story
- Thinking/worrying about what you are going to say next

Do any of the responses above surprise you as being not helpful? Think about possible scenarios and what the person who is sharing might need from the listener. For example, if I am complaining about my doctor, is it helpful for the listener to take my side and start bashing the doctor alongside me? It would be one thing if I told my doula that I fired my doctor today. In that case, sure, validate my choice and act of empowerment. However, short of a done deal, I have a problem to solve, and if you jump into solving it for me, or adopting a specific point of view, you are not supporting my need for a sounding board. Clearly, I am not ready to fire my doctor, or I would have done so, which means that something else is going on here. If you pass judgment on the person I am having an issue with and I am not ready to end that relationship, I

might switch gears to defending the person/relationship. A skillful doula will find a way to be a good, engaged, active listener as I unpack my own issue.

Embrace attitudes that enhance communication:

- Accept the person, without judgment, as separate from their behavior.
- Be okay with human fallibility.
- Respect others' wisdom and ability to make choices that are right for them, even if those are different from choices you would make.
- Respect is conveyed in your attitude, behavior, words, tone of voice, and comments about others.
- Respect involves a willingness to suspend an authoritative role and acknowledge the other person's autonomy.
- Accept that everyone has a reason for why they feel or behave as they do (you may not know the reason, but there is always a reason).
- Demonstrate curiosity and genuine interest in the person's experience and perspective.
- Your body language supports the development of rapport and trust (eye contact; open and attentive attitude; postural alignment, such as leaning into the conversation or positioning yourself at eye level; understanding nod; etc.).
- Give 100% of your attention. Suspend your own frame of reference, agenda, judgment, and mental chatter and simply meet them where they are at.
- Convey concern and acceptance.
- Stay grounded and centered.
- Do more listening than talking. Ask yourself, "Who's doing most of the talking?"

Active Listening Techniques

The goal of active (aka "reflective") listening is to facilitate communication. The techniques have the effect of encouraging the other person to elaborate, clarify and validate their thoughts and emotions. When used correctly, the person continues to talk. The techniques are especially useful in the following situations:

1. When a person has a problem that needs to be solved
2. When a person is experiencing strong feelings or concerns
3. When a person has a problem with another person's behavior
4. When two or more people are in conflict

Open-Ended Questions. Use open-ended, tentative questions that require more than a "yes" or "no" answer. Open-ended questions do not lead the conversation, make presumptions, or set priorities for the person. Rather, they encourage spontaneous sharing.

> "How do you feel about ...?"
> "What do you need right now?"
> "How are you coping?"
> "What things are concerning you?"

"Can you describe what's going on?"
"How is your partner doing?"

Reflective statements. This technique involves repeating back to the person what you heard them say. It is not in the form of a question, but rather a statement. Your tone does not rise at the end of the reflection; it stays flat. This technique typically results in direct feedback about accuracy from the person. When overused, the technique can be annoying to the person you are attempting to engage. The following are examples of simple reflective statements.

Client	Doula
"I am so tired."	"You're really tired."
"My back hurts."	"Your back is really hurting."

There are limited uses for simply stating back to someone what you heard them say. One scenario where it might be helpful is to repeat back to a healthcare provider their recommendation, especially if a debate over a course of action is underway. It is a form of validation. You are acknowledging that you heard and understand their advice.

Doctor	Client
"We would like to break your amniotic sac to get this labor going."	"I understand you think it will help my labor get going if you break the bag of waters."
"Your baby is large, and you may need a cesarean."	"I understand you have concerns that my baby is too large for a vaginal birth."

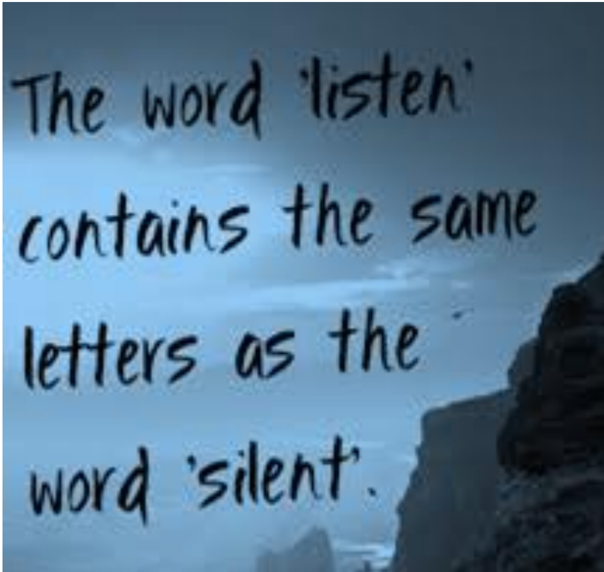
In most situations, however, simply parroting back what someone has said to you is not well received. It is better to adapt, based on context. A more complex reflection incorporates meaning. Sometimes you may be making a bit of a guess here, but that's okay. Again, the point is that the person feels heard and they continue to communicate. If your guess is wrong, they can correct the response or tweak it a bit to better communicate their thoughts.

Client	Doula
"I can't believe how tired I am!"	"You had no idea that caring for a newborn would be so hard." "It's exhausting doing so much on your own."
"I'm worried about the pain."	"You're afraid the pain can't be managed. "You're afraid the pain will be more than you can bear."
"My mother is not being helpful!"	"Your mother doesn't seem to know how to help you right now." "You expected your mom to be more of an asset at this time."

Validation. Never minimize the person's feelings or situation and don't put words in their mouth. Minimization often occurs when we attempt to make someone feel better by reassuring them, e.g., "you can always have another" (in response to pregnancy-related loss). Minimization never feels supportive. It would be better to say …

> "This is really painful for you …"
> "I'm here."

Silence has value. Silence punctuates a feeling or realization or heavy disclosure. It invites the person to go on and provides space for them to experience their feelings. You may need to simply sit with the discomfort of no solution. Do not rush in to rescue but allow them to fully vent or explore. This is healing.



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Clarification/Summary/Feedback. Feedback can only be shared *after* rapport has been established and the person feels heard. Only then is it appropriate to share your impressions of the situation, their feelings, or struggle. Provide a *tentative* summary of what has been shared.

> "Let me see if I understand ..."
> "It sounds like you … Does that feel accurate to you?"

Problem solving. When/if the person is ready, you can encourage brainstorming.

> "What would happen if you did …?"
> "What have you tried so far?"
> "What has worked for you in the past?"

Help the person prioritize what must be decided or done right away. What can wait? What resources do they have? Who else is available to help? And so on.

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Universal Precautions

HIV (Human Immunodeficiency Virus) and Hepatitis B and C may be transmitted when the body fluids (blood, mucous, breastmilk, amniotic fluid, vaginal secretions and, to a lesser extent, urine, saliva, and meconium) of an infected person come into contact with a break in your skin, or your mucous membranes (your eyes, mouth, or nasal passages). These viruses are killed by soap and water, bleach, alcohol, and antiseptics.

Who is more likely to carry HIV or Hepatitis B or C?

It is possible for anyone to unknowingly carry these viruses. Those at greater risk, however, include people who have used IV street drugs and those who have had a sexual partner who is bisexual or has been an IV drug user. Receiving a blood transfusion of infected blood also presents some risk.

Precautions for Doulas

- Be aware of the location of any breaks in your skin (cuts, scratches, scabs, rashes, insect bites or stings, skin conditions, hangnails, etc.). These are potential entry points for infection.
- Wear washable clothing (including shoes or slippers).
- Use disposable gloves and put a couple extra gloves in your pocket for easy access when at a birth or providing intimate care. Wear gloves before touching anything that might have body fluids on it. For example, before handling sheets, towels, gowns, hot compresses, etc. It's okay to help yourself at the hospital—boxes of nonsterile gloves are readily available in the room.
- Wash your hands frequently with soap and water, and especially after any potential exposure.
- Do not handle used or uncapped needles or sharp instruments. These are supposed to be disposed of by hospital personnel according to specific protocols. Let the medical caregivers do it.
- Double plastic bags should be used and labeled "medical waste" before disposal of used gloves, blue pads, etc.
- Use caution when handling the placenta or the unbathed newborn. The parents should be holding the newborn in most circumstances, not the doula. When disposing of the placenta (at a homebirth for example), wear gloves, place the placenta in a plastic container and double bag it. If putting it out for trash collection, mark it "medical waste" and put it out shortly before pick-up. Wash hands and other exposed areas afterwards. Doulas who provide placental encapsulation services receive specialized training in safe handling of the placenta.
- In cases of known infection, items of protective clothing may be worn including gloves, glasses or goggles, and more.
- Shower and launder your clothing after leaving the client.

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Body Mechanics & Safety Tips

1. Be proactive.
2. Stay mindful.
3. Listen to any feedback from your body.
4. Trust your intuition.
5. Say “no” or ask for help if necessary.

As doulas, we can become so focused on serving our clients and meeting their needs that we forget to take care of our own bodies. In the moment, when there is urgent need—to help someone to the bathroom, change position, or deliver a comfort measure (e.g., counterpressure on the low back of a woman in labor)—we often jump in and do what is required to support our clients in the moment. Sometimes we pay a price for our efforts if we push past our own physical limitations.

I have learned the hard way to conserve my energy at a birth and stay mindful regarding body mechanics. Some births can be grueling. I am no longer able to hold a woman in a supported dangling squat, even through one contraction. Instead, we come up with other ways for her to adopt the position that don’t involve me overstraining to hold her weight. Likewise, I may not be capable of catching a postpartum mom who suddenly becomes lightheaded on her way to the bathroom. To stay on the safe side, I ask a second person for help. If I am physically supporting a laboring mother in a position—for example, inviting her to lean back on me between contractions—I need to make sure that I have the proper support in place for my back to sustain that position. I can try the position through one contraction and then adjust (e.g., ask for a pillow) if I detect any strain. Self-sacrifice is inappropriate in this situation.

If you are a woman, your legs are stronger than your upper body.
Rather than using the muscles of your arms and back to deliver counterpressure on a laboring woman’s sacrum over several hours, try leveraging your body weight for the same effect. For example, you might have the mother on hands and knees draped over a birth ball or positioned as shown in the picture below. The doula sits behind the woman and uses her body weight and gravity to lean in with the counterpressure.

Similarly, if the mother is on the bed at the same level as the doula, where the gravity assist is more difficult, the doula can take a stance (one foot forward, one foot back) and lean into the counterpressure technique. Working from a broader base of support in this position, the doula is more stable. At the same time, she is pulling strength from her legs, leaning in rather than pushing from the shoulders and back. If delivering the technique over a period of hours, remember to frequently switch the position of your legs.

Teach others how to help.
Family members generally want to help but may not know how. Once the doula discerns which techniques are helpful, she can teach them to other willing helpers, rotating support efforts across the team.

Use pillows.
Childbirth educators have long recommended that expectant parents bring pillows from home with them to the hospital (with the caveat to use colored pillowcases to distinguish them from hospital property). These are always useful. It is hard to confuse a real pillow from a hospital "pillow," so even if used to simply rest or for sleep after the birth, it is often welcome to have one's own favorite pillow.

Pillows can benefit everyone's body mechanics. For the new mother, a pillow can help with positioning the baby at breast—getting mom comfortable first and then bringing baby to the breast (rather than bringing the breast to the baby from an awkward position that strains the mother's back, e.g., baby in lap with breast dangling above as mom leans over the baby).

I have used pillows many times for my own comfort at a birth, for example, sitting in a straight chair with mom leaning back on me between contractions to rest. If I am straining or uncomfortable in that position, or my back hurts, the whole exercise is pointless. Mom will pick up on my tension and it will not be restful for her. She will mirror my need to shift away from the discomfort. A pillow can make all the difference. Doula relaxes, laboring mother relaxes.

Doulas can also keep an eye out on the body mechanics and needs of other helpers and offer them support or suggestions.

Special Caution after Delivery
The first time a new mother gets out of bed after giving birth—often to use the bathroom—is the time of greatest risk of her fainting. The risk is higher in cases where increased blood loss has occurred. However, the true definition of a hemorrhage is not in measuring the quantity of blood loss but in how compromised the person is from the blood loss that has occurred. So, for example, a nutritionally optimized mother with a maximum normal blood loss of two cups may feel perfectly fine, while an anemic mother with the same blood loss may feel light-headed. Emotional shock, overwhelm, trauma—the deer-in-the-headlights appearance—are all situations for doulas to be extra cautious.

- Take it slow.
- Have mom sit up on the side of the bed and rest for a minute or two, ensuring there is no light-headedness and that her blood pressure has time to accommodate the positional change.
- Have a helper, one person on each side of her, accompany her to the bathroom.
- Ask her to take a couple of slow deep breaths before standing.
- Tell her to let you know if she becomes light-headed. If this occurs, immediately bring her carefully to the floor, allowing her head to be lower than her heart if possible. If a chair is at hand, she can sit on the chair (or toilet) and put her head between her knees until she recovers. Then safely transfer back to the bed.

Fainting Symptoms (a progression)
- Pale
- Cold sweat
- Light-headed
- Person reports that “I feel weird” or “I don’t feel good.”
- Ringing in the ears.
- Tunnel vision—one starts to “black out.” Peripheral vision is the first to go. Eyes are wide open.
- Loss of consciousness

If the person who is experiencing this progression of symptoms remains upright, their body will cause them to lose consciousness which is the correction needed for blood flow to return to the head. The safest thing to do is to ensure they do not fall or safely contain the fall.

Doulas & Dads/Partners
Birthing mothers are not the only people who have ever fainted at a birth. Any observer may have that reaction, including the doula. The precipitating event for observers tends to be witnessing invasive medical procedures, for example, placement of an IV, an internal fetal heart monitor positioned intra-vaginally inside the uterus, cutting of an episiotomy, administration of an epidural in the mother’s spinal column, a cesarean operation, or even invasive suctioning of

the newborn. (Folks might imagine the precipitating event to more likely be seeing blood or the delivery of the placenta, but that has not been my experience.)

Doulas should stay alert and tune into partners' reactions to what is unfolding in the room. A blank stare in a pale face should alert you to check in with how the person is feeling. Guide them to lie or sit down and put their head between their knees. Stay close until they recover. A cold washcloth can be refreshing. If you notice yourself having this reaction, remove yourself from immediate support efforts and take corrective action.

The tendency for the lay person to have this reaction is one reason why medical caregivers may be reluctant to let dads, partners and doulas stay in the room for the administration of an epidural or why the anesthesiologist may decline to give consent for more than one support person to be present in the surgery suite. These policies may be successfully negotiated if team members trust that you can handle yourself and they will not be placed in the position of worrying about you or a fainting episode occurring.

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The Doula's Role Prenatally

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Prenatal Visits

A minimum of one face-to-face prenatal visit with the client is highly recommended. Most doulas do two or more visits, in addition to generous phone support. The first prenatal visit takes place after the Client Contract has been signed and a second visit is often scheduled around 36 weeks gestation. If there is a probability a backup doula is going to be involved, the client should have the opportunity to meet her as well. The purpose of prenatal visit(s) is to become acquainted and comfortable with one another and to gather essential information about the clients' plans and desires. It also gives the doula an opportunity to clearly explain the scope of her services. I always let clients know that prenatals are *their* time and that they are welcome to invite other members (if any) of their birth support team (e.g., partners, family, friends).

Suggestions of Topics to Cover During Visit(s)

- Become acquainted with details of the birth: setting, caregiver, etc.
- Review logistical and business concerns, including fees, terms of payment, services included/excluded, how to reach the doula when labor begins, and so on.
- Determine clients' level of experience and preparation. Are they planning on attending childbirth classes? Offer additional information and resources as needed.
- What are her hopes and anticipated needs for her upcoming labor and birth?
- What are her partner's hopes and needs? What role is the partner comfortable with? How can you work together to best meet the woman's needs?
- Discuss or help formulate a birth plan.
- What are their expectations of the doula?
- Discuss any fears or concerns she or her partner(s) may have.
- Is anyone else invited to attend the birth?
- For experienced mothers, go over previous birth experience(s) in detail. If the mother has had a previous cesarean, explore her desire and confidence to plan a VBAC.
- Doulas may want to demonstrate a couple of comfort techniques. This provides the opportunity to introduce touch into your relationship and as a means of developing trust. Get the partner involved!

Record Keeping

- Basic information such as names (woman and partner), due date, hospital, phone numbers, and email addresses
- Directions to client's home
- Copies of business agreement/contract
- Birth Plan (priorities, special requests)
- Brief notes (with dates) from prenatal meeting(s)
- Brief notes (with dates) from phone conversations
- Write up a brief labor and birth summary

- Notes (with dates) from postpartum meeting(s)
- Records of fees collected, mileage, expenses

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Choosing Your Birth Support Team
Quiz for Partners

This quiz focuses on how to assemble a birth support team designed to help parents achieve their goals and best vision for the upcoming birth.

A Preliminary Note

Assuming parents have already chosen a medical caregiver and place for the birth, I would like to emphasize that it is their right to feel comfortable with that choice. If they are expressing doubts about their choice of care provider or birth center or have considered switching to another provider/setting, it may not be too late to do so (even at the very last minute). Here's a hint: If moms are regularly coming home from prenatal visits in tears, then something is off. See if opening lines of communication can provide clarity or resolve any issues. It does not get easier to communicate in labor. Concerns are best addressed prenatally, in a forthright manner, and parents have a right to feel supported in their choices.

Goals for This Exercise:

- Moms: (1) Try to anticipate the types of support that you will respond to and (2) understand that your partner may not be the best person to meet ALL your needs in labor.
- Dads/Partners: (1) Understand the type of support that your partner may require in labor and (2) consider what your role at the birth will be.
- Establish good communication regarding mutual expectations and problem-solve any issues *before* the birth (e.g., before an unwanted mother-in-law shows up).
- Plan for success: Give the mother permission to get her needs met in labor. Trust me, this is MUCH better than having unarticulated needs, making assumptions that your partner will meet them, and then being disappointed or resentful when un-communicated needs don't get met. Needs don't go away when we don't honor them; in fact, they often get more assertive!
- Remember, whatever is best and safest for mom, is also best for the baby. Your birth is about you and your family. It is okay to ask family and friends to respect your wishes.

How to Do This Exercise

- Each partner fills out their section of the quiz.
- Next, find a time to come together and share your questions and answers with each other.
- Explore any topics where you might have mismatched expectations or where one person's needs are not a good fit for the partner's ability to fulfill that need. Just identify mismatched areas or points of potential conflict, without judging them.
- Next, come up with positive solutions for identified challenges. This might involve exploring, for example, hiring a doula to ensure everyone's needs get met.

Questions for the Expectant Mother

1. When feeling stressed, anxious, unwell, or in pain, what do you do to make yourself feel better?
2. What types of activity help you to relax? Warm bath, music, massage, dark, quiet room, specific activities? Other? List everything that has worked for you in the past.
3. Rate each of the following according to the extent you find it comforting.

	Very comforting	Somewhat helpful	Unsure	Probably not helpful	Not comforting
Company of others					
To be left alone					
Focused attention & reassurance					
Verbal directions & reassurance					
Massage, touch					
Just be present					

4. When others have helped you through a challenging experience, what have they done (specifically) that was helpful? Was there anything that was not helpful, or even made the challenge more difficult for you (even if it was well intentioned)?
5. What are your expectations of your partner during your upcoming labor and birth?
6. Make a list of the people in your life who meet the following criteria:

- Are available to be present at my baby's birth
- Want to be present at my baby's birth
- Would be an asset during the labor and birth process (make it easier on me)
- Share similar beliefs about birth
- Can provide unconditional, nonjudgmental, non-inhibiting support
- Have confidence in me and my capacities
- Are not afraid of birth
- Will be able to witness me in pain without becoming overly upset

- Possess a personality and style capable of meeting my needs in labor, especially helping me to relax

7. Now, identify the person(s) on the list who can also best complement your partner's capacities, limitations, and preferences.
8. Who do you feel would be your ideal support team?

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Questions for the Partner

1. How active a participant in the labor and birth process do you anticipate being? (Put a check after each item below that best describes your preferred role. It's okay if your answers reflect ambivalence. Just go with your gut.)

	✓
Primary support person	
Part of a team providing support	
Witness to birth and emotional support only	
Very hands-on, help with positioning, massage, comfort measures	
Help in making all decisions	
Would like to help catch the baby, cut the umbilical cord	
Want to take a back row seat; view the birth from the mother's perspective	
Would feel disappointed if there wasn't much for me to do to help	
It would be okay with me if I wasn't very involved with hands-on support	
I would prefer to not be present for the birth	
Unsure about my role; want to see how it goes	

2. Is there anything your partner could do in labor that would frighten or upset you?
3. When it comes to supporting your partner, what are your strengths?
4. Are you aware of any expectations regarding your role at the birth that make you feel uncomfortable?
5. Are there any individuals whom you feel strongly should not be present at your baby's birth?
6. Who do you feel would be your ideal birth support team?

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Informed Decision Making:
Choosing Medical Interventions

Yes	Maybe	No
Use medical tools when the benefits of the tool clearly outweigh the harms.	Ask more questions when the benefits and risks are similar or unclear. If mother and baby are okay now, consider waiting a little longer before acting.	Do not use elective, routine or purely convenient medical interventions which can result in HIGHER complication rates for mother and baby.

Find out what is going on.

- What is the problem?
- Could you tell me more about this?
- What are my treatment options?

Assess your risk.

- Are my personal odds higher or lower than the average? It is important to know whether you have health or demographic factors that affect your relative risk for undesirable obstetrical outcomes.
- Is this a routine recommendation or is this a specific recommendation for me and my situation?
- What factors increase my likelihood of having this happen?
- Why are you recommending this to me?

Assess alternative treatments.

- Are there other things I can do?
- What are my treatment options?
- What happens if I wait?

Consider waiting.

- What happens if we watch and wait?
- Is there a chance we are over-treating by acting now?
- Are we treating a known problem or are we treating a potential for a problem?

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Birth Plans

What is a Birth Plan?

The short answer is that the birth plan is a *tool to facilitate communication.* It is a written description of how the mother/partner would like to be supported during labor, delivery, and immediately postpartum. It also includes their preferences for the baby's care during these times. Ideally, a birth plan facilitates communication on three levels:

- Between the mother and her partner
- Between the couple and their doula and/or other members of the support team
- Between the couple and their medical care providers

A birth plan is only useful or helpful to the extent that it *facilitates* effective communication, helping everyone to be on the same page.

What a Birth Plan is Not

- ✓ A script for how labor and birth will unfold
- ✓ A contract between the couple and their health care providers
- ✓ A list of procedures the mother wants to avoid
- ✓ More than two pages of information

Planning for labor may seem overwhelming when you consider all the available options. Parents may wonder about the value of it, since one can't really plan how labor will unfold and it's not realistic to plan for every contingency (the birth plan would be ten pages long and no one would read it!). Your birth plan is an introduction to you and how your support team (medical and otherwise) can best support you and your baby through this experience. It might explain what pain relief techniques you would like to try, what interventions you would like to avoid or what atmosphere you would like to cultivate in the labor room. It can help to set the tone for your birth.

Many women today are attended by doctors and midwives who work in large group practices. You may have an excellent relationship with a doctor or midwife, but there is no guarantee that she/he will be the same person who attends you in labor. And no matter how good your prenatal communication and relationship is with your doctor or midwife, you do not know the nurses at the hospital, and they do not know you. A birth plan helps people get to know you at a time when you may not be in the frame of mind to introduce yourself and explain your needs and preferences.

During labor, if situations arise in which a decision must be made, it is easy for a nurse or doula to check your birth plan for guidance. It lets them know what options you would like to try and what options you would like to avoid if possible.

How to Write a Birth Plan

Understand your options.
The first step in writing a birth plan is to find out what your options are. Different doctors will give you different choices for handling the same situation. Different hospitals or birth centers will vary in environment, protocols, and available options. Review the **Birth Plan Checklist** included below. Read the list and determine which options appeal to you and which options you don't think you want. You can use this list to explore your caregiver's beliefs and protocols. You should also take the Birth Plan Checklist on a hospital/birth center tour to find out how hospital policies may affect your options. Ask lots of questions on your tour, even if you are the only one asking questions! Some hospital tour guides may adopt an approach that is best summarized as "how to be a good patient in our hospital." When they understand that you are interested in all your options, they should be able to switch gears and accommodate you. If you are not satisfied with the options available through your current caregiver/place of birth, then you may want to explore other choices available in your area.

Examine your feelings and consider your priorities.
Once you know your choices, it is important to determine how you feel about them. Some items will be important, and others will seem small or unimportant. There is no right or wrong; it is simply a matter of understanding who you are and how you want things handled. The **Ideal Birth Worksheet** (below) is designed to help you work through your feelings and rank your choices according to their level of importance. Both the mother and her partner (if any) should engage in this process, discuss their feelings, and make any necessary compromises. In the written birth plan, list your choices in order of priority, most important first.

Determine whether you can get what you want.
As you create your birth plan, be sure and bring it with you to prenatal visits with your doctor or midwife. It is important to begin this process of claiming ownership of your birth during the prenatal period and to begin a discussion with your care provider. The provider can let you know if your requests are realistic, likely to be honored, or even possible within the context of your chosen birthplace and given your personal circumstances and medical history. In some cases, you may learn that your provider does not particularly want to enter a discussion about your preferences, seems impatient with the entire subject, or flatly states that they cannot support your choices. If you are not getting a receptive response, consider whether there is

room for negotiation and compromise. You are the customer, and you are paying the bill. You have some power here, but you will only be as powerful as you believe yourself to be.

Prepare for a positive experience.
Be sure to phrase your final birth plan in a pleasant and polite tone. Do not present your preferences as a list of demands. This can help everyone feel more confident and increase your chances of having the birth experience you want.

Birth Plan Tips

- ✓ Make it short and easy to read.
- ✓ Divide it into two sections—one for labor and birth and one for postpartum mother-baby care.
- ✓ Put the most important items first.
- ✓ Use positive, flexible language (e.g., how you would like to be supported rather than what you don't want people to do).
- ✓ If you use a template, inject some personality into it so care providers can connect with you.

Choices regarding immediate postpartum care of the newborn
Expectant parents are encouraged to consider their preferences regarding the following medical procedures and protocols commonly used with the newborn and to begin a dialogue with their care provider prior to the birth. As you sort out your priorities, you can begin to incorporate your preferences into a Birth Plan. For a hospital birth, typically it is the labor and delivery nurse's job to see that routine procedures are accomplished. If it is important to you to do some things differently than her protocols may require, then it is essential that you get her on board with your plan.

Do you have preferences about any of the following?

- Delay cord clamping until the cord has stopped pulsating.
- Refrain from routine suctioning of the baby and provide only if/when necessary.
- Allow for immediate, undisturbed, skin-to-skin contact between mom and baby.
- Stabilize baby's temperature via skin-to-skin on mom or dad rather than using warming table.
- Delay all routines until one hour postpartum (e.g., weighing, measuring, eye drops, etc.).
- Perform routine procedures bedside or even while mom is holding baby, if possible.

- Allow mom and baby time to figure out breastfeeding on their own. Provide support only if asked to do so. Care providers should ask for permission before doing any hands-on breastfeeding support techniques.
- Allow parents to be involved with giving baby his/her first bath; or have it done bedside; or delay until parents are ready.
- Rub vernix "in" rather than "off."

These procedures are routines, but may be negotiable:

- Administration of Vitamin K within first hour after birth; may need to request a waiver form
- Blood sugar checks (heel poke), especially indicated for 9+ pound babies; may request to keep baby at breast as an alternative (if baby is not breastfeeding, supplementation may be required to prevent dangerous drop in baby's blood sugar)

These procedures are required by state laws:

- Antibiotic drops in eyes within first hour after birth (prevention against gonorrhea infection that can result in blindness in the newborn); parents may be able to sign a waiver in some care settings.
- Newborn Screening (heel poke for blood samples); difficult to opt out of this one; see Limitations to Parental Rights below.

These procedures require explicit parental consent (meaning you have the right to postpone or decline altogether):

- Circumcision
- Hepatitis B and other vaccines

Limitations to Parental Rights

In the United States, parents do not retain the legal right to decline recommended medical treatments for their minor children. So, once a family interfaces with the medical system, they are at risk of losing ultimate decision-making power over their child's medical care. Of course, many doctors will include parents in treatment choices and decisions. However, if parents are refusing what doctors believe to be lifesaving treatment (e.g., antibiotics or blood transfusions), doctors can get a court order granting them legal custody of the child due to "medical neglect." These situations can become quite contentious, but the courts typically come down on the side of the medical professionals rather than the parents.

Get a Second Opinion

If treatments are recommended for your newborn, especially treatments that require re-hospitalization of the baby or a disruption in breastfeeding (e.g., for jaundice), consider bringing in your private pediatrician for a second opinion rather than relying solely on the advice of the hospital's neonatal team.

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Consider Early Discharge

If your birth went well, meaning mom feels pretty good and the baby is healthy, then you may want to consider leaving the hospital environment sooner rather than later. This will work especially well if you have a knowledgeable helper at home—your mom, a doula, or an experienced friend. It is a myth that anyone “gets more rest” in the hospital and no one would ever argue that the food is good. In addition, hospitals are notorious for being a good place to acquire an infection. While you may feel a bit overwhelmed at the prospect of going home soon after the birth, you really don’t need to remain hospitalized if there are no specific health concerns.

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Ideal Birth Worksheet

This exercise will help you sort out your thoughts and wishes about your upcoming birth. For this exercise, imagine you are having your perfect labor—everything works out exactly how you want it to.

The Uncontrollable Issues

In real life, you cannot control these things but if you could, how would your labor happen?

- When and where does labor begin?
- Who is with you when labor begins?
- How strong are your contractions?
- How quickly do your contractions progress?
- How long do you push?

The Almost-Controllable Issues

There are some circumstances in labor which you might have control over or might not. It all depends on how your labor unfolds. If you have a choice about these issues, how do they happen?

- How does your midwife assist you?
- Where do you labor?
- Where do you give birth?
- What tools do you use to cope with labor?
- Who labors with you?
- What techniques will be used to help you?
- What techniques will not be used in your labor?
- What happens after the baby is born?

The Most Important Issues

After working through the previous two lists of questions, you should begin to have identified the issues that are most important to you. Complete these sentences:

- My top three priorities for this birth are …
- For me, the ideal place to give birth is …
- I want to be sure that the following labor tools are available at my birth …
- For my birth, the ideal clinical personnel are …
- I want to have the following people there for my emotional support and well-being …
- For me, the best approach to pain relief is …
- The following are also important to me …

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Birth Plan Checklist

Use this checklist to make sure you have covered everything you feel is important in your birth plan. You do not need to have something written for all these areas; this is only a list of areas you *may* have strong preferences about.

- Important Issues
  - Concerns (Why? Tell your story, briefly)
  - Health Issues
  - Fears
- Pain Management Preferences
  - First stage medications
  - Epidural
  - Water immersion
  - Non-drug comfort measures
  - Consider requesting that staff refrain from offering pain meds or asking you to rate your pain if you are attempting a natural birth
- Medical interventions you wish to use or avoid
  - For inducing or speeding up labor
  - For pain management
  - For monitoring
  - Routine administration of Pitocin for third stage (a.k.a. “active management”)
- 2nd Stage
  - Positions you are willing/wishing to try
  - Style of pushing
  - Preferences for perineal support
- Preferences in case of cesarean
  - Type of cut on uterus (low transverse vs. vertical)
  - Who should remain with mother/baby?
  - Skin-to-skin with baby as soon as possible
- Postpartum care of baby
  - Immediate undisturbed skin-to-skin with baby?
  - Delay cutting the cord until it stops pulsing?
  - Timing of routine assessments (e.g., weighing, measuring, newborn exam, etc.)
  - Routine medical interventions (e.g., Vitamin K, eye prophylaxis)?
  - Breastfeeding?
  - Rooming in or baby to nursery?
  - First bath
  - Intact penis or circumcision?
  - Consent to vaccines, or no? (If you are not opposed to vaccines but don’t want to give them on the first day of life, you can always follow up with your private pediatrician in a few weeks.)
- Other Important Items
  - Identification of support team

- Photos/videos
- Privacy needs
- Environmental issues (lighting, music)
- When to discharge
- Educational needs (anything you want to be sure to learn about baby care before you leave)

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Birth Plan Guidelines Summary

By Amy Gilliland, Ph.D., BDT(DONA)

1. Start out with a general statement introducing yourself, your philosophy, and your reasons for choosing this hospital or birth center.

2. Use positive language whenever possible.

3. In general, it is more positive and descriptive to state what you do want rather than what you don't want. "To avoid an episiotomy or tearing of the perineal tissues, please use warm compresses and help me to breathe the baby out slowly."

4. Be specific. "I want to be free to move around during labor as I choose," rather than "I want an active birth."

5. Don't try to cover everything, only those areas most important to you. The reader can get bogged down in detail and your main message can get lost.

6. Use organizational headings that help to guide the reader. Some suggestions are" During Labor—First Stage; Birth; Infant Care; Supporting Breastfeeding; Emergencies. You may or may not want to title the introductory paragraph.

7. Some parents wish to include sections on emergencies such as a cesarean operation, intensive care for their infant or the baby's death.

8. As you read what you have written, ask yourself: "How do I feel reading this?" Put yourself in the place of a birth parent, hospital staff member, and doctor.

9. Ask your caregiver to confirm your discussions and approach by signing the document. You may also wish to sign along with your partner and doula.

10. If you are planning a homebirth, it is wise to prepare both a homebirth plan and a hospital birth plan. It is especially important if you will be arriving at the hospital after a complication at home. In some areas, it is unwise to reveal your homebirth arrangements. You may wish to discuss this further with your midwife or doctor.

11. When completed, use a highlighter pen to call attention to the most important phrases (like the use of bold type on this sheet of guidelines).

12. Bring several copies of the final birth plan to the birth center with you. It is helpful to have a roll of painter’s tape to post the plan around the room, making it accessible to the care providers.

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Talking to Health Care Providers

Aim to be collaborative partners. Both you and your health care provider want what is best for you. Be confident about what you want. Share what you know and ask your care provider to fill in the blanks and provide the background for their suggestions. Don't be afraid to point out when your knowledge differs from their suggestions and recommendations.

1. Explain what you want:
   I am hoping that it's possible to …
   Is there any reason we cannot …?
   What would it take for me to be able to …?

2. Explain why you want it. Here's some sample language:
   I lean toward _______________ treatments and believe _______________
   I am hoping to achieve _______________ because of _______________
   I strongly value _______________ because my background is _______________
   I'm most comfortable making decisions when _______________
   My best sources of information come from _______________

3. Listen carefully to your health care provider's recommendations:
   Active listening with an open mind and heart allows you to see the reason and reasoning behind your care provider's suggestions. It also sets the expectation for what you expect in return.

4. Clarify for understanding:
   Could you tell me more about this? (Make sure you understand what the concern is.)
   Is this a routine recommendation or is this a specific recommendation for me and my situation?
   Are there other things I can do? (Is this the only solution or are there other choices?)
   What happens if I wait? (indicates how quickly you must decide)
   What are the risks of doing nothing? (Helps determine how serious the problem is.)
   What is the likelihood of that happening?

5. Make a decision.

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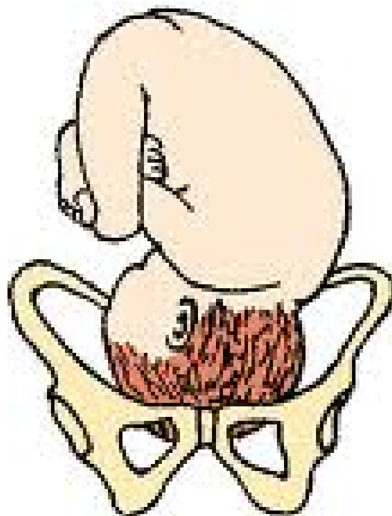
Optimal Fetal Positioning

What is Optimal Fetal Positioning?
"Optimal Fetal Positioning" is the term used to describe the best possible position for your baby to be in prior to birth. The optimal position is when your baby lays head down, facing your back, with your baby's back on either side of your belly button. This is known as **"occiput anterior."**

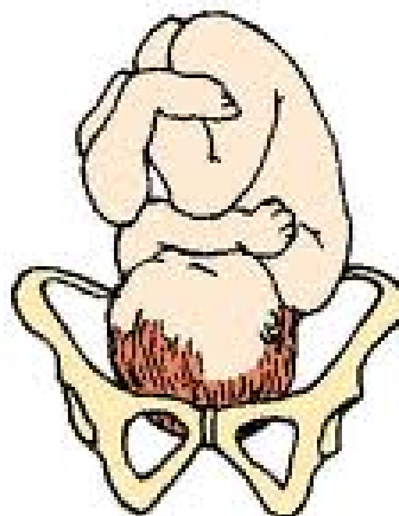
Having your baby lie in the occiput anterior position makes for an easier birth. In that position, your baby is best lined up to pass through your pelvis. Your baby's head is flexed with his chin tucked into his chest, which means the smallest part of his head is presenting first and he can more easily maneuver his way through your pelvis.

Conversely, when babies engage in the pelvis in the **"occiput posterior" position** (baby's back lying along mom's spine and facing her belly), it typically causes a dysfunctional labor pattern with greatly increased pain, often centered in the back. Common features of a posterior labor are:

- ✓ Slow progress, often stalled completely at 5 or 6 cm dilation
- ✓ Asymmetrical dilation of the cervix, due to the baby's head not fitting well into the bony pelvis and, therefore, not being well applied to the cervix
- ✓ Low back pain, often intense; may be somewhat neutralized by counter pressure on the sacrum
- ✓ Back pain that does not go away between contractions



ANTERIOR



POSTERIOR

If mom does reach complete dilation with a posterior-presenting baby, it often takes a tremendous effort to push out a baby in this position. Many cesareans are done for lack of progress, in either the first or second stage of labor, due to this cause.

In the case of a baby presenting in the **breech position** (butt, knees, or feet coming first), current practice dictates cesarean delivery. Approximately 3 percent of babies will be breech at term. While vaginal breech delivery (for certain breech presentations) can be safe, overall, there is a higher incidence of complications in breech deliveries. The current generation of doctors have not been trained in handling vaginal breech deliveries. Instead, this knowledge has been passed on by a few old-timers and homebirth midwives. Ironically, some women are choosing to have homebirths with their breech babies as their only option to surgical delivery.

Since the risks are higher with both posterior and breech presentations, certainly it makes sense to do everything in our power to encourage babies into the optimal fetal position prior to delivery.

How Can You Avoid a Posterior Baby?

First off, if it's not broken, you don't need to fix it and you can relax! Try to "tune in" to your baby's position prenatally. At prenatal visits after 30 weeks gestation, most care providers begin to put hands on your belly during a prenatal visit to determine the baby's size and position in the pelvis. Old-time doctors and most midwives are familiar with "the art of palpation" and have developed this skill. Many of the younger generation of doctors (and some medicalized midwives) have become overly reliant on ultrasound for the "window into the womb" that it provides and have not mastered this skill. They may not believe it is important to determine the baby's position unless they suspect a breech presentation.

If your care provider IS putting hands on, engage them in a conversation about what they are feeling. Ask them if they know where the baby's back is. If, at 30 weeks, your baby is determined to be in a breech or posterior position, then just make a note of it. Typically, at this point in the pregnancy, the baby is still floating well above the pubic bone and there is plenty of room to turn. If, at subsequent prenatals, the baby has adopted a different position, then that is simply a sign that there is plenty of room and the baby is still moving. However, if at subsequent prenatal visits, your baby shows a pattern of preferring a breech or posterior position, and he/she has not moved out of that position by approximately 36 weeks, then it may be time to get proactive and do what you can to encourage the baby to turn.

Keep in mind that the back of your baby's head and back are his/her heaviest body parts. Placing the mother's body in an upright or slightly forward position helps to encourage those heaviest parts of your baby to point down and face your back. Below are some ideas to keep in mind during the last few weeks of your pregnancy, to help your baby engage in the optimal position:

- Mentally draw a line starting from your back through your body and out through your belly button. Try to consistently sit and stand in a position where that line would be parallel to the floor.

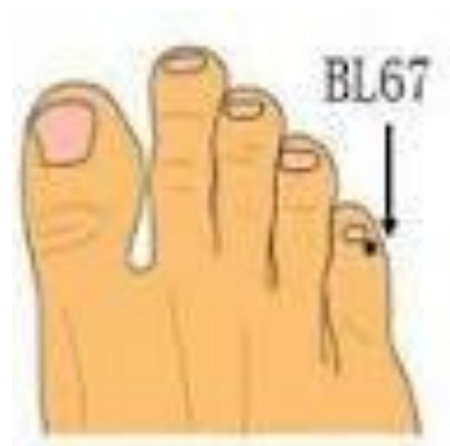
- Positions to avoid are:
    - Sitting in chairs that have you leaning back in a slouch position (e.g., recliner chairs, bucket car seats, cushy couches). Placing a foam wedge on your car seat can help keep your posture straight in bucket car seats.
    - Crossing your legs reduces the space in front of your pelvis where you want your baby to be, while opening the space at the back of your pelvis.
    - Lying on your back to sleep.

- Positions to encourage are:
    - Sitting on a birth ball
    - Sitting on a kitchen chair backwards, straddling the back
    - Sitting in any position that keeps your knees lower than your hips
    - Walking
    - Swimming with your belly down (i.e., front crawl, breaststroke)
    - Sitting in yoga positions such as tailor position or with heels together
    - Lying on your side to sleep (or, even better, on a ¾ angle leaning towards the bed)
    - Adopting a hands-and-knees position and doing "pelvic rocks" several times a day (this position is my favorite, especially for very late pregnancy; try moving to the floor for a few pelvic rocks after each trip to the bathroom)

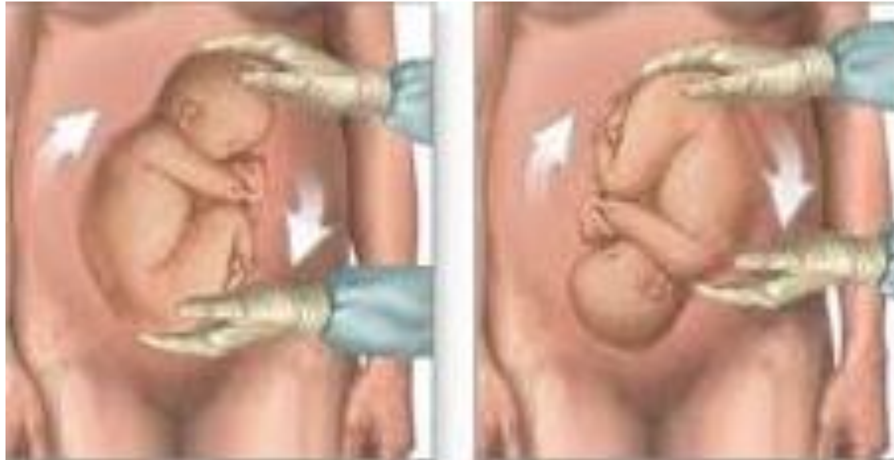
Strategies to Turn Breech Babies

- Breech tilt position: mom lies on an inclined plane, with feet elevated and head down at an angle of approximately 30 degrees; rest in this position for approximately 15 minutes; repeat 2–3 times per day until baby turns.

- Moxibustion; technique from Traditional Chinese Medicine involves applying the herb Mugwort (which has been rolled into a compressed cone shape) to an acupuncture point on the baby toe, and lighting it on fire, thereby transferring heat to the point; used in China for centuries to turn breech babies, it has been written up in the American Journal of Obstetrics and Gynecology as being an evidence-based practice; find an acupuncturist or practitioner of Traditional Chinese Medicine in your area who is familiar with the technique.



- External version is offered by some hospitals; technique involves manually forcing the baby to turn to a head-down position; done in conjunction with ultrasound because it sometimes causes fetal distress; waiver for surgery must be signed ahead of time; procedure is widely reported to be painful by mothers.



Other Techniques/Treatments for Breech and Posterior Presentation

- Webster Technique; chiropractic technique with good success rate
- Visualization; picture your baby in the optimal fetal position; hang pictures around your home
- Homeopathic Pulsatilla and Natrum Muriatricum are two of the most indicated remedies for encouraging the baby to adopt the optimal fetal position; see information following.

Tune In!

"Belly Mapping" is a fun way to "tune in" to your baby's position in the womb. It can be very empowering for mothers to learn how to determine their baby's position. It helps them connect with the baby and their own body and realize that they are the experts on their body, that this information is not some unknowable mystery that only technology or experts can access. Check out Gail Tully's website, http://www.spinningbabies.com for more information. She has a book and classes for parents and training for professionals.

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What to Bring to the Hospital or Birth Center
(for Parents)

Small Bag for Labor
Chap Stick
Massage lotion
Oil for the perineum
Essential oils if desired
Something to pass the time in early labor (cards, book, etc.)
Fluids for mom (see article "The Birth Marathon: Food & Drink for Labor & Birth")
Snacks for partner
Bathing suit and change of clothes for partner
Toothbrush and toothpaste for partner
Music, iPod
Birth ball and pump
T-shirt (or clothing of your choice) to labor in (if desired)
Warm socks
At least two pillows (in colored pillowcases)
10 copies of your Birth Plan + highlighter + masking tape

Suitcase
Nightgowns (2)
Robe and slippers
Toothbrush and toothpaste
Comb, brush, etc.
Deodorant or other toiletries
Shower cap
Underpants
Nursing bras
Going home clothes (that fit at 6 months)

For the Baby
Infant car seat safely installed (have this checked by a certified technician)
Receiving blanket, outdoor blanket
Outfit to wear home, undershirt, booties, cap
Diapers

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Baby Stuff: What Do You Really Need?

Bedding, Towels
- Baby towels & washcloths (not necessary; regular towels work just fine; hooded baby towels are nice)
- Bumper pads, pillow, blanket, comforter (no longer considered safe; not recommended)
- Fitted mattress cover and crib sheet (an extra set would be convenient)

Clothing *
- Overall, used infant clothing is abundantly available at significant savings; infants grow out of their clothes before they wear them out; just check for stains on used clothing.
- A newborn might go through three or more outfits in one day. Plan on needing to do a load of laundry every three days or so.
- Pick items that are easy to take on and off; onesies are fine, but it's nice to have some two-piece outfits as well (then you only have to change the half that needs it).
- A couple of cotton hats
- Socks

Diaper Options (choose one or try a combination approach) *
- Cloth diapers, diaper covers, diaper pail or
- Diaper service (pick up and deliver once a week; service provides the diaper pail) or
- Disposables (buy newborn size)
- Diaper wipes (convenient, but water and a cloth work too)
- Diaper bag or backpack*

Equipment
- Baby monitor (convenient but not necessary)
- Bottle warmer (not necessary for breastfeeding moms)
- Electric breast pump (for breastfeeding moms who need to leave baby for hours at a time; basic pump plus accessories which must be sized for the mother; storage bags/bottles) *
- Highchair (won't be needed for a few months) *
- Infant car seat*
- Stroller (most folks appreciate this option, though some devoted babywearers find strollers to be superfluous)

Furniture
- Bassinet (baby typically grows out of this by about three months; not necessary)
- Bouncy seat (not necessary)
- Crib & crib mattress (unless you are committed to co-sleeping; might still be a good option for naps)

- Changing table or changing pad for top of existing dresser (convenient and can double as storage for clothing, but not necessary)
- Dresser (not necessary)
- Rocking chair (nice, but babies like to be bounced on a birth ball as well; be sure arm height of chair is not too high for nursing baby)
- Wind-up swing (not necessary; if someone gives/loans you one, you can give it a try; not useful past three months)

Miscellaneous

- Baby bath (a variety of devices are on the market; convenient, but not necessary; a towel-lined sink works too)
- Mirror for back seat of car so driver can see baby's face*
- Nursing pillow (not necessary, see if you feel you need one)
- Pacifiers (not recommended for at least the first three weeks, until milk supply is well established; may be habit forming)
- Pack n' Play (convenient for overnights)
- Personal care items such as baby shampoo, soap and cream (buy natural baby care items if possible; usually calendula based, which is gentle for the skin); baby comb & hairbrush*
- Receiving blankets (at least 3; some larger-size blankets are nice) *
- Shade for car window next to baby*
- Sling or baby carrier (lots of brands and styles on the market) *
- White noise machine (not necessary)

The following items should NOT be previously owned:

- Breast pump
- Car seat (unless you know the history; if a car seat has been involved in an accident, it is no longer trustworthy)
- Crib mattress, or ill-fitting mattress for crib (danger of SIDS)

* These items are needed.

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The Doula's Role during Labor & Birth

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The Process of Labor and Birth

Pre-Labor Changes

Changes in Late Pregnancy (last four weeks or so):

- Baby engages ("drops") in the pelvis. For first-time mothers, this typically happens approximately two weeks prior to birth, though it can be weeks prior or even wait until labor has begun. For a second or more baby, engagement can happen any time.
- Mom may feel increased pressure on her bladder; pressure on diaphragm is relieved; sometimes pubic bone feels sore.
- Emotionally, mom may be feeling discouraged, anxious, excited, tired of being pregnant, etc.
- Cervix begins to soften, ripen, and move forward, typically any time after 36 weeks.
- Cervix may begin to efface (thin) and dilate (open).

Signs of Impending Labor (one day or two prior to onset of labor):

- Frequent, loose bowel movements (may also accompany onset of contractions)
- Nesting instinct with sense of urgency regarding chores, errands, purchases that must happen *NOW.* (Note to partners: this is not necessarily a rational process; just go with it.)

First Stage of Labor (Effacement and Dilation of Cervix)

Three ways for labor to begin:

1. Bloody show: mucus plug dislodges from the cervix; because there are capillaries in the cervix and the cervix is changing, the mucus is likely to be tinged with blood; may or may not be accompanied by noticeable contractions.
2. Contractions: the pattern here can be pretty much anything from one per hour lasting 15 seconds, to every 10 minutes, lasting 30 seconds or more; endless variations; may or may not be accompanied by bloody show; contractions may feel like menstrual cramps or may be felt in the low back as an intermittent backache; contractions do not go away when mom changes her position or activity level; most women report that labor contractions feel "different" than the toning contractions of late pregnancy (aka "Braxton-Hicks contractions"). The term "false labor" is used when a woman experiences contractions that are regular for a time but disappear altogether when she changes her position or activity level.
3. Spontaneous Rupture of Membranes (SROM): bag of water breaks and fluid gushes from the vagina; can also be experienced as a slow leak which may be hard to differentiate from urine leakage (not terribly uncommon in late pregnancy with weight

of baby directly on top of the bladder); care provider can determine the difference with simple office visit to check pH of fluid that is present; expect differences among care providers regarding willingness to wait for labor contractions to begin on their own once SROM has occurred; note whether or not the fluid is clear or has a brownish-green tint to it; if it is not clear, then the baby has passed meconium in utero (the first bowel movement) indicating a need to monitor the baby more closely in labor. SROM is the first sign of labor in about 10 percent of women; it is more typical for the bag of waters to break later in the birth process (>7cm dilation).

Early Labor (0–4 cm dilation):

- Cervix continues to ripen, efface, move forward, and begins dilating.
- Contractions progress, with bloody show and/or rupture of membranes.
- Contractions get longer and stronger and closer together.
- Mom may feel excited, confident, optimistic, anxious, performance anxiety, etc.
- Mom can talk through contractions and do other activities between contractions.
- Mom may focus more than necessary on the contractions.

What to do?

- Check the instructions your doctor/midwife/doula has given you regarding when they want to be notified if you think you are in labor and follow those instructions; medical caregiver will advise when it is time to come in; doula may join you at home or at the hospital.
- If membranes are ruptured, do not put anything inside the vagina; be careful about hygiene (keeping bacteria from the rectum away from vaginal opening); refrain from tub baths until you are in active labor.
- An adrenaline rush often accompanies the onset of labor; remind mom to save this energy for the hard work that is to come; help her to relax, deep breathing, warm bath if membranes are intact, etc.
- If at night: SLEEP (or at least rest)!
- Eat, drink, empty bladder frequently. VERY IMPORTANT!
- Alternate distracting activities (bath, music, walk, cards, reading, movie, computer games) with rest if tired.
- When contractions become more regular, time them for a while (4 or 5 at a time, every few hours or when labor seems to have changed).

Active Phase (4–8 cm dilation):

- Cervix is now 100% effaced and 4 cm dilated.
- Contractions continue to get longer and stronger and closer together, typically 3–5 minutes apart and lasting at least 1 minute.
- Mom's attention is increasingly drawn inward; no longer distractible; the labor has become everything—getting through one contraction at a time, recovering and getting ready for the next contraction.

- Mom is working hard; may be sweating and breathing differently; can no longer talk through a contraction; she may be tensing during contractions.
- Cervix continues dilating and baby's head begins to rotate as he/she moves deeper in the pelvis.
- May continue to see bloody show or bag of waters may rupture anytime.
- "Moment of truth;" mom may feel trapped, discouraged, recognizing labor is not within her control.
- May resent disturbances and interruptions.
- May want pain medications. If not, then natural pain management techniques and comfort measures can be used.

What to do?

- o When the shift happens to active labor, you may want to head to the hospital/birth center or have your midwife on her way to you (for homebirth).
- o In any case, doula (or other support team members) should join you now.
- o Drink fluids and keep bladder empty.
- o Help mom with relaxation; begin coping ritual.
- o Provide relief with comfort measures.
- o "Labor voice," murmuring soothing, encouraging words.

Transition (8–10 cm):

- Contractions are very close, peak intensity (1–2 minutes apart, lasting approximately 1.5 minutes); contractions may piggyback.
- Mom may vomit.
- Mom may get lost in the intensity of the labor; feel afraid or panicky.
- Mom may scream, thrash, tense, weep, or protest; she is likely to say she "can't go on," "how much longer?" and so on.
- Bloody show may be present, or rupture of membranes may occur.
- Mom may start to feel "pushy."

What to do?

- o Move in close, establish eye contact and provide minute-to-minute support.
- o Remind her that this is the shortest phase of labor.
- o Hang in there!

The Rest and Be Thankful Phase of Labor (10 cm dilated):

- For some women, labor can slow down at complete dilation.
- This resting phase is often not acknowledged by some care providers who may call for Pitocin or encourage voluntary pushing efforts.
- Mom may experience relief, renewed energy, enthusiasm, hope, or readiness to "get on with it."

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<u>What to do</u>?

- o Empty bladder now, before pushing efforts begin.
- o Drink something with a little sweetness to it (cup of hot tea with a generous spoonful of honey).
- o Negotiate with care provider regarding letting labor unfold at its own pace.
- o Help mom get comfortable, dark room, quiet.
- o Rest!

2nd Stage of Labor (Descent and Birth of Baby)

Descent Phase:

- Contractions are 3–5 minutes apart and lasting about 1 minute, perhaps a little longer.
- Mom may feel an urge to push with contractions.
- Mom may feel rectal pressure, as though she must pass a bowel movement.
- Mom may spontaneously hold her breath for part of a contraction or make deep grunting sounds.
- Baby rotates and descends.
- It may take a few contractions for mom to get her new rhythm and feel effective with pushing.
- As baby makes it under the pubic bone, the head may start to be visible at the vaginal opening; a little more with each contraction but disappearing between contractions.
- Mom may try to pull away from/resist sensation of pressure and stretching as baby moves down.
- Mom may pass stool during this phase, as the baby compresses the lower bowel.
- The nurse or midwife is in the room now, until the birth; if an OB is attending, they will come in close to the end while the L&D nurse will be attending to you during most of the second stage.
- Caregivers may be doing coached or directed pushing.

<u>What to do</u>?

- o Encourage mom to try different upright positions (especially if progress is slow).
- o Keep breathing and use lower (not high-pitched) sounds.
- o “Down and out.” “Let the baby come.”
- o If a lot of stool is passing, or mom is especially concerned about it, see if she can do some pushing on the toilet for a while.
- o Provide physical support for positioning, if needed.
- o Encourage her and give her progress reports; if mom wants to see, set up a mirror for her, or encourage her to reach down and touch her baby’s head, or tell her when you can first see the baby’s head.
- o Keep offering fluids.
- o Cool wash cloths to face and neck, between contractions.

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- Remind caregivers regarding any points in your Birth Plan related to episiotomy or immediate post-birth care (e.g., delayed cord clamping, skin-to-skin).

Crowning and Birth:

- Baby's head no longer rocks back and forth, but remains visible at vaginal opening, even between contractions.
- Mom feels a burning sensation as baby's head stretches her tissues.
- Caregiver may perform an episiotomy at this time.
- Caregiver (OB or midwife) is in charge now.
- As the head emerges, the baby rotates and then the shoulders are born one at a time, followed by the rest of the baby's body.
- Baby may be placed directly on mom's belly, with the cord intact (recommended), or the cord may be severed, and baby removed to warming table for routine procedures.

What to do?

- When mom feels "the burn," help her slow down pushing efforts by panting; if her breath is going in and out, she is not pushing; establish eye contact if necessary to help her with this; keep the breath in the upper chest, like a pant.
- Care provider applies a little counter pressure to perineum, oil, hot compresses, if desired.
- Remind doctor/midwife of pertinent requests in Birth Plan (especially regarding episiotomy, cord cutting if requesting delay).

3rd Stage (Delivery of the Placenta)

- Contractions continue, though with much less discomfort.
- As the uterus gets smaller and smaller, the surface area where the placenta is embedded shrinks. After three or so contractions, the placenta releases from the uterine wall, followed by a gush of blood.
- Attendant will encourage mom to push out her placenta.
- Once the placenta has been delivered, the nurse/midwife will periodically check the uterus for firmness, to ensure that it stays contracted to shut off blood vessels at the site and control bleeding.
- Baby is either skin-to-skin with mom (recommended) or under heat lamp in container, typically a few feet from the bed.
- Putting baby to breast releases oxytocin, which helps the uterus to contract.

What to do?

- Continue to advocate for your Birth Plan.
- Allow the baby access to the breast.

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Immediate Postpartum Period (first 2 hours)

- Some moms may get "the shakes."
- Continue bonding/breastfeeding.
- Routine medical procedures for newborn (weighing, Vitamin K, eye prophylaxis, newborn bath); can be delayed at parental request.
- Nurse/midwife stays nearby and monitors mom's bleeding and baby's vital sign.
- Mom helped up to the bathroom, to keep bladder empty.
- Mom washed up a bit or an herbal bath is prepared for mom and baby (homebirth, some birth centers).
- Meal for mom and partner.

What to do?

- o Warm mom with blankets.
- o Continue to advocate for your Birth Plan (perhaps delaying non-critical newborn procedures for an hour or two).
- o Take pictures; make phone calls; receive visitors, if desired.
- o Celebrate! Rest.

After Cesarean Delivery

- Mom will go to the post-op recovery room with partner. Baby will accompany, provided baby is not in a Special Care Nursery or the Neonatal Intensive Care Unit (NICU).
- Other visitors may be allowed in at this time.
- If the baby is in NICU, dad/partner may want to stay with the baby; doula or other support team member stays with mom until she is stable enough to be brought to baby.
- Mom may have "the shakes." Some women feel nauseated from the anesthesia after surgery. Anti-nausea medications may be administered.
- Good pain control should still be in place from the epidural.
- Once stable, mom and baby are transferred to a postpartum room; may go back to room where she was laboring in some hospitals.

What to do?

- o If baby is with you, enjoy your baby, skin-to-skin, near the breast; baby may root and latch on his/her own; just provide access.
- o Continue to advocate for any parts of your Birth Plan involving after-birth care.
- o If dad/partner is with the baby elsewhere, touch your baby if possible; talk to your baby; call your baby by name; let the baby know you are there.
- o If mom and baby are separated, have a support person relay information (and pictures!) of baby to mom; back and forth, until they are together.
- o Take pictures, make calls, receive visitors if desired.
- o Celebrate! Rest.

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APGAR Score

The Apgar Score is a system of evaluating the health of the newborn baby. It is given at one- and five-minutes post-birth, so the score is always reported as two numbers, e.g., 7/9, 10/10. The baby can be given 0, 1, or 2 points for each of five indicators. Typically, the five-minute score is equal to or higher than the one-minute score.

	0 Points	**1 Point**	**2 Points**
Activity (muscle tone)	Absent	Arms & legs flexed	Active movement
Pulse	Absent	Below 100 bpm	Above 100 bpm
Grimace (reflex irritability)	Flaccid	Some flexion of extremities	Active motion (sneeze, cough, pull away)
Appearance (skin color) *	Blue, pale, dusky	Body pink, extremities blue	Completely pink
Respiration	Absent	Slow, irregular	Vigorous cry

*****Non-Caucasian babies—not as visible; check palms, soles, around the mouth

0–3 = severely depressed / 4–6 = moderately depressed / 7–10 = excellent condition

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Hormones of Labor:
Their Functions during Labor & Early Postpartum

By Penny Simkin, with permission, www.PennySimkin.com

Oxytocin. Known as the hormone of "calm and connection" or the "love" hormone, oxytocin contributes to uterine contractions, the urge to push, the "fetal ejection reflex," the "letdown" of breastmilk, maternal behavior, and feelings of well-being and love. It has the opposite effects of catecholamines, described below.

Endorphins. These morphine-like hormones increase with pain, exertion, stress, and fear, and tend to counteract associated unpleasant feelings. During labor they are instrumental in creating the trance state (withdrawing and instinctual behavior) characteristic of women in active labor. They contribute to the "high" feelings that many unmedicated women have after birth, because once the stress or pain ends, the woman has the leftover euphoric effects of the endorphins.

Catecholamines. The stress hormones (adrenalin or epinephrine, noradrenalin or norepinephrine, cortisol, and others) are secreted when a person is frightened, angry, or is in real or perceived danger. These are the hormones of "fight or flight." Their physiologic effects enable the person's body to endure, defend against, or flee a dangerous situation. Catecholamines tend to counteract the effects of oxytocin and endorphins. In the first stage, contractions may either space out or continue without progress in dilation. Also, the fetal heart rate may slow, and/or the woman may become tense, alert, fearful, and protective of her unborn child.

The term, "fight or flight" accurately describes the *physiological* response to danger of all mammals, including humans, as well as the *behavioral* response of males. Recent studies of females in fear or danger find that their *behavior* is better described as "tend and befriend," that is, protecting their offspring and reaching out for support.

Ironically, although catecholamines may cause problems in the first stage, it's different during the second stage, when a surge of catecholamines is normal, and helps mobilize the strength, effort, and alertness needed to push the baby out.

Prolactin. The "nesting hormone" prepares the breasts for breastfeeding during pregnancy and after birth, promotes the synthesis of milk, and has mood elevating and calming effects on the mother. It plays a role in the altruistic behavior of a new mother—the ability to put the baby's needs before her own.

The fetus and newborn also produce these hormones, which contribute to fetal well-being during labor, neonatal adaptation, initiation of breastfeeding, and other functions.

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Stress, Pain, and Catecholamines
Anger, fright, or stress cause the following responses:

Physiological Response	Behavioral Response
✓ Dilated pupils ✓ Increased oxygen uptake ✓ Blood shunted from internal organs (including the uterus) to external skeletal muscles ✓ Increased heart rate and blood pressure ✓ Increased Estrogen (women) ✓ Increased Testosterone The body prepares for action and expenditure of energy.	"Fight or Flight" Defend oneself or run away "Tend and Befriend" Protect offspring and others, and seek supportive networks

The release of stress hormones in labor causes the following responses:

First Stage of Labor	Second Stage of Labor
✓ Decreased blood flow to the uterus ✓ Decreased uterine contraction ✓ Increased duration of first stage ✓ Decreased blood flow to the placenta ✓ Fetal production of catecholamines causes fetal conservation of oxygen and decelerations in fetal heart rate ✓ Negative or pessimistic perception of events by mother ✓ Need for reassurance and support	✓ Same fetal effects listed for first stage of labor ✓ "Fetal ejection reflex" (rapid expulsion of the baby)

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Pain Theory

Gate Theory of Pain

Based on premise that an area of the spinal cord acts as a "gate," which regulates the flow of messages to the brain. Receptors are attached to fibers. The small fibers are responsible for sending pain signals while the large fibers transmit other sensory signals, like vibration, rubbing, movement, and pressure. The idea is that stimulation of the large fibers competes with pain receptor messages in the small fibers, thereby "closing the gate" in the brain.

Neuromatrix Pain Theory

Sensations are processed in a "body-self neuromatrix" which is made up of sensory, cognitive, and affective components. Each person's ability to cope is a reflection of this neuromatrix, parts of which are rooted in our core nature and parts of which have developed through experiences over time and are unique to that person. This theory incorporates the Gate Theory and takes it a step further. See diagram on the following page.

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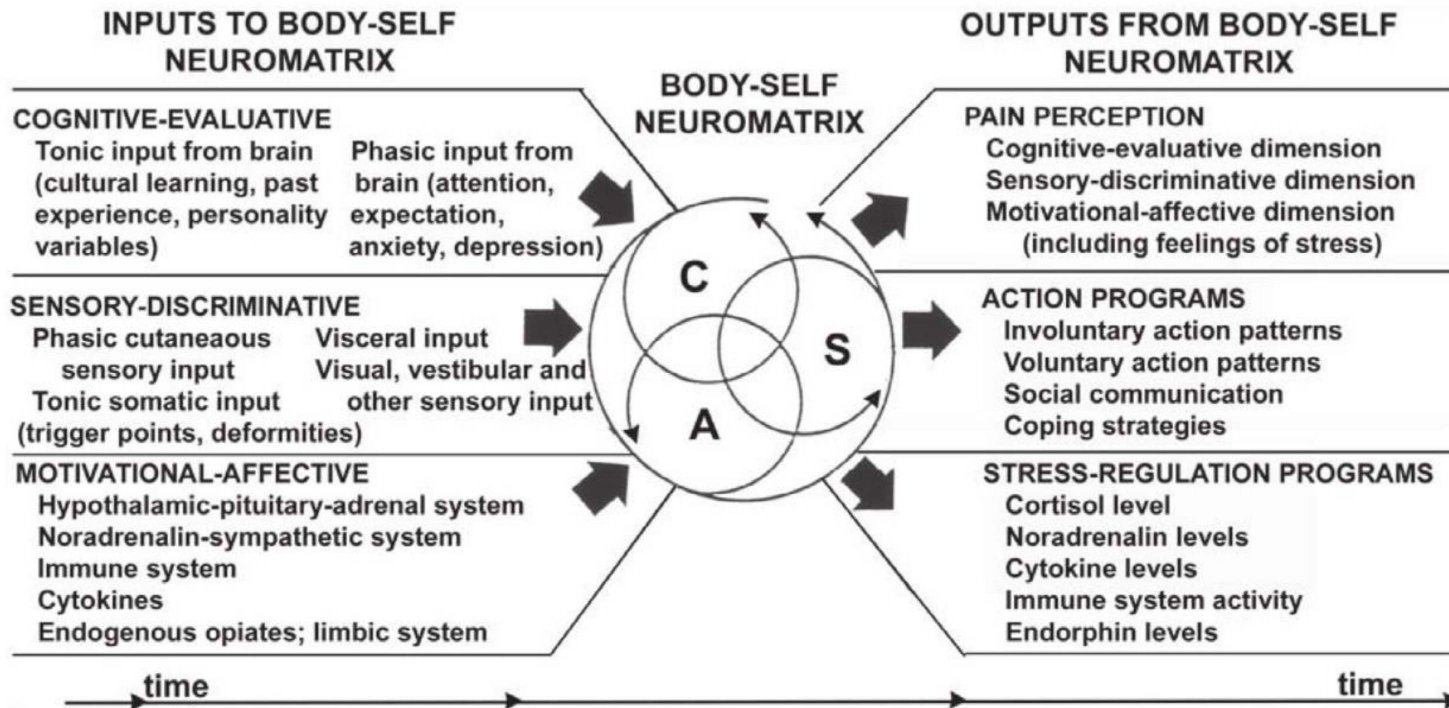

Figure 1. Factors that contribute to the patterns of activity generated by the body-self neuromatrix, which comprises sensory, affective, and cognitive neuromodules. The output patterns from the neuromatrix produce the multiple dimensions of pain experience as well as concurrent homeostatic and behavioral responses.

From *Pain and the Neuromatrix in the Brain,* by Melzack

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The Three R's: Relaxation, Rhythm, and Ritual

There are three characteristics common to women who are observed to be coping well with pain in labor.

1. They can **RELAX** during labor and/or between contractions. In early labor, relaxation is a realistic and desirable goal. As labor progresses, many women cope much better if they don't try to relax during contractions. They may feel better if they move or vocalize during the contractions, or even tense parts of their bodies. It is vital, however, that they relax and remain calm between contractions.

2. The use of **RHYTHM** characterizes their coping style. This can be anything from slow dancing with their partner, to leaning over a birth ball and swaying the hips, bouncing on the birth ball, counting out loud, using a rhythmic breathing technique, repeating sounds or words, and so on.

3. They find and use **RITUALS.** The ritual is repeated use of personally meaningful rhythmic activities with every contraction. At first, women may draw heavily on coping measures they learned in childbirth class. However, those who cope well usually do more than that—they discover their own rituals spontaneously in labor. If disturbed in their ritual or prevented from doing the things they have found to be helpful, laboring women may become upset and stressed.

Women are most likely to find their own coping style when they feel safe and supported, are free from restrictions on their mobility and vocal sounds, and are also free from disturbances to their concentration, such as other people talking to them, or doing procedures on them during contractions. Following are some examples of unplanned, spontaneous rituals discovered by laboring women:

- One woman felt safe and cared for when her mother brushed her long, straight hair rhythmically during the contractions.
- Another rocked in a rocking chair in rhythm with her own pattern of breathing.
- Another wanted her partner to rub her lower leg lightly up and down in time with her breathing.
- Another wanted her partner to count her breaths out loud and point out to her when she was beyond the number of breaths that meant the halfway point in the contraction.
- Another dealt with her back pain by leaning on the bathroom sink, swaying rhythmically from side to side and moaning, while her partner pressed on her low back.
- Another let her breathing follow the rhythm of her partner's hand moving up and down, "conducting;" she focused entirely on her partner's ring as her guide.
- Another integrated several rituals into one—slow dancing with her partner for every contraction as a helper lightly brushed behind her knees (as a reminder to relax the

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joint) at the onset of the contraction; she repeated the words “baby” and “open” out loud; and wanted an ice-cold washcloth to refresh herself between contractions.

Once a woman finds a ritual, she depends on it for many contractions, even hours. Changing the ritual or disturbing it throws her off. Most women change their ritual from time to time in labor, when a change of pace seems necessary. Sudden abandonment of the ritual is a sign of progress in the labor.

Adapted from materials authored by Penny Simkin in the DONA International Birth Doula Training Manual

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The Birth Marathon: Food & Drink for Labor & Birth

Despite research that concludes that moms should have access to food and drink in labor, many moms birthing in U.S. hospitals today are faced with instructions to not eat solid food and are restricted to ingesting clear liquids only. If labor goes on longer than your blood sugar can hold out and contractions or your energy begins to wane, try the following options. Your overall strategy here is to achieve a stable blood sugar throughout labor. This can be challenging, not just due to restrictive hospital policies and the limitations of what is available on site, but because:

- some women feel nauseous from the onset of labor
- some women respond to pain with nausea and vomiting
- digestion does slow during active labor because blood flow is concentrated to the uterus
- you may not have an appetite
- you may fear vomiting (remember, however, that nausea is one of the symptoms caused by low blood sugar!)

Strategies

- Some women experience an urge to load up on carbohydrates in the 24-hour period before the onset of active labor, like what an athlete may do in preparation for running a marathon on the following day. Go for it! (I had bread, salad, and pasta for dinner at a local restaurant 12 hours before my second child was born and never felt nauseated in labor, which started about 5 hours after the meal.) This strategy is especially recommended if you are facing a scheduled induction. You don't want the hard work to hit after you've been essentially fasting for 24 hours or more.

- EAT WHILE YOU ARE STILL AT HOME IN EARLY LABOR. This is key and must be maintained throughout the day. Don't just settle for breakfast and stop there. Eat every 2–3 hours, whatever appeals. You may want to avoid heavy, greasy foods such as pizza or fast foods (which don't digest easily under the best of circumstances).

- Avoid substances that will spike your blood sugar such as pop and other forms of concentrated sugar (read your labels!). These will dehydrate you and lead to your blood sugar crashing.

- Eat a banana on the way to the birth center/hospital. Despite most TV depictions of how women go into labor (i.e., a sudden contraction alerts her to the need to rush to the hospital where she gives birth soon after on her back, typically involving various emergencies for dramatic effect), most women have plenty of time to take care of

themselves at home and head to the birthing center/hospital with little need for high drama.

- During labor, try a variety of the suggestions below, alternating them. A little protein here, some electrolytes there, something sweet to boost your energy, the Pregnancy Tea … you get the idea. That will keep you going if your labor is long. This is especially important for women who might be admitted to the hospital early in labor or whose labor is being induced.

- Drink lots of water, at least 4 ounces per hour throughout your labor, more if it's a hot day and you're sweating a lot. Have your support team help you with this. (Note to partners and doulas: It's your job to encourage the mom to drink throughout her labor. If she is willing to drink, asking for it and consistently taking several gulps when offered, then just keep the supply coming and keep an eye on her to ensure she doesn't stop drinking at some point. However, if the mom is disinterested in drinking and reluctant to do so, then frequent small sips will be necessary. Keep offering!)

- Finally, don't hesitate to accept IV fluids if you can't keep anything down over a long period of time and are getting dehydrated. While most healthy women will not need routine IV fluids, dehydration can cause your labor to be dysfunctional and nonproductive. An IV can turn the picture around and is an appropriate use of medical intervention.

Raspberry Leaf Tea Labor Cubes

Before labor begins, make up a VERY strong tea (two quarts of boiling water with 2 cups of dried red raspberry leaves added). Simmer with the lid off for at least 20–30 minutes as the volume reduces considerably. Strain and add ¼ cup of honey (raw is best if possible). Pour into ice cube trays and freeze, adding water, if necessary, for at least one tray's worth. Store in a zippy bag at home or take with you to the birth center/hospital (usually you can store them in the freezer of the small room refrigerator or in the common "nutrition room" refrigerator). The honey gives mom a boost of energy, while the concentrated raspberry leaves provide minerals and may assist in bringing back strong contractions. In between the contractions, mom can easily crunch the cubes into a satisfying slush.

Electrolyte-Balanced Sports Drinks

There is a large variety of sports drinks on the market these days. Avoid the overly sweet, chemically generated metallic blue and other colored products not found in nature. See what's available at your local health food store and find something you like. Have 2–3 quarts on hand for labor (your support team will appreciate these as well). I like a product called Recharge and it comes in several flavors.

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Miso Broth

If you're unfamiliar, miso is a paste made from fermented soybeans. It is high in protein and tastes salty. If you haven't tried miso, there are several different flavors available in the refrigerated section of your local health food store. Give them a try and find one you like. The paste can be brought with you to the hospital and kept in the refrigerator. Mix one tablespoon of miso into one cup of hot water. Avoid boiling miso as it kills many of the nutrients. There are also packets of instant "miso soup" on the market. This is a good option for doulas and midwives to carry to births.

Concentrated Home-Made Chicken or Beef Broth

Place one whole (preferably organic) chicken or a couple of beef bones in a large soup pot. Bring to a boil and spoon off the scum that will rise to the surface over a 10-minute period and discard. Roughly cut up 1 onion, 3 carrots (washed, with skins on) and 3 stalks of celery, including tops. Chop up 2–3 garlic cloves and throw those in too (you can even leave the skins on as a timesaver). Cover and reduce heat, simmering for 1½ hours. Allow cooling and strain out the solids (make chicken salad with the meat). Put in refrigerator overnight so that the layer of fat on top solidifies. In the morning, remove and discard the fat layer, but don't worry if a little is left behind. Return the broth to the stove uncovered and bring to a boil, allowing the liquid to reduce to a rich-colored (and tasty!) broth. Add salt to taste at the very end. Freeze in small containers to have on hand for labor.

Herb Tea and Honey

Bring a variety of your favorite herbal teabags and some raw honey with you to the hospital. When energy flags, especially in the second stage of labor, a cup of tea with a generous spoonful of honey can give you the boost you need to get the job done. Ginger tea can settle the stomach if nausea is an issue.

Hot Drinks

Americans are big on iced drinks, but in many parts of the world, ingesting iced drinks is not recommended. Many cultures, from China to South America, have prohibitions against iced drinks for women in labor or postpartum. The wise women grandmas-to-be will not allow it. Feed the fire. You are supposed to get hot in labor! You will sweat. You will be uncomfortable. It's okay. It's more efficient.

Labor Food

Women have been using tubes of concentrated carbohydrates found in the runners' stores (aka "goo"). Lots of flavors, promoted as digesting rapidly and easily while vigorously exercising, and easy to just take a squirt. Be sure and follow up with water as it is very concentrated. Rave reviews from birthing moms. Other labor foods include:

- yogurt or kefir or fruit smoothies
- light foods that appeal
- bananas (worth mentioning twice due to portability and high potassium content)

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Positions for Labor

Squatting Positions

- Squat with rebozo and partner; doula wears rebozo around her hips while mom hangs on and squats
- Rebozo suspended over closed door, mom straddles large peanut ball
- Lap squat: mom straddles partner's lap, facing him/her; partner grasps own wrists behind mom to secure her; doula behind mom for safety – OR –
- Lap squat with doula behind partner AND rebozo for safety
- Lap squat reverse position, mom leans back on partner
- Dangle (partner sits on ledge, each foot on a stool; mom places arms over partner's upper legs and dangles)

Standing Positions

- Forward leaning/swaying
- Forward leaning/swaying w/ball on table
- Slow dancing w/partner (mom sets the rhythm, partner follows)
- Add figure-8 to slow dance w/partner

Sitting Positions

- On ball (rocking, figure-8, light bouncing)
- Backwards-facing chair (toilet), resting forward
- Two-partner pass on birth ball; mom on ball, leans back on partner; doula in front; moms is passive as her two helpers pass her back and forth
- Forward leaning into partner on ball; mom on ball, partner on chair, mom leans into partner; doula has access to her back
- Semi-lunge in bed with peanut ball (2 variations)
- Rebozo pull to release pelvis (2nd stage); rebozo around doula's waste; mom in sitting position, pulls on rebozo while bearing down

Kneeling Positions

- Kneeling – leaning in
- Over ball – add swaying
- Over top of birth bed
- Forward leaning over peanut ball
- Fire hydrant with peanut ball

Lying Down Positions

- Side-lying with pillows/bolster
- Tuck position with peanut ball

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The Value of Affirmations

Our values and beliefs influence what happens to us by aligning our energy with them and making it more likely that they will manifest in our lives. Much of our life has a self-fulfilling character. We attract what we fear, or we can often say, "I knew that would happen to me." Since what we say about ourselves (positive or negative) strongly influences what unfolds in our lives, it is possible to take advantage of this by creating or using positive affirmations. Repeating or writing affirmations such as the following can help you to realize their truth and to identify and release any blocks from the past that may stand in the way of these statements manifesting in your life. By employing affirmations, we can reprogram deep-seated, often subconscious, patterns in our lives that are not serving us well.

Pregnancy Affirmations

- My body is beautiful and strong.
- My baby is growing beautiful and strong.
- I am and will be a good parent to my child(ren).
- The Universe loves and supports me and my baby.
- My baby and I are ready for the Divine Plan of our lives to unfold.
- The baby is naturally developing and doing just what he/she should.
- Pregnancy is natural, normal, healthy, and safe for me and my baby.
- My baby knows when it is time to be born.
- My body will go into labor on its own, at the perfect time.
- I am doing a great job taking care of myself and the baby.

Birth Affirmations

- My body knows how to give birth and I will let it.
- Contractions help my baby to be born.
- Each contraction brings me closer to meeting my baby.
- Strong contractions are good ones.
- I am strong and I can let my contractions be strong.
- I am calm and relaxed. My baby feels my calmness and shares it.
- The baby and I are rested and ready for the work we will do.
- With each contraction my cervix dilates a little more.
- My contractions are massaging the baby and hugging him/her.
- The baby is descending naturally.
- The baby's head fits perfectly in my pelvis.
- I am opening.
- My tissues are stretching beautifully, just as they should.
- I accept the healthy pain of labor, if and when it is here.
- I feel the love of those who are helping me.
- I attract wonderful people to support me in labor.

- My health care providers are very respectful of my wishes.
- I send love to my baby and call him/her to my arms.

Postpartum Affirmations

- My body is beautiful and strong.
- I am proud of all that I have accomplished.
- My body knows how to make milk.
- My body is making the perfect amount of breast milk.
- I know how to nurse my baby.
- I am adjusting to life with my new baby.
- I share in the strength and wisdom of all mothers.

Suggestions for Working with Affirmations

- Work with one or more every day. The best times are just before sleeping, before starting the day or when you are feeling troubled.

- Write each affirmation 10 or 20 times on a sheet of paper, leaving space in the right-hand margin of the page for the "emotional response." As you write the affirmation down on the left side of the page, jot down whatever thoughts, considerations, beliefs, fears, or emotions come to your mind. Keep repeating the affirmation and notice how the responses on the right change.

- Put specific names and situations into the affirmation. Include your name in the affirmation. Say and write each affirmation in the first, second and third person. "I (your name) love myself. You (your name) love yourself. (Your name) now loves herself."

- Play with the vocabulary in the affirmation. Make it personal and meaningful. Be specific about your desired result.

- Record your affirmations and play them back when you can. A good time is while driving or when going to bed.

- Try looking in the mirror and saying the affirmations to yourself out loud. Keep saying them until you can see yourself with a relaxed, happy expression. Keep saying them until you eliminate all facial tension and grimaces.

- Sit across from a partner, each of you in a straight chair with your hands on your thighs and knees barely touching. Say the affirmation to your partner until you are comfortable doing it. Your partner can observe your body language carefully. If you squirm, fidget or are unclear, you do not pass. He or she should not allow you to go on until you say the affirmation very clearly, without contrary body reactions and upsets. Then your partner says them back to you, using the second person and your name.

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Continue until you can receive them without embarrassment. This is harder than it sounds!

- Don't give up! If you ever get to a point where you begin to feel upset, shaky, or afraid about something negative you discover, don't panic. Keep on writing the applicable affirmation over and over until your mind takes on a new thought. As it does, the negativity will fade away and you will feel lighter and better. Remember, it is just as easy to think positively as negatively. In fact, it is easier. Negative thinking takes more effort.

- Don't be afraid to experiment. Affirmations can be useful in all areas of your life—for problems at work, problems with health, personal growth ...

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Visualizations for Birth

Visualization is a great relaxation technique. It can be done in many situations and has great potential to be very individualized. When we talk about visualization, most people think of things like reading scenarios of walking through the forest or lying on the beach listening to waves. That can be a visualization exercise. However, what works best is usually something personal.

Many people enjoy reliving a positive experience, a date, a vacation, their wedding. This is done by the retelling of the story by your partner. Be sure to include all the details to help you remember—sights, smells, tastes and sounds. Using all the senses is important.

Explaining what is going on in the body and using those images as a relaxation tool is also beneficial. For example, remind the mother that what she is feeling is her cervix opening and provide a visual image, such as a flower bud opening. Some women will even choose a single, inanimate object. It might be a photo, a special relaxation card or whatever works.

Visualization for relaxation is a basic skill for labor and childbirth. Many childbirth classes teach visualization to promote relaxation and reduce pain and fear in labor. Following the fear-tension-pain cycle, we know that to help reduce pain, we need to reduce fear and tension.

Here is a simple exercise for visualization:

- Begin by taking a few deep abdominal breaths. This will help you release tension and center yourself. Then picture an image that represents tension, this could be any image, but the exercise will be most effective if you choose a picture that represents something to you from your own life. Examples might be a closed cervix or fist, a contraction, or a crying baby.

- Continue the deep breathing as you find this tension image. As soon as you have focused on an image, begin to find a way to relax the image. That is, have the cervix soften and open in your mind; watch the contraction work and then ease; or have the crying baby brought skin to skin and calm.

- You can use this during contractions or afterward as you try to scan your body for tension after the contraction is over. When you are done with this visualization exercise, consider repeating an affirmation to praise yourself and reinforce the relaxing thoughts.

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Encouragement in Labor

During labor, one of the most powerful tools of the coach is the ability to assure the mother that she is doing well and to encourage her to continue what she is already doing. You may not believe it, but many a laboring mother has been helped by three little words, "You're doing great!" It sounds too simple to be true, but it is.

During active labor, the mother may not realize how far she has come. She is taking her labor one contraction at a time and, unlike those supporting her, she may not see it as one contraction closer to giving birth. She may not even recognize that she has a significant portion of her labor behind her. That is one of the reasons a coach is so important. The coach becomes the mother's "eyes and ears," watching what is happening and letting the mother know where she is. Comments such as "I can't do this!" can be calmed by responses such as, "but you've been doing this for an hour and you're doing great." Suddenly, the mother will have a new-found confidence to continue.

Transition is a time of confusion for a mother. She cannot get comfortable, and she doesn't seem to know what to do. Coping techniques that were working may suddenly stop helping. She may not even remember that she is in labor for a baby. It is at this point that the reassuring words of her coach can help a woman most. She will need to be reminded how close she is to pushing and to holding her baby. She will also need to be reminded what to do. She may not remember for more than a few seconds, so repeat yourself without getting frustrated. Looks of panic on the mother can be responded to with, "I'm right here, we're almost done."

What are the magic words of encouragement that will help the mother? That will depend on who she is and what your relationship is with her. In some instances, "I love you" will be reassuring. In other cases, "You're doing perfectly, it's beautiful to watch you" will reassure her. As her coach, you should know the mother well enough to know what will relax and reassure her. You may also try repeating an encouraging phrase several times. Lines such as the following, said to the mother during a contraction, can give her something to focus on, while reassuring her that what is happening is normal.

See sample words of encouragement on the following page.

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You're doing so well.

That's it … That's the way.

You're doing it!

You are so strong—strong enough for this.

You're working with the contractions so well.

You are relaxing beautifully.

It's okay to cry.

That was a good one!

I'm right here.

I will help you.

You can do it.

Say with me, "I can do it."

Each contraction is bringing our baby closer.

We will meet our baby soon.

I'm proud of you.

Let's just get through this one.

Perfect, just perfect.

The baby is moving down; the baby will be here soon.

You're doing exactly what you need to be doing.

The stronger it feels, the better it works.

You are doing so well.

Your body is working perfectly.

Everything is working perfectly.

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Bishop's Score for Induction of Labor

This is the table used to determine how successful an induction of labor might be. It is recommended that the Bishop's Score be greater than 9 for induction to be successful. To ensure your own induction's success rate, inquire about your Bishop's Score. The unfortunate reality is that there are inductions being performed with scores as low as 2 that make induction very difficult and success rates low. Induction with a low Bishop's Score decreases a woman's ability to cope with the increased pain of induction and increased length of labor. When combined with artificial rupture of membranes (in an effort to boost the success rate), the risk of infection for mom and baby, as well as the incidence of cesarean delivery, go up. We encourage you to make informed decisions for both you and your baby!

Bishop's Score
0, 1, 2, or 3 points are assigned for each parameter listed.

Position of Cervix
0 Posterior (towards the back)
1 Mid-position
2 Anterior (towards the front)

Consistency of Cervix
0 Firm
1 Medium
2 Soft (ripe)

Effacement of Cervix
0 0-30%
1 40-50%
2 60-70%
3 >80%

Dilation of Cervix
0 Closed/0 cm
1 1-2 cm
2 3-4 cm
3 >5 cm

Baby's Station (degree of engagement in mom's pelvis)
0 -3
1 -2
2 -1, 0
3 +1, +2

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Cervical Sensations

0 None
1 Slight
2 Strong and frequent
3 Coordinated with some or all toning contractions

+ Vaginal Secretions

0 No increase
1 Increased mucus
2 Increased with bloody mucus

+ Toning Contractions

0 None to slight
1 Mild
2 Strong, sporadic, frequent
3 Almost regular, visible on abdominal observation

Modifiers: Add 1 point to score for each of the following

- Preeclampsia
- Each prior vaginal delivery

Subtract 1 point from score for each of the following:

- Postdates pregnancy
- Nulliparity (never having borne children)
- Premature or prolonged rupture of membranes

Total Score = sum of all points for each parameter

Interpreting Your Score

7 or less: Do **not** attempt induction without ripening the cervix first
9 or more: Favorable to attempt induction
12 or more: You are quite ready for labor or in early labor; consider if there is anything you need to feel ready

Note

+ All items with a “plus sign” are added by Anne Frye, *Holistic Midwifery Volume II,* and have been proven helpful from a midwifery-model perspective. All others are original components of the Bishop’s Score. If only using only the original components, then 7 and above is considered a favorable score.

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The Doula and the Epidural

By Penny Simkin, with permission, www.PennySimkin.com

As doulas, most of us enter the labor support field with a deep belief in the normalcy of birth and the ability of the human body to accomplish childbirth safely with a minimum of interventions. We also believe that childbirth carries the potential for growth and fulfillment for women who are well cared for and nurtured through labor. We perceive that our role of mothering the laboring woman improves her obstetric and newborn outcomes while facilitating mother- infant attachment and increasing her confidence as a woman and a mother. There is much scientific evidence that confirms all these beliefs.

The growing popularity of doulas among expectant women and couples is due, at least in part, to the women's desire to improve the likelihood of a good outcome. They also recognize the value of having a familiar, knowledgeable, experienced person with them continuously through labor and birth, to reassure and comfort them and to help them communicate with staff. Until recently the women most likely to request additional labor support were those who had a strong desire for natural childbirth or for a vaginal birth after a previous cesarean. Today, women who plan epidurals want a doula, not only for emotional support, but also to help with side effects of the epidural and with positions and pushing.

Wherever it is available, the epidural block, a relatively safe, highly effective form of labor pain relief is desired by most laboring women. But there are trade-offs and a price to be paid for the benefit of pain relief. Even when well-informed, many women are willing to give up a lot if they don't have to experience pain. Among the trade-offs is decreased participation by the mother—almost complete passivity—thus shifting greater responsibility for maintaining comfort and labor progress to the care- giving staff. Other trade-offs are listed in the table under "Associated effects of an epidural."

Doulas recognize that their role shifts when a woman has an epidural. Certainly, the woman does not require encouragement in using labor-coping techniques, the intense eye to eye, breath to breath support, or the hands-on comfort measures that doulas excel in. In fact, the woman often falls asleep as soon as the epidural takes effect, or chats as if she weren't in labor, or watches TV! Many a doula has asked herself, "What am I doing here?" as the woman lies comfortably in her bed, with the nurse busily monitoring the equipment. We often feel unimportant and uninvolved as we sit quietly by the bedside, make small talk, or take a break. Sometimes we feel like leaving. Should we?

Are we unimportant, unneeded, and useless to the woman with an epidural? The answer is, "Absolutely not," but now we must play a different role. The woman with an epidural still needs and deserves sensitive and appropriate labor support, because emotional distress and anxiety do not necessarily go away when pain is alleviated. The immediate relief from pain will lift her spirits and perhaps enable her to sleep, but later, distress or anxiety often

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resurfaces, focused not on pain, but on other things, such as worry about the pain returning; how long labor is taking; the baby's well-being; inability to move; the "dead" feeling in her lower body; side effects of the epidural; boredom; the withdrawal of her partner's support (her partner often goes to sleep, leaves her alone, or watches TV); "forgetting" she is about to have a baby.

Although the doula is no longer needed to help the woman cope with her pain, she can minimize many of the undesired side effects of the epidural. She still provides emotional support, reassurance, and information. She helps the woman remain focused on her labor and her baby. She helps the woman get into favorable positions and to push appropriately during the second stage. The doula's role is still to nurture and protect the woman's memory of the birth, and to help her have a vaginal birth.

See the table for suggestions for specific ways a doula can help prevent some of the clinical problems and the emotional stress that is often associated with epidurals. The doula maintains her focus on the woman as the central player in the childbirth drama, even though the clinical care providers must take on a much more active role in maintaining safety and labor progress. Thus, the doula not only ensures that the woman's emotional needs are met, but she also helps the mother utilize the important resources (positions, pushing, active mental participation, early breastfeeding) that only she can contribute to a favorable outcome.

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How the Doula Helps the Woman with an Epidural

POSSIBLE ASSOCIATED EFFECTS OF AN EPIDURAL	HOW A DOULA MAY HELP
Anxiety, pain, involuntary movement during administration of the epidural (especially when the procedure does not go smoothly).	• Intensive coaching with relaxation, breathing techniques, reassurance, calming voice, positive messages. • Acknowledgment of how well she is doing, even though it is challenging.
Disappointment that she needed an epidural.	• Reassurance, support for decision.
Woman falls asleep for a few hours.	• Take a break: nap, make phone calls, get a meal. • Chat with partner or staff. • Read, knit, do paperwork. • Do not leave.
Inability to move her lower body and legs.	• Help her change positions, especially if progress slows or fetal heart rate drops.
Woman almost “forgets” she is in labor—making it very challenging later, when suddenly, almost by surprise, she is expected to push her baby out.	• When she is awake, remind her that she is in labor by pointing out when she’s having a contraction, having her feel some contractions with her fingers. • Point out when her baby moves.
Extra interventions (intravenous fluids, Pitocin, continuous monitoring, bladder catheterization, forceps or vacuum extractor, and others).	• Be sure the woman understands what they are and why they’re being done. • Reassure that these are expected. They often accompany an epidural.

POSSIBLE ASSOCIATED EFFECTS OF AN EPIDURAL	HOW A DOULA MAY HELP
Drop in blood pressure and resulting flurry of activity (oxygen mask, position changes) by staff to restore it to normal.	• Explain to the woman and partner, "They are moving quickly because your blood pressure has dropped. These things will help bring it up. Your job is to cooperate and breathe the oxygen deeply." • Remain calm; help with position changes, if needed.
Inadequate pain relief.	• Notify nurse. • Help her resume self-help measures: relaxation, attention focusing, patterned breathing.
Full bladder, which can slow labor.	• Look for or feel for soft bulge above pubic bone; draw nurse's attention to it. • Keep track of woman's voiding.
Unexpected side effects, such as those listed below (a–e).	• Provide or help the woman get information on "trade-offs" ahead of time.
a. Fever (prevention and treatment).	• Use cold compresses, fanning • Concern is to avoid confusing this side effect with an infection, leading to prophylactic antibiotic treatment
b. High anesthesia level; woman feels frightened, as if she can't breathe.	• Call nurse. • Speak calmly. Acknowledge her feeling that she is not breathing. Reassure her that she is breathing.

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POSSIBLE ASSOCIATED EFFECTS OF AN EPIDURAL	HOW A DOULA MAY HELP
c. Ineffective pushing. (Many caregivers delay pushing until the head is visible at the perineum. This reduces the need for instrumental delivery.)	• If she can tolerate it, suggest she let epidural wear off to increase urge to push. • Discuss delaying pushing until the head is visible at the perineum. • Use monitor for motivation and biofeedback; watch it and report to her how high the contraction intensity number goes when she bears down; give her a number as a goal.
d. Persistent asynclitism or malposition.	• Try to know fetal position. • If possible, postpone maximal pushing until she feels an urge to push, the fetus is occiput anterior, or head is visible at perineal outlet. • Change mother's position.
e. Long-term postpartum backache, other joint pain.	• Try to prevent joint strain by ALWAYS respecting the limits of her joints; don't jerk or wrench or twist her limbs. • Support numb limbs, when assisting with position changes or with pushing.

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Steps for Reducing the Need for a Cesarean

- Eat properly, get plenty of rest and exercise, and avoid undue stress.
- Develop trust in the birth process; take personal responsibility for the birth rather than expecting the doctor/midwife to take care of everything.
- Avoid all routine or "just-in-case" interventions; if a clear problem exists, use the least invasive interventions first.
- Choose supportive providers and birth environments, even if it means changing late in pregnancy.
- Use alternative treatments for the four major indications for cesarean, together responsible for about 80% of all cesareans. These include: previous cesarean, prolonged labor, fetal distress, and breech presentation.

Alternative Approaches to Prolonged Labor

- Patience and emotional support; slow progress is not inherently dangerous; arbitrary time limits are inappropriate; the diagnosis should not be made before active labor (cervix 4–6 cm and effaced, contractions regular, painful, and progressive)
- Ambulation and position changes
- Help with relaxation, including massage, warm water, mental imagery, slow deep breathing and other means
- Nipple stimulation to increase natural oxytocin
- Avoid epidural anesthesia or medication, or let it wear off when the second stage is reached or if progress stops.
- Meet fluid and calorie needs; total fasting in labor stresses both mother and baby
- Physiological pushing, in an upright position, only with the mother's reflexive urges, with an open mouth and throat

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To Minimize Fetal Distress, AVOID:

- Supine or back reclining positions (less than 45 degrees from the horizontal)
- Artificial rupture of membranes, except for specific medical need
- Sedation and anesthesia
- Pushing with prolonged breath holding
- Continuous electronic fetal monitoring in low-risk labor; fetal scalp sampling is advised to confirm distress

Alternatives Approaches to Breech Presentation

- Attempt to turn the baby before labor through postural exercises, external cephalic version, or acupuncture.
- Vaginal breech birth by skilled attendant for full-term, normal-sized frank and complete breech babies, without hyper-extended head.
- See www.SpinningBabies.com for more alternative approaches.

Other Steps to Reduce Risk of Cesarean

- Be a good consumer; shop around for your midwife or doctor. Ask what the cesarean rate is for your caregiver and for your place of birth.
- Take personal responsibility for yourself and your pregnancy through excellent nutrition, prenatal care, self-education, and decision making.
- Avoid induction of labor.
- Write a Birth Plan; make sure it is in your chart at the hospital.
- Stay home until active labor is established.
- Don’t go alone! Take your well-prepared partner and a professional doula; it’s your best investment in cesarean prevention.
- Get up to urinate at least once per hour.
- Change positions frequently—active birth works best!
- Walk, walk, and walk some more.
- Eat and drink to appetite and thirst.
- Avoid all drugs—anesthesia and/or analgesia.
- Avoid IVs and minimize use of electronic fetal monitoring.
- If you want a VBAC (vaginal birth after cesarean), find a practitioner who has a high success rate.

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Active Management of Third Stage of Labor

Definitions and Related Facts

Postpartum hemorrhage and complications of third stage of labor

- Blood loss greater than 500 ml (a little over two cups), with severe postpartum hemorrhage being loss of 1,000 ml or more, and very severe being a loss of 2,500 ml or more.
- Anemia in the mother can pre-exist or be the result of hemorrhage; severe cases may necessitate a blood transfusion.
- Postpartum hemorrhage is the main cause of maternal death in several countries, the vast majority of which occur in the developing world.

Active management of third stage

- A uterotonic medication is administered to all mothers immediately prior to or after delivery.
- Early clamping and cutting of the umbilical cord, often before the cord ceases to pulse (thereby cutting off the transfer to the baby of his/her full blood volume).
- Wait one minute, after clamping the cord, and initiate controlled cord traction for delivery of the placenta.

Expectant management of third stage

- Signs of placental separation are awaited, and the placenta is delivered spontaneously via normal uterine contractions.
- May involve nipple stimulation by putting the baby to breast immediately after delivery, stimulating an oxytocin surge in the mother.
- Medical interventions that interfere with the body’s natural oxytocin release may reduce the effectiveness of the normal physiological process (because oxytocin release can be inhibited by anxiety and excess adrenaline, oxytocin augmentation in labor, and administration of epidural or narcotic analgesia).
- The umbilical cord is left intact until it has ceased pulsing and baby has received his/her full blood volume.
- Uterotonic drugs are used only in cases of excess bleeding.

What does the evidence say?

Medical recommendations in favor of active management over expectant management of third stage of labor are based on a Cochrane Review of eight studies involving 8,892 women. For all women, irrespective of their risk for severe bleeding, active management protocols reduced the incidence of severe postpartum blood loss, maternal blood transfusions, and postpartum anemia. At the same time, the following statistically significant negative effects of active management were noted:

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- Increase in mother's blood pressure, afterpains, vomiting, and use of drugs for pain relief; these effects are due to administration of a specific uterotonic (choice of drug used, specifically ergometrine).
- Increase in the number of women returning to the hospital ER after discharge due to bleeding (thought to be caused by controlled cord traction leading to retained shreds of membrane or placenta). It should be noted that such bleeding takes place away from immediate access to medical assistance—a concern of greater significance for women in low-income countries where access to medical care is more limited.
- Decrease in newborn birth weight due to early cord clamping leading to a 20 percent reduction in the baby's overall blood volume and a higher incidence of anemia in the infant.

Conclusions

"It must be emphasized that this review includes only a small number of studies with relatively small numbers of participants, and the quality of evidence for primary outcomes is low or very low."

"Although the data appeared to show that active management reduced the risk of severe primary postpartum hemorrhage at the time of birth, we are uncertain of this finding because of the very low-quality evidence. Active management may reduce the incidence of maternal anemia following birth, but harms such as postnatal hypertension, pain, and return to hospital due to bleeding were identified."

"In women at low risk of excessive bleeding, it is uncertain whether there was a difference between active and expectant management for severe PPH."

"Women could be given information on the benefits and harms of both methods to support informed choice. Given the concerns about early cord clamping and the potential adverse effects of some uterotonics, it is critical now to look at the individual components of third-stage management. Data are also required from low-income countries."

Source:

Begley, C., G. Gyte, D. Devane, W. McGuire, and A. Weeks. (2019). Active versus expectant management for women in the third stage of labor. *Cochrane Library.* Retrieved from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007412.pub5/full

My Commentary

Question for Parents to Consider. For low-risk women, especially those experiencing drug free labors, do the benefits of active management of third stage of labor outweigh the risks?

Parents are encouraged to discuss the benefits and risks of the active management approach with their midwife or doctor as it applies uniquely to their situation.

When Things Are Happening Fast and Informed Consent. In my experience, in healthcare settings where active management is routine, informed consent for this practice is rare. Two specific pieces of active management—early cord clamping and administration of Pitocin—are completed within a minute after birth. Therefore, many parents (being distracted) may not even notice what is done until after the fact. Parents who prefer an expectant management approach will need to discuss their preferences with their care provider, express their wishes in a birth plan, and then be prepared to advocate for their preferences at the delivery. Keep in mind that whomever parents discuss this topic with prenatally is not necessarily the same person who will be attending the birth.

Mixed Management Option. Further study is needed on the “mixed management option” based on the mother’s risk factors. A mixed management approach might be most beneficial for someone with a high-risk birth. For example, for someone with low iron, one option might look like this: IM Pitocin immediately following the birth to decrease the chance of hemorrhage (active management), delayed cord clamping to allow the baby to receive his/her full blood volume from the placenta (expectant management), and careful cord traction once the cord is done pulsing (mild active management).

Keep in Mind. Medical interventions that interfere with the body’s natural oxytocin release may reduce the effectiveness of the normal physiological process (i.e., oxytocin release can be inhibited by anxiety and excess adrenaline, oxytocin augmentation in labor, and administration of epidural or narcotic analgesia). This should be taken into consideration by women preferring an expectant management approach.

Delayed Cord Clamping. In a post on Lamaze International's *Science and Sensibility* blog, pediatrician Dr. Mark Sloan examines common objections to delayed cord clamping and what the evidence says about its benefits. Dr. Sloan concludes, “*The evidence of benefit from delayed cord clamping is so compelling that the burden of proof must now lie with those who wish to continue the practice of immediate clamping, rather than with those who prefer—as nature intended—to wait.”*

Prevent Anemia. If active management of third stage is promoted as a benefit to anemic mothers (those with low blood levels of iron who might suffer more from even a normal blood loss at their birth), then let’s become as proactive as possible about preventing and treating anemia prior to the birth through proper nutrition and supplementation.

The Midwifery Model of Care. I believe routine active management of the third stage of labor is inconsistent with the Midwifery Model of Care [www.cfmidwifery.org]. It violates the basic tenet of respect for the birth process as it unfolds uniquely, as well as the belief that birth is a normal life process for which women’s bodies are well designed. This is to be distinguished from the medical model approach wherein birth is viewed as an emergency waiting to happen

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and interference with the normal process is common. In my area, hospital-based certified nurse midwifery practices are aggressively mandating an active management approach to the third stage of labor.

See also:
Sarah Buckley, “Leave Well Alone: A Natural Approach to Third Stage of Labor”
https://sarahbuckley.com/leaving-well-alone-a-natural-approach-to-the-third-stage-of-labour/

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Physical Labor Support Summary Sheet

Remind Mom of Physical Needs

- Eat to appetite
- Drink at least 4-6 oz of fluid per hour
- Pee every hour
- Rest if she can

Environment

- Music
- Essential oils
- Dim lights
- Fewer people
- Familiar items
- Change (music, temperature, surroundings, position)
- Partner vocalization matching

Stalled Labor

- Confront fears
- Examine expectations
- Change any comfort measures
- Change environment
- If at the hospital, consider going home
- If having a homebirth, consider sending midwives home
- Stop thinking
- Nap
- Reset mood in the room
- Acceptance of where she is today, in this moment

Back Labor

- Hands and knees with pelvic rocks
- Swirl on birth ball
- Belly dancing
- Sterile water papules
- Get into a deep tub, belly up
- Check out techniques taught by Gail Tully of spinningbabies.com

Comfort Measures

- Heating pads
- Rice socks
- Showers or baths
- Birth ball
- Massage
- Change positions!
- Visualizations
- Mantras
- Movement (dance, walk)
- Double hip squeeze
- Counter pressure on lower back
- Vocalizations

Nausea/Vomiting

- Peppermint tea
- Smell peppermint essential oil (2 drops on washcloth)
- Are you hungry?
- Environmental temperature change can decrease nausea
- Drink fluids slowly
- Consider IV

Asynclitic Baby

- Stairs
- Lunging
- Belly dancing
- One knee down and one up
- Knee-chest position
- Hands and knees with pelvic rocks

Exhaustion

- Rest between contractions
- Food and drink
- Consider Rx for sleep
- Consider IV

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Checklist of Comfort Measures for Labor

Relaxation/Tension Release

- Visual body scan for tension with feedback (either verbal or touch)
- Conscious release
- Roving body check

Rhythmic Breathing

- Slow it down
- Releasing breaths, elongated exhalation
- Patterned breathing (e.g., "he-he-hooo")

Vocalization

- Chant, mantra
- Exhalations with sound
- Moaning
- Affirmations

Comforting Touch

- Acupressure
- Hand & foot rub
- Light stroking (effleurage)
- Firm pressure / counter-pressure
- Crisscross on back
- Holding, hugging
- Centering or grounding techniques

Hydrotherapy

- Birth tub
- Jacuzzi
- Shower (on back or belly)
- Bathtub
- Pouring water over belly

Attention-Focusing Strategies

- Visualizations
- Affirmations
- Focal point
- Counting
- Eye contract

Positional changes of all kinds, using a variety of supports

- Birth ball
- Peanut ball
- Squat bar
- Pillows

- Rebozo
- Available furniture and grips
- Partner/doula
- Keep moving!!

Warm packs / rice sock / compresses

- Lower back
- Lower abdomen

Cold packs / compresses (between contractions)

- Face
- Neck
- Breasts

Specific Backache Measures

- Double-hip squeeze
- Knee-chest/open knee-chest
- Hands & knees with/without birth ball
- Pelvic rocking
- Lunge, asymmetrical positions

Emotional Support

- Feedback & verbal reminders
- Encouragement & reassurance
- Praise
- Patience
- Convey confidence in her
- Undivided attention
- Eye contact
- Take Charge Routine (firm direction in case of mounting anxiety or pain response)
- Anticipatory guidance and progress reports
- Match her mood
- Take contractions one at a time

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Cheat Sheet for the Birth Partner

At-a-Glance Summary of Stages of Labor & Support Reminders

Early Labor (at home)

- Encourage mom to eat to appetite.
- Remind her to drink fluids.
- Help her to REST for the big event (no last-minute housecleaning!).
- Remind mom to keep her bladder empty.
- If labor starts in the middle of the night, encourage mom to go back to sleep.
- Keep mom company and distract her—walk with her, play cards, watch TV, dance, etc.
- Encourage mom to change positions frequently, favoring upright positions.
- Time contractions, from time to time, and keep a written record. (Time from onset of one contraction to the onset of the next one; that is the frequency of the contractions. Also note how long the contraction lasts.) Do this for an hour or so and then put the stopwatch aside. Can check again later if it feels like things are picking up.
- Watch mom for visible signs of tension, especially in response to contractions, and help her to relax (baths, massage, deep breathing, verbal reminders).
- If mom seems anxious, ask her what she needs to feel safe.
- Ask her if there is anything she needs done around the house "to feel ready."
- Keep your care providers and support team updated.
- Realize that if you tell friends and family that you are in labor, you are inviting their energy and possible intrusion into the experience. Would it be better to let them know after the baby is born?
- Protect her from any negative people or influences.
- Tell her how well she is doing.
- Enjoy this time together.

Eat, Drink, Pee, Rest, Sleep, Distraction, Encouragement, Relax, Protect, Emotional Support

Active Labor

- Eliminate distractions in the environment; add to comfort with pillows, dimmed lights, music, etc.
- Control the presence of visitors, in alignment with your birth plan.
- Help navigate any decisions regarding her care, using your birth plan as a guide.
- Keep lips and mouth moist.
- Give her a back massage.
- Encourage her to drink fluids and urinate at least once per hour.
- Encourage mom to change positions frequently, favoring upright positions.

- Remember the 3 R's—Rhythm, Relaxation, Ritual.
- Recognize when she is coping well (rhythmic movement, relaxation) and protect the ritual.
- Help her find a ritual that works if she is struggling.
- Suggest immersion in water (if she is able) or a shower.
- Tell her you are proud of her.

Drink, Pee, Protect, Informed Decision Making, the 3 R's, Massage, Support, Move, Encourage, Guide, Praise

Transition

- Remind her to take one contraction at a time.
- Breathe with her.
- Help her to rest and relax between contractions (big breath out).
- If she panics, move in close, establish eye contact and help her stay focused for every contraction.
- Change the ritual if the one she was using isn't working any more.
- Expect it to get a little hairy; this just means that she is progressing (remind her of this!).
- Remember that this is usually the shortest part of labor.
- Don't give up on her if she gives up on herself.
- Hold intent for her if she has lost it temporarily.
- Validate her feelings.
- Tell her that you love her.

Face-to-face, Breathe, Stay Calm, Hold Intent, Validate, Reassure

2nd Stage/Descent and Birth of Baby

- Help her find the most comfortable and productive position
- Whisper words of encouragement. "You're doing just fine." "Just like that."
- Encourage her to rest between contractions.
- Remind care providers about any key items in the birth plan related to 2nd stage and immediate postpartum care for the baby (e.g., hot compresses to perineum, skin-to-skin, delayed cord clamping, etc.).
- Enjoy your baby!

Positioning Support, Encouragement, Advocacy, Delight

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3rd Stage/Delivery of Placenta

- Stay focused on the mom and the birth (it's not over yet; phone calls can wait).
- If she is reluctant, remind her that there are no bones in the placenta ("Almost done.").
- Give her a drink of something sweet.
- If she is shaky, ask the nurse to get her warm blankets.
- Encourage skin-to-skin contact with the baby.
- Continue to advocate for birth plan, as needed.
- Enjoy your baby!

Focus, Drinks, Warmth, Protect, Celebrate

Immediate Postpartum Recovery (First Two Hours)

- Keep mom and baby together, skin-to-skin.
- Baby will likely want to latch at the breast if given access. Ask for privacy if you like.
- Now you can make your calls! (Make an assessment whether you want visitors right away.)
- Take pictures.
- Have a meal.
- Celebrate!
- REST.

Skin-to-Skin, Breastfeeding, Privacy, Eat, Pictures, Celebrate, Rest

If Things Don't Go as Planned

- Help with informed decision making. Remember the questions:
    1. How will this help mom or baby?
    2. Can you describe the procedure involved?
    3. What are the risks or unintended consequences?
    4. Urgency? What are the consequences of giving it more time?
    5. Choices? Is there anything else that can be tried instead?
- Continue to advocate for pieces of the Birth Plan that can still be accomplished (e.g., skin-to-skin immediately after a cesarean delivery may be possible, even while mom is still on the operating table).
- Try to minimize the downside of any medical interventions (e.g., she does not need to lie flat on her back in bed just because she has fetal monitors strapped on or even an epidural in place).
- Understand that you are doing your best and that birth is unpredictable. Hang in there.

Informed Consent, Advocacy, Adaptation, Stay with it

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Additional Suggestions for Partners & Doulas

- Wear comfortable clothing and shoes. You could be on your feet for a long time.
- Bring a bathing suit or pair of shorts that you can wear in the shower (or birth tub if that is part of your plan).
- Bring a change of clothes.
- Pack food and drink for yourself.
- Keep your breath fresh by bringing a toothbrush and toothpaste.
- Bring a copy of the birth plan and have a good understanding of mom's wishes and desires.
- Recruit additional help for the labor room if you are feeling like you could use some support.

BRING:
Comfortable Clothing, Food & Drink, Breath Freshener, Birth Plan

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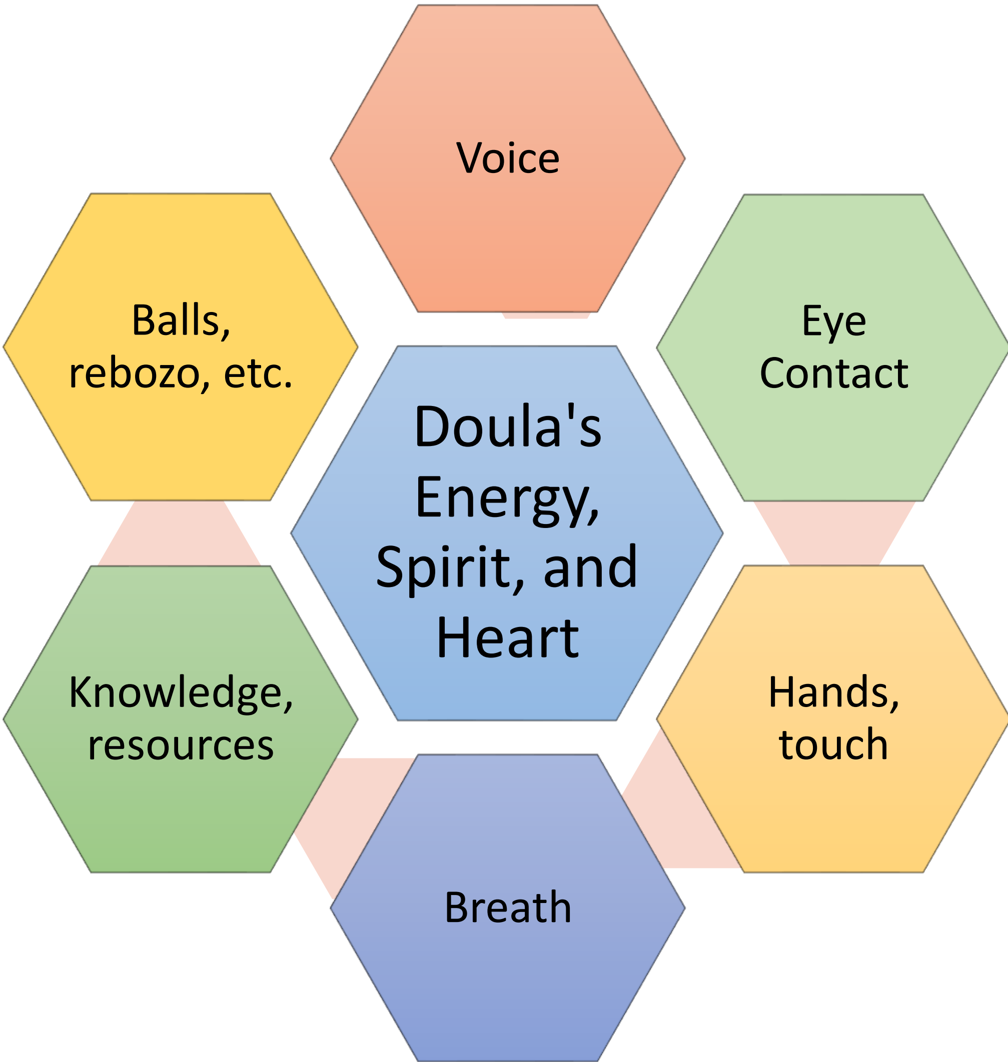
The Doula's Toolbox



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The Doula's Role Postpartum

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Postpartum MotherBaby Care

The following are some things parents should be watching for over the first 24 hours and early days postpartum.

Mother

Bleeding

Pay attention to how much you are bleeding. When you have been lying flat for any period, blood from your uterus will pool in the vagina. Upon rising, you will feel a small gush of blood soaking your pad. This is normal. However, if you continue to bleed actively, it means that your uterus has stopped contracting. To get it contracting again, nurse your baby. You can also apply firm pressure to the uterus. Lie on your back and place the flat of your hand (or your partner's hand) on your belly, between the pubic bone and your navel. Rub firmly and deeply in a circular motion. As you do so, you will feel your uterus coming into a ball under your hand. It will be about the size of a grapefruit. (Your nurse or midwife can show you how to do this.) Keep nursing and it should stay contracted. Check for firmness from time to time, especially the first day or two. If you are soaking a sanitary pad every thirty minutes or less, and these measures do not bring it under control, or if you are compromised from blood loss (i.e. feeling lightheaded, passing out), then you are bleeding too much. Call your doctor or midwife.

You may notice a blood clot or two falling into the toilet when you pee. It's good that the uterus works those out, otherwise they can contribute to extra bleeding. Passing clots may be accompanied by uterine cramping as the uterus works a little harder to contract around the clots and push them out. If you are concerned about the size or quantity of clots that you are passing, call your doctor or midwife.

Fluids

You should have something to drink within easy reach over the next few days. Partners can help with this. Mom needs sufficient fluids to create a healthy milk supply and to flush systemic fluids, no longer needed to support the pregnancy, from her system. Extra fluids may also be present due to administration of IV fluids in labor. Water, Pregnancy Tea, and juice are all good choices. Every time you sit down to nurse your baby, just make it a habit to have a drink with you.

Urinating and Bowel Movements

It is important to keep your bladder empty after birth. A full bladder will displace your uterus and keep it from contracting properly, thereby contributing to extra bleeding. A small plastic squeeze bottle (peri bottle) will be provided at the birth center or hospital or included in your homebirth kit. Use it to rinse your perineum, in place of toilet paper, and then pat (rather than wipe) yourself dry. If you feel burning and stinging when you pee, you probably have a tear on

your bottom. Fill the peri bottle up with warm water before you pee and squirt it over your perineum while you are peeing. This will dilute the urine and decrease discomfort.

Over the first few days, you may notice that you are urinating large quantities rather frequently. This is just the body dumping those extra systemic fluids. Most women find that they are also sweating, sometimes alarming quantities, soaking nightgowns and bed sheets. Not to worry … just think of it as losing a couple of pounds the easy way. Keep up your intake of fluids and the body will get the right message—to eliminate these unneeded fluids rather than hold on to them.

It is not uncommon after giving birth to feel as though you don't want to push anything else out of your body for a while. Sometimes women will get constipated postpartum because of this concern. Post-cesarean moms may also have this challenge, due to the constipating effects of narcotic pain relievers. You may want to have some prophylactic prunes or prune juice, or whatever has worked for you in the past as a natural stool softener. If you keep things soft and moving, it really won't hurt at all, despite your fears.

Afterpains and Discomforts
After each baby, the uterus seems to have to work a little harder to stay contracted. Afterpains can be quite intense for some women after a second or third baby. Most women barely notice post-birth contractions after a first baby.

Most Common Big Mistake New Parents Make
Too much company over the first few days! It is understandable that you will feel proud of your baby and want to share him/her with family and friends. But a constant stream of visitors will interfere with establishing the breastfeeding relationship and getting much needed rest. You will need to sleep when the baby sleeps and this is likely to be very unpredictable for a while. The more you rest, the quicker you will recover. Visitors should stay briefly and be asked to contribute in some way (run an errand on their way over, bring a meal, throw in a load of laundry, change those sheets for you, etc.). Folks who have never had a baby themselves won’t “get it.” You will need to be explicit about your needs. Try to come up with a plan for controlling the flow of visitors and communicate it clearly. You don’t want to be planning your sleep around scheduled visitors—it will be enough to have it dictated by the baby’s needs.

Baby

Nursing
Your baby will most likely sleep once you are all settled. Many babies sleep for a good stretch right after birth, anywhere from three to six hours, or so. This is your best opportunity for a nice recovery sleep. My advice is to turn the ringer on your phone off, delay visitors and go for it. Have your nurse put a “Sleeping—do not disturb” sign on your door. It won’t stop interruptions altogether, but it will cause some folks to think twice before barging in. Over the next few

weeks, your baby may want to nurse as often as every hour or two, occasionally going for longer stretches, and gradually sleeping more at night. So, sleep when you can!

Nurse your baby frequently whenever he/she is awake. If the baby seems fussy or is rooting around, nurse. This will help your milk to come in quickly and then your baby may stay content for longer periods of time. If your baby just wants to sleep and sleep, or only latches on for a minute or two at a time and then falls asleep at the breast, you may need to wake the baby up to nurse. Try a bath or a diaper change to stimulate the baby and keep trying.

Lungs

Sometimes during the first day or two, babies have some mucous they need to clear out. Typically, they clear it effectively on their own through sneezing. Occasionally, a baby may bring up some mucous which lodges in the back of the throat. They may gag on it, or you may hear it rattling there. (Stay calm—this is not life-threatening.) Simply hold the baby face down, with their chest lower than their head. You can pat their back a bit and/or use a bulb syringe to suction the mucous out if necessary. When using a bulb syringe, be sure and squeeze all the air out of it before inserting it in the baby's mouth. Release your pressure once the syringe is in place and it should suck that stuff out. Remove the syringe from the baby's mouth, empty it on a diaper or whatever is handy, and repeat the process as needed. (This is rarely necessary.)

You won't be left alone after your birth until your attendants are confident that both you and the baby are stable. Some babies' lungs sound a bit rattly, while all their other vital signs are good. Babies' respirations are normally uneven. They may not take a breath for a few seconds and then take three or more quick ones in a row (30 to 50 breaths per minute is normal). Persistent fast respirations indicate that the baby is working too hard to circulate oxygen in the bloodstream and may also be a symptom of infection. If the baby's color is nice and pink all over and they are nursing, it's probably fine. A baby who is working too hard to breathe and circulate oxygen is not likely to have the extra energy to nurse.

Cord Stump

When you change your baby's diaper, keep an eye on the cord stump over the first 24 hours. There should not be active, bright red bleeding from the stump. Over the next few days, the cord stump will rot and fall off. It may smell a little funky while this is happening, but that is normal and is not a sign of infection. However, if the skin around the base of the stump is red and puffy, or there is any discharge, then the baby's umbilicus may be infected. This is rare but can happen. While the cord is drying up, allow as much air as possible to get at it, keeping it outside of the diaper. Recent research has shown that the best "treatment" for the cord is to do nothing. Application of rubbing alcohol to the stump was never an evidence-based practice, though it was commonly recommended.

Urine and Meconium

Most babies will pee and pass meconium in the first 24 hours of life. It's a good idea to pay attention to this and make sure that the baby has been peeing and passing meconium. If helpers are changing diapers for you, ask them to pay attention too. Meconium is a very sticky substance and is often hard to clean off the baby’s bottom. Applying a little bit of olive or vitamin E oil on the baby's bottom will make the cleanup easier. Over the first few days of life the color of the baby’s poop will change, eventually turning into yellow breastfed baby poop.

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Postpartum Herbal Healing Bath

The postpartum herbal bath is wonderfully healing for both mom and baby. The recommended herbs have astringent and antiseptic properties which soothe and heal sore bottoms, help dry up the baby's cord stump and prevent infections. You and your baby can take a minimum of one bath per day for the first five days postpartum. If you have stitches or any lacerations, you may want to take two baths per day for two to three weeks, or until healing is complete. Hydrotherapy on its own is widely recommended for pain relief and healing. Add the herbs and speed the healing process! Plus, it smells good (unless you are not a fan of Lavender, in which case, just leave that herb out of the mix).

Caution: If you are post-surgery, then follow your doctor's recommendations regarding how long to wait before immersing the incision site in water.

Ingredients
Calendula flowers
Comfrey leaves
Lavender flowers

Directions
Boil a gallon of water or just use a large stock pot (it is not necessary to measure the water). Once the water boils, turn off the heat and add the contents of one pre-mixed bath to the pot. Cover and let steep for at least one hour (longer is better). When ready, pour the herb water through a strainer directly into the bath water. Discard the herbs. The mixture can sit at room temperature for up to 24 hours. If not used within 24 hours, strain out the herbs and refrigerate the fluid. It will keep for 2–3 days in the fridge. You can brew up the next batch just after the current bath is finished. Then, whenever you're ready for your next bath, it's ready for you.

As you are running the bath, keep the bathroom door closed to keep the room warm for the baby. Try gathering a few candles for subdued lighting which encourages the baby to open his/her eyes and overall makes for a lovely experience.

It's a good idea to have a helper if you are bringing your baby into the bath. Mom can get in first while the bath is hot and then bring baby in once it cools down a bit. Most newborns love the bath but will startle when first brought in. Have your helper hand the baby to mom and simply support the baby's head with both hands, allowing the body to immerse and float between your legs. Try to let as much of the baby be under water as possible so he/she doesn't get cold. Watch your baby relax and unfold as he/she settles in. Relax and enjoy!

You will find that the bath brings good pain relief that lasts for a period afterwards. Feel free to take as many as you like, with or without the herbs. You can also use a sitz bath (often

supplied by the hospital or available at your local pharmacy). These just sit on the toilet (especially helpful if you don't have a tub at home) and offer a swirling stream of hot water for your bottom to soak in from a hanging plastic bag connected to the bath by a narrow plastic tube. These work well and save you from having to get undressed and wet all over each time you would like a soak.

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Breastfeeding Guide

By Barbara Robertson, MA, IBCLC

Is my baby getting enough?

New mothers are typically concerned about whether their milk supply is sufficient. You will know if the baby is getting enough calories by counting daily stools and wet diapers. Within the first 24–48 hours the baby will pass his first stool, called meconium, which is dark and tarry. By days three to six, the baby should have two to five yellow seedy stools in a 24-hour period.

During the first two to four days, babies wet only a couple times per day. By day five or six, as mother's milk becomes more plentiful, a baby should have six to eight wet diapers in a 24-hour period. Urine should be odorless and clear to pale yellow in color.

Signs of dehydration in infants include: lethargy; a sunken soft spot (anterior fontanel) on the baby's skull; dry, loose skin; diminished or absent wet diapers with concentrated urine or orange staining due to uric acid crystals; dry mucous membranes (look in the baby's mouth—are saliva bubbles visible?); temperature; and fast respirations (persistently greater than 30–50 breaths per minute). (These last two symptoms may also indicate infection in the newborn, which is an emergency.)

How often and how long should I nurse?

Women are often surprised to discover that it is normal for an exclusively breastfed infant to nurse every 1½ hours in the first couple of weeks. Feeding may last 30 minutes to one hour. Frequent feeding promotes adequate weight gain. Furthermore, milk production follows the principle of "supply and demand." Nursing at least 8–15 times every 24 hours will ensure a sufficient milk supply to meet the baby's needs.

Remember: Feedings are variable in duration and intensity during the early weeks. The ZEN of breastfeeding is to "watch the baby, not the clock." Check for adequate wets and stools. It is the frequency of breastfeeding rather than the duration that stimulates milk production.

Weight gain

Initially babies typically lose up to 10 percent of their birth weight. By day three to five, the baby will begin gaining about ½ to 1 ounce per day. Babies should regain their birth weight by day 10. After day 10, babies should gain a minimum of 4 ounces per week. If infants follow this pattern, you can feel confident that they are getting enough milk.

Be aware that weighing the baby on different scales (such as one at the hospital, one at home, and one at the pediatrician's office) is likely to yield slight differences in calibration which do not reflect a failure-to-thrive or insufficient milk supply problem. Weighing the baby too frequently (daily or more than once per day) should be discouraged. Trust your eyes and intuition as well.

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Newborn Babies and Sleep

Excerpted with permission by Elizabeth Pantley, Author of
The No-Cry Sleep Solution* and *Gentle Baby Care
www.pantley.com

Congratulations on the birth of your new baby. This is a glorious time in your life—and a sleepless time too. Newborns have very different sleep needs than older babies. This article will help you understand your baby's developing sleep patterns and will help you have reasonable expectations for sleep.

Read, Learn and Beware of Bad Advice

Absolutely *everyone* has an opinion about how you should handle sleep issues with your new baby. The danger to a new parent is that these tidbits of misguided advice (no matter how well intentioned) can truly have a negative effect on our parenting skills and, by extension, our babies' development … *if we are not aware of the facts.* The more knowledge you have the less likely that other people will make you doubt your parenting decisions. When you have your facts straight, and when you have a parenting plan, you will be able to respond with confidence to those who are well-meaning but offering contrary or incorrect advice. So, your first step is to get smart! Know *what* you are doing and know *why* you are doing it. Read books and magazines, attend classes or support groups—it all helps.

The Biology of Newborn Sleep

During the early months of your baby's life, he sleeps when he is tired, it's that simple. You can do little to force a new baby to sleep when he doesn't want to sleep, and conversely, you can do little to wake him up when he is sleeping soundly. Newborn babies have very tiny tummies. They grow rapidly, their diet is liquid, and it digests quickly. Although it would be nice to lay your little bundle down at bedtime and not hear from him until morning, this is not a realistic goal for a tiny baby. Newborns need to be fed every two to four hours—and often more frequently.

Sleeping "Through the Night"

You may believe that babies should start "sleeping through the night" soon after birth. For a new baby, *a five-hour stretch* is a full night. Many (but not all) babies *can* sleep uninterrupted from midnight to 5 a.m. (Not that they always do.) This may be a far cry from what you may have thought "sleeping through the night" meant! What's more, some sleep-through-the-nighters will suddenly begin waking more frequently and it's often a full year, or even two, until your baby settles into an all-night, every-night sleep pattern.

Falling Asleep at the Breast or Bottle

It is natural for a newborn to fall asleep while sucking at the breast, a bottle, or a pacifier. When a baby *always* falls asleep this way, he learns to associate sucking with falling asleep; over time, he cannot fall asleep any other way. This is the most natural, pleasant sleep

association a baby can have. However, a large percentage of parents who are struggling with older babies who cannot fall asleep or stay asleep are fighting this powerful association. Therefore, if you want your baby to be able to fall asleep without your help, it is essential that you *sometimes* let your newborn baby suck until he is sleepy, but not totally asleep. When you can, remove the breast, bottle or pacifier from his mouth and let him finish falling asleep without it. If you do this often enough, he will learn how to fall asleep without sucking.

Waking for Night Feedings

Many pediatricians recommend that parents shouldn't let a newborn sleep longer than four hours without feeding and most wake far more frequently than that. No matter what, your baby *will* wake up during the night. The key is to learn when you should pick her up for a feeding and when you can let her go back to sleep on her own. Here's a tip that is important for you to know. Babies make many sleeping sounds, from grunts to whimpers to outright cries and these noises don't always signal awakening. These are what I call *sleeping noises* and your baby is asleep during these episodes. Learn to differentiate between sleeping sounds and awake sounds. If she is awake and hungry, you'll want to feed her promptly, so she'll go back to sleep easily. But if she's asleep, let her sleep!

Help Your Baby Distinguish Day from Night

A newborn sleeps sixteen to eighteen hours per day and this sleep is distributed evenly over six to seven sleep periods. You can help your baby distinguish between night sleep and day sleep, and thus help him sleep longer periods at night. Have your baby take his daytime naps in a lit room where he can hear the noises of the day. Make nighttime sleep dark and quiet, except for white noise (a background hum). You can also help your baby differentiate day from night by using a nightly bath and a change into pajamas (or other ritual) to signal the difference between the two.

Watch for Signs of Tiredness

Get familiar with your baby's sleepy signals and put her down to sleep as soon as she seems tired. A baby who is encouraged to stay awake when her body is craving sleep is an unhappy baby. Over time, this pattern develops into sleep deprivation, which complicates developing sleep maturity. Learn to read your baby's sleepy signs—such as quieting down, losing interest in people and toys, and fussing—and put her to bed when that window of opportunity presents itself.

Make Yourself Comfortable

It's a fact that your baby *will* be waking you up, so you may as well make yourself as comfortable as possible. Relax about night waking right now. Being frustrated about having to get up won't change a thing. The situation will improve day by day. Before you know it, your newborn won't be so little anymore—she'll be walking and talking and getting into everything in sight during the day and sleeping peacefully all night long.

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Infant Sleep Environment Safety Checklist

Recommendations that apply to infant sleep in both cribs and adult beds

- Use a firm mattress. A soft mattress can result in infant suffocation.
- There should be no gaps between the mattress and the frame of the crib or bed. Infants and small children can become wedged in gaps and asphyxiate.
- Bedding should fit tightly around the mattress. Fitted sheets that become loose from a corner can cover and smother a baby.
- Avoid strings or ties on all nightclothes (both baby's and parents'). These pose a strangulation risk.
- Avoid soft bedding and other items, including comforters, pillows, featherbeds, stuffed animals, lamb skins, bean bags, etc. Bumper pads should not be used. Each of these poses a risk of suffocation.
- Keep baby's face uncovered to allow ventilation.
- Put baby on his or her back to sleep. Babies sleeping on their backs are less likely to become victims of sudden infant death syndrome (SIDS).
- Adults should avoid smoking. Exposure to tobacco, both pre- and post-delivery, is associated with a higher risk of SIDS.
- Avoid overheating the room in which the baby sleeps and avoid overdressing the baby. Overheating is associated with an increased risk of SIDS.
- Avoid placing a crib near window treatment cords or sashes. These pose a strangulation risk.

Advice specific to cribs

- When baby learns to sit, lower the mattress level so that he or she cannot fall out or climb over the side rail.
- When baby learns to stand, set the mattress level at its lowest point.

- When baby reaches a height of 35 inches or the side rail is less than three-quarters of his or her height, move the baby to another bed. Babies can fall from their cribs if the side rails are not at the right level in relationship to the mattress surface.

- Hang crib mobiles well out of reach and remove them when baby starts to sit or reaches five months of age, whichever comes first. Mobiles become strangulation or choking hazards if baby can reach them.

- Remove crib gyms when baby can get up on all fours. Babies can become entangled in these and risk strangulation.

- Keep baby warm by dressing him or her in a blanket sleeper or “sleep sack.”

General advice regarding infant sleep

- Do not sleep with baby on sofas or overstuffed chairs.

- Do not place baby (particularly one born prematurely) to sleep in car or infant seats as these can fail to adequately support the infant’s upper body, block the baby’s airway and put baby at risk for suffocation.

- Parents who choose to bed share with their infants must be proactive. They must evaluate their sleep environment and make it as safe as possible for their baby. Both parents should feel comfortable with the decision to place the baby in the chosen environment, whether crib or adult bed, and should be committed to following that environment's safety precautions, as noted above. No one sleeping environment can guarantee that a baby will be risk free, but there are ways of reducing risk in both cribs and adult beds.

Risk factors for bed-sharing

- Very small premature or low birth-weight babies appear to be at greater risk when bed-sharing but benefit greatly from co-sleeping nearby but on a separate surface.

- Do not sleep with baby if you are currently a smoker or if you smoked during pregnancy.

- Do not sleep on the same surface as your baby if you are overly tired or have ingested alcohol/sedatives/drugs (or any substance that makes you less aware).

- Baby appears to be safest when sleeping beside his/her breastfeeding mother.

- Older siblings or other children should not sleep with babies under one year old.

- Do not swaddle your baby when bed-sharing. Baby may overheat (which is a risk factor for SIDS), and a swaddled baby is not able to effectively move covers from the face or use arms and legs to alert an adult.

- Other potential hazards: very long hair should be tied up so that it does not become wrapped around baby's neck; a parent who is an exceptionally deep sleeper or an extremely obese parent who has a problem feeling exactly how close baby is should consider having baby sleep nearby, but on a separate sleep surface.

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Postpartum Planning Guide for Parents

Hint: After the baby is born, pull out this guide and re-read it!

These are guidelines for the first few weeks following an uneventful birth. In the case of twins, prolonged or difficult labor and birth, cesarean delivery, maternal hemorrhage, severe perineal lacerations, or health issues with the baby requiring extended hospitalization, your plan should allow extra time for care and recovery.

Healing is a process, not a result.

1. **Plan for household help.** Recruit the support of one or two emotionally positive people to free the mother of household responsibilities (laundry, shopping, errands, cleaning, meal preparation, childcare for older siblings) for two to six weeks. This person should be able to see what needs to be done and do it without lots of direction. Sometimes partners may have to fill this role, but ideally it should be someone that the baby doesn't have to share (partners are tired too). If extended family support is available to you, that can work or, if you can afford it, consider hiring a postpartum doula.

2. **Control visitors.** Inform close friends and family when visiting privileges will begin after birth. It is important to control who, when, how many at a time, and for how long you want to welcome visitors. You will, no doubt, be eager to show off your baby. On the other hand, visitors arriving just as you have an opportunity to sleep, or when you should be focusing on breastfeeding your baby, will prove to be more stressful than enjoyable. Turn the ringer off your phones to sleep. Post signs saying "We are sleeping now. Please come another time." Plan for short visits and ask guests to bring food or help with chores. Remember that people who have never had a baby before will be clueless as to your needs. You will need to clue them in. Failure to control the number and timing of visitors is the most common mistake new parents make.

3. **Sleep when the baby sleeps.** Calculate the average amount of sleep you need to feel okay under normal circumstances. Can you normally get by on six or seven hours, or do you need eight or nine to feel well? You will still need this same amount of sleep after the baby is born, though admittedly it will be interrupted sleep. One strategy is to not get up and get dressed, receive visitors, or go about your day until you have managed to sleep your required amount. On some days, this may be well into the afternoon hours. Resist the temptation to "do everything" when the baby is sleeping if you have not gotten your eight-hour minimum (or whatever) during the last twenty-four hours. The longer you rest now, the sooner you will recover.

4. **Heal.** Listen to your body and take care of yourself. Milk supply and postpartum healing are your top priorities. In addition to sleeping, make sure you are drinking plenty of fluids and eating properly. Take sitz baths if you have stitches—even two or three times per day to promote healing and control pain.

5. **Recruit help with meals.** Make a list of things your family likes to eat. Post this list on the refrigerator for all to see. This provides a quick answer for those asking to bring a meal. It may be helpful to appoint someone to organize meals for the family. Online calendars are a great tool. When folks sign up to drop off a meal, make it easy for a meal to be left for you without necessarily having to be awake to receive the meal or invite guests in (e.g., cooler on the porch). In addition, you may want to freeze some meals ahead of time and stock up on non-perishables. Use these when your helpers start to fade.

6. **Consider paying for help.** This may include housecleaning, childcare for your other children, using a diaper service for the first six weeks, or hiring a postpartum doula. If you can't afford to hire help, perhaps ask for help as a shower gift rather than accumulating a bunch of stuff you don't really need.

7. **Ask for what you need**. Postpartum can be emotionally high and low all at the same time. Hormones are changing dramatically. You may just need someone to listen to you and validate your feelings about your birth, about becoming a mother, or other challenges you are experiencing. Lots of new parents are disturbed by some of the emotions they are experiencing postpartum as they go through this tremendous adjustment to parenthood. It's okay. Talk about it. You are not alone.

8. **Have realistic expectations.** Newborns "only" sleep, eat, and poop, but they do it every hour (or so). It takes more time and energy than most people realize. Imagine a sphere about 1" in diameter. That's how big a newborn's tummy is! As breastmilk is easily digested, it moves quickly out of the stomach and the baby is hungry again. As your baby grows, he/she will grow a bigger stomach and be able to space out their feedings a bit more. Each baby is different, some sleeping five hours at a stretch from the early weeks on, and others waking every hour and a half to nurse for months. Let your baby lead the way at first. Try and keep it in perspective; things change quickly.

9. **Understand that siblings go through adjustment too.** While accepting help to care for them, try to keep established rituals intact so that your child doesn't feel abandoned or utterly displaced. If you normally read a book to your child before bedtime, then make every effort to continue to do so. It is not uncommon for toddlers to relapse with toilet training efforts when there is a new baby in the house (don't despair with this!). Consider recruiting helpers to take your child for an outing. Breastfeeding mothers of toddlers find that having a "special" basket of toys that only comes out when it's time to nurse the baby is a good strategy. Or limit video watching to only breastfeeding times,

or listen to books on tape together, to be continued at the next breastfeeding session. You can get creative here.

10. **Take a little time for yourself each day.** At first, it can feel as though, if you are meeting the baby's needs, then your needs don't get met. It is only normal that you may feel sad or even resentful about this. Try to identify what activity you miss the most. Are you longing for a walk in the fresh air, girlfriend time, computer play time, or missing your exercise regime? Try to carve out even a half hour where you and your partner give each other permission to get at least that one need met. Make a list right now of three things you find relaxing, rejuvenating, or inspiring.

11. **Don't forget to take time for each other.** Many new moms experience a drop in their sex drive for a while after giving birth. This is normal, it's okay, and it will return. Breastfeeding a baby involves a great deal of intimacy and new moms may feel "touched out." A fear that sex will hurt, especially if there was trauma to the perineum or vagina, is understandable. Also, your hormones are not helping because your body is not really trying to get pregnant right now. With the ebb and flow of cycles and desire, you may find yourself solidly in the ebb. For breastfeeding mothers, the hormones that promote fertility and the presence of cervical mucus remain suppressed (timing is variable on this, lasting anywhere from a few weeks postpartum through the full time that mom breastfeeds). This means that the vagina may be dryer than usual, requiring lubrication for sex to feel comfortable. There are all kinds of intimacy. A dinner by candlelight, a "date night," a walk together without the baby, or willingness to pleasure your partner without feeling you are required to respond in kind are all creative solutions. Patience and mutual consideration are key.

12. **Postpone major life changes.** When possible, avoid moving or changing jobs during the childbearing year (pregnancy through at least three months postpartum). Many new parents imagine they require more space for their expanding family. Consider whether you truly need a dedicated nursery or a bigger home or all that baby gear. Keep it simple and play it by ear. Having a baby is change enough.

13. **Develop a support network.** Hook up with both new and experienced parents for support, guidance, and feedback. In the end, this will normalize what you are experiencing OR help you determine that your situation is not normal and that you need extra help. Either way, it should prove validating.

14. **Give yourself credit.** Parenting is a huge life change, bringing more love and laughter into your life along with new challenges. The difficult times and the adoration you feel for your baby do not necessarily balance out to a happy medium. It can be both joyful and hard. It may take some time for you to find your new rhythm.

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Handling Unwanted Advice

Excerpted with permission by Elizabeth Pantley,
Author of *The No-Cry Sleep Solution* and *Gentle Baby Care*
www.pantley.com

> *"Help! I'm getting so frustrated with the endless stream of advice I get from my mother-in-law and brother! No matter what I do, I'm doing it wrong. I love them both, but how do I get them to stop dispensing all this unwanted advice?"*

Just as your baby is an important part of your life, he is also important to others. People who care about your baby are bonded to you and your child in a special way that invites their counsel. Knowing this may give you a reason to handle the interference gently, in a way that leaves everyone's feelings intact. Regardless of the advice, it is *your* baby, and in the end, you will raise your child the way that you think best. So, it's rarely worth creating a war over a well-meaning person's comments. You can respond to unwanted advice in a variety of ways.

Listen first.
It's natural to be defensive if you feel that someone is judging you; but chances are you are not being criticized; rather, the other person is sharing what they feel to be valuable insight. Try to listen—you may just learn something valuable.

Disregard.
If you know that there is no convincing the other person to change her mind, simply smile, nod, and make a non-committal response, such as, "Interesting!" Then go about your own business...your way.

Agree.
You might find one part of the advice that you agree with. If you can, provide wholehearted agreement on that topic.

Pick your battles.
If your mother-in-law insists that the baby wear a hat on your walk to the park, go ahead and pop one on his head. This won't have any long-term effects except that of placating her. However, don't capitulate on issues that are important to you or the health or well-being of your child.

Steer clear of the topic.
If your brother is pressuring you to let your baby cry to sleep, but you would never do that, then don't complain to him about your baby getting you up five times the night before. If *he* brings up the topic, then distraction is in order, such as, "Would you like a cup of coffee?"

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Educate yourself.
Knowledge is power; protect yourself and your sanity by reading up on your parenting choices. Rely on the confidence that you are doing your best for your baby.

Educate the other person.
If your "teacher" is imparting information that you know to be outdated or wrong, share what you've learned on the topic. You may be able to open the other person's mind. Refer to a study, book, or report that you have read.

Quote a doctor.
Many people accept a point of view if a professional has validated it. If your own pediatrician agrees with your position, say, "My doctor said to wait until she's at least six months before starting solids." If your *own* doctor doesn't back your view on that issue, then refer to another doctor—perhaps the author of a baby care book.

Be vague.
You can avoid confrontation with an elusive response. For example, if your sister asks if you've started potty training yet (but you are many months away from even starting the process), you can answer with, "We're moving in that direction."

***Ask* for advice!**
Your friendly counselor might be an expert on a few issues that you can agree on. Search out these points and invite guidance. She'll be happy that she is helping you, and you'll be happy you have a way to avoid a showdown about topics that you *don't* agree on.

Memorize a standard response.
Here's a comment that can be said in response to almost any piece of advice: "This may not be the right way for you, but it's the right way for *me*."

Be honest.
Try being honest about your feelings. Pick a time free of distractions and choose your words carefully, such as, "I know how much you love Harry, and I'm glad you spend so much time with him. I know you think you're helping me when you give me advice about this, but I'm comfortable with my own approach, and I'd really appreciate if you'd understand that."

Find a mediator.
If the situation is putting a strain on your relationship with the advice-giver, you may want to ask another person to step in for you.

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Search out like-minded friends.
Join a support group or on-line club with people who share your parenting philosophies. Talking with others who are raising their babies in a way that is like your own can give you the strength to face people who don't understand your viewpoints.

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Edinburgh Postnatal Depression Scale (EPDS)

This screening tool has been studied extensively and validated across cultures. It is available in many different languages. It is valid for use in both the prenatal and postpartum periods.

How to Introduce Screening to Clients: What to Say

- “Have you heard/has anyone told you how common depression and anxiety are during the perinatal period?”
- “The first year after birth is really stressful with adjusting to a lot of changes and we know lots of moms experience depression and anxiety because of that.”
- “This questionnaire asks about how you’ve been feeling. We’ll discuss it after you’ve filled it out.”
- You can use the questionnaire as a conversation starter. “Tell me how you’ve been feeling.”
- “Women who experience depression and anxiety don’t always recognize it, or they think there is something wrong and blame themselves.”
- “I just want *you* to have the information, so that if you do have depression or anxiety symptoms, you can get help and feel better.”

If necessary, reassure clients that suffering from depression and/or anxiety, or having disturbing thoughts or suicidal thoughts, is not sufficient grounds for removal of the infant from their care. In other words, you will not report screening results to Child Protective Services.

Instructions for Use

1. The PDS relates to how the mother has been feeling DURING THE PREVIOUS WEEK.
2. ALL 10 items must be completed.
3. The PDS is a self-report scale, so only in exceptional circumstances, as when a mother has poor understanding of English or difficulty reading, should the doula help with its completion. If the mother asks questions, simply respond: “Do your best.” Or “Whatever it means to you.”
4. The PDS should be administered in such a way as to avoid the possibility of the mother discussing her answers with others, as this has been found to influence results. It should always be handed back immediately on completion to the doula.
5. Scores for individual items range from 0–3 according to severity, as shown on the attached sheet. The total score is calculated by adding the scores for each of the 10 PDS items.
6. **A SCORE OF 10 OR MORE** indicates that the mother is at risk for depression and requires further assessment. It is not a diagnosis of a PMD. Refer to her medical provider for further evaluation.

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Name _______________________ Baby's Birth Date __________ Today's Date __________

Please circle the answer that best describes how you have felt over the past 7 days.

1. I have been able to laugh and see the funny side of things.
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things.
   - 0 As much as I ever did
   - 1 Somewhat less than I used to
   - 2 A lot less than I used to
   - 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong.
   - 3 Yes, very often
   - 2 Yes, sometimes
   - 1 Hardly ever
   - 0 No, not at all

4. I have been anxious or worried for no good reason.
   - 0 No, not at all
   - 1 No, not much
   - 2 Yes, sometimes
   - 3 Yes, often

5. I have felt scared or panicky for no good reason.
   - 3 Yes, often
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

6. Things have been too much for me.
   - 3 Yes, most of the time I haven't been able to cope
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped well
   - 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all

8. I have felt sad or miserable.
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all

9. I have been so unhappy that I have been crying.
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, not at all

10. The thought of harming myself has occurred to me.
    - 3 Yes, quite often
    - 2 Sometimes
    - 1 Hardly ever
    - 0 Never

Processing the Birth Experience with the Mother

By Penny Simkin, with permission

The childbirth experience lives on in the new mother's thoughts and emotions as she integrates her prior expectations with all its rewarding, challenging, painful, frightening, exhausting, and demanding aspects. She needs to make sense of her birth by reconstructing it and putting into words what happened and how she felt. If she feels triumphant, powerful, and fulfilled by her child's birth, having a chance to recall the details and relive the joy will reinforce the positive aspects, enhance her self-esteem, and deepen her satisfaction. Negative or mistaken impressions, however, do not go away if they remain unresolved. In fact, they tend to fester and grow. If the birth was traumatic for mom or baby, early processing and reframing may even prevent Post-Traumatic Stress Disorder or Postpartum Depression. If she is angry at or disappointed in herself, in people who were there, or over the events that occurred, she will benefit from a caring, empathetic listener who acknowledges and validates her feelings. When the time is right, this person can help her to a more comfortable or positive perspective.

Suggestions for the Doula

1. Before the birth, indicate that you will be most interested in the woman's feelings after the birth and make sure to allow enough time for a thorough discussion.
2. Goals when reviewing the birth experience:
    a. For the woman, a feeling that she is heard, understood, respected, and cared for
    b. For the doula, greater understanding of what the experience was for the woman
    c. Planting "seeds of accomplishment"—compliments in reference to specific events from the labor
3. Some notes of caution:
    a. Processing can take a long time, especially when the experience was frightening or traumatic.
    b. Repression of recall protects the new mother as she takes on the tasks of new parenthood. She may not deal with her feelings about the birth at all, or for months, or even until a subsequent pregnancy.
    c. Even if she is not ready, the doula can plant seeds of accomplishment that the mother will recall when she begins to process the birth.
    d. Sometimes the doula (or whoever is the listener) is the target of anger or disappointment. It requires patience, non-defensiveness, and effective communication skills to respond appropriately.
    e. Some women have birth experiences that require intensive professional

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counseling to come to terms with a negative experience or a poor outcome.

f. Some women are traumatized by birth experiences that would not be troubling to others; it is important to accept her perceptions as her reality because prior life events can make some women more vulnerable than others.

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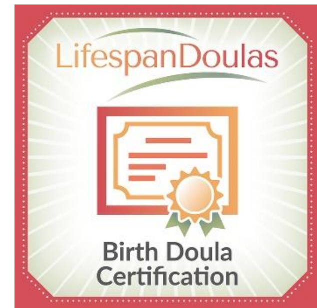
The Business of Being a Doula

Birth Doula Certification through Lifespan Doulas



Certification is optional.

You are not required to be certified as a birth doula in order to register with the MDHHS Doula Initiative and become eligible for Medicaid reimbursement for your services to eligible families. Proof of training is required. If you would like to be professionally certified, there are some additional requirements, listed below. The Birth Doula Workshop and the online self-paced study modules fulfill the first two requirements of our Cross Certification process listed below.

Fee: $100

Purchase the Lifespan Doulas' Cross Certification for Birth Doulas. A Directory listing on Lifespan Doulas, good for one year, is included with your certification. (Your year starts when you let us know you are open for business.)

Requirements

1. Complete a professional birth doula training program (Done!).

2. Complete a Breastfeeding Basics class designed for professionals (Done!).

3. Complete the required reading:

    - ✓ *The Birth Partner, 5th Edition,* by Penny Simkin
    - ✓ *Breastfeeding Made Simple,* by Mohrbacher and Kendall-Tackett
    - ✓ *Natural Hospital Birth*, 2nd Edition, by Cynthia Gabriel
    - ✓ *The Doula Business Guide, 4th Edition*, by Patty Brennan

4. Pass the comprehensive Birth Doula online certification exam with a score of 85% or higher. Access to the exam will be given within 24 hours of paying the $100 certification application fee. Look for an email from **Thinkific** to access the exam. The exam is an open-book, self-paced exam; you can save your progress as you go and complete the test in multiple sessions if desired. You can take the exam as many times as necessary to achieve a passing grade.

5. Agree to abide by the Lifespan Doula Scope of Practice.

6. Complete and submit the online Birth Doula Cross Certification Application. We will acknowledge receipt of your application within 24 hours of submission. Provided all requirements have been met, we will mail your certificate within two weeks. Your certification has no expiration date. It is a lifetime certification. There are no ongoing fees or requirements.

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The Value of Certification Exercise

Consider how much you value the following potential or purported benefits of professional birth doula certification and rate them accordingly.

Potential Benefits	Greatly value	Value somewhat	Unsure	No value
Ability to command higher fees				
Validation that you have mastered the core knowledge and skills required of birth doulas				
Increased credibility and esteem among healthcare providers				
Increased trust and credibility with clients				
Appreciate the validation conferred by earning credentials; increases self-esteem				
Increased competitiveness for related employment opportunities (add to resume)				
Directory listing on Lifespan Doulas' website (helps with marketing)				

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Steps to Enroll as a Medicaid Provider

Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be on the **MDHHS Doula Registry** and enroll as a Medicaid provider. Qualified individuals must be at least 18 years of age and possess a high school diploma or equivalent. MDHHS will certify doulas who have completed training provided by an MDHHS approved doula training program or organization. Doulas must provide proof of training to MDHHS upon request. Once you are approved to be placed on the MDHHS Doula Registry (Step 1), you may proceed to steps 2 –5 outlined below.

Step 1: Complete an MDHHS Doula Registry Application

Step 2: Apply for a Type 1 (Individual) National Provider Identifier (NPI)

Learn more about how to apply for an NPI

Step 3: Register for SIGMA Vendor Self-Service (VSS)

Step 4: Register for a MILogin Account for Access to CHAMPS

Step 5: Complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS)

Please review the links on the Michigan.gov/Doula website, as many of the next steps have additional information, training modules, and contact information provided for your convenience. I would also encourage you to review the "Beginner Guide for Doula Providers" posted on the provider alert webpage Professional (michigan.gov) as you navigate steps 2–5.

If you haven't already done so, please subscribe to Michigan Doula Initiative Emails and Updates.

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Comparison of Doula Business Models

Excerpted from The Doula Business Guide Workbook, 4th Edition, by Patty Brennan

Which model best suits your skills and personality and skill set?

Comparison Parameters		Independent Doula	Doula Partnership	Doula Collective	Doula Agency Owner	Agency Doula
Peer Support	**Camaraderie, not being isolated**	Doing your own thing; may feel isolated	Sharing everything with your partner(s)	Doing your own thing AND collaborating	Lots of interaction	Part of a group
	Ease of backup	Must arrange on your own	Shared on-call	Backup by group members	Set policy	Backup provided
	Time off call	Up to you; arrange backup or refrain from taking clients	Yes	Variable; depends on the group	Always responsible for business	Depends on policies; doulas accept assign-ments on a case-by-case basis
Degree of Control	**Control over business decisions**	Complete control	Shared equally with partner(s)	Complete control over your own business; consensus on group operations	Complete control	No control

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Comparison Parameters		Independent Doula	Doula Partnership	Doula Collective	Agency Owner	Agency Doula
Degree of Control (continued)	**Speed of decision making**	As slow or fast as you alone are capable	Slower due to need to come to agreement; more partners yield a slower process	Slow; more members yield a slower process; challenge of getting group members together	As slow or fast as you alone are capable	N/A
	Control over choice of clients, backup	Complete control	Shared with partner	Good control; depends somewhat on group policies	Complete control	Variable; depends on policies but often matches are made and doulas assigned
	Accountability (who responsible to?)	Responsible to self and clients only	Responsible to self, partner(s), and clients	Responsible to self, group members and clients	Responsible to self, agency doulas and clients	Responsible to self, agency owner, potentially other doulas (e.g., if working in teams) and clients
	Job security	High, if … *	High, if …	High, if …	High, if …	Can be fired or agency can stop making referrals any time)

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Comparison Parameters		Independent Doula	Doula Partnership	Doula Collective	Agency Owner	Agency Doula
Marketing	**Branding**	Sole control	Shared with partner	Done by the group	Complete control	No control
	Website creation	Sole control	Shared with partner(s)	Group control; or already done if joining an existing group	Complete control	No involvement
	Social media, blogging	Sole control	Shared with partner(s)	Shared by group members	Complete control	Not required
	Events, other	Sole control	Shared with partner(s)	Shared by group members	Complete control	May be asked to attend "Meet the Doulas" events or other promos
Simple vs. Complex	**Getting set up**	Complex; solely responsible for everything	Potentially easier since you can split the tasks; however more complex as you negotiate all aspects of the partnership agreement	May be relatively simple if you are joining a well-established existing collective	Complex; lots of decisions and tasks	Simple; few responsibilities; if independent contractor, then responsible for that piece
	Ongoing administrative tasks	Everything is up to you	Split equally with partners (theoretically)	Depends on what the group decides	Everything is up to you	Relatively little; just what the owner requires

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Comparison Parameters		Independent Doula	Doula Partnership	Doula Collective	Agency Owner	Agency Doula
Simple vs. Complex (continued)	**Communication challenges**	Very little; responsible to communicate with clients, backup doulas	Challenges increase with number of partners	High potential for issues; increases with number of group members	Complex; lots of people to communicate with and manage	Medium; communicate with owner and other doula team members
Control over Reputation		Complete control	Actions of partner(s) reflect on you, for better or worse	Actions of other group members reflect on you, for better or for worse	Actions of agency doulas reflect on owner, for better or for worse	Can control your own reputation but are associated with the agency brand and overall reputation
Income Potential**		Keep all client fees; occasionally pay for backup	Split the income between the partners	Keep all client fees; may need to pay a fee to collective to cover administrative expenses	Keep percentage of fees	Payment amount pre-determined; agency keeps a percentage; may make it easier for new doulas to earn an income sooner rather than later

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* The caveat here is that the business owner must have the skills and determination to stick with it and do what is required to be a successful small business owner.

** The real answer on "income potential" is, "It's up to you!" Each model has its pros and cons and there are many parameters for success.

For more information on doula business models and structures, see Chapter 1 of *The Doula Business Guide, 4th Edition.*

Examining Your Priorities Exercise

Take out two different colored highlighters (e.g., pink and yellow).
Use the pink to highlight any items above that are of value to you or items that strike you as a strong advantage.
Next, highlight any items in yellow that strike you as a strong disadvantage.
Don't over-think it at this point. Just go with your gut.
Now, rank the highlighted items according to their importance to you.
A picture should be starting to emerge. Which business model appears to most happily fit who you are today?

Remember, some of these categories are not mutually exclusive and where you start out does not necessarily dictate where you end up. You could, for example, work on building an independent practice as you accept jobs with a doula agency.

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5 Key Questions for Start-Up Birth Doula Businesses

If you are setting up a practice, just know from the start that your business will be a work in progress. You will always be learning and tweaking things as you go. It is likely that your personal gifts and interests will guide you to specialize in certain areas over time. You may want to acquire new skills and add services as you go. You may find that certain tasks are outside your comfort zone and that is okay. What follows are some considerations so that you can begin to conceptualize your services and how to present yourself.

1. Who are you serving?

- People who live in a specific geographic area or radius from your home?
- Teen mothers? Single moms?
- People who are members of a specific religious or cultural community?
- Specialty focus such as LBGTQ+ community?
- People of a certain income bracket?
- Other?

2. What services will you offer? Defining your core package of services includes the following information:

- Number and length of prenatal visits?
- Define the "on-call" period.
- Number and length of postpartum visits?
- What does phone/texting support look like?
- Anything else included in your fee?

Perhaps you are planning on providing additional services (e.g., childbirth education, prenatal yoga, massage therapy, placental encapsulation)? These can be sold ala carte, and you don't need to have everything decided prior to beginning to provide doula services to clients.

3. What are your professional boundaries?

Part of defining your services is deciding not just what you will offer, but also what you are not willing to do. It is helpful to set clear expectations for your clients. What are you comfortable with? What types of tasks/services are outside your comfort zone? Make no assumptions. The more transparent you can be up front, the less chance you will have misunderstandings and disappointments later. You may not be able to anticipate every need and expectation in advance but do your best and then communicate clearly what your boundaries are. And remember, you can always change a boundary with the next family who engages your services if that is what you need to do. If you are unsure about a specific request, you can tell the family you will think about it and let them know. Below, are a few key boundary questions for birth doulas to consider. See also Values Clarification: Setting Your Professional Boundaries (pp. XX).

- How far are you willing to travel to serve a client? Will this be defined by miles from your home to the client or to the hospital/birth center where she expects to give birth?
- How many clients do you expect to be able to serve in a month? (This is a guessing game at the beginning, but you will learn what you can handle.)
- Will you go to clients' homes in early labor? Or meet them at the hospital/birth center?
- Will you set limits for how long you spend at a birth before calling in backup support?

4. What will you charge?
Birth doulas typically charge a set fee for a package of services (as defined above). Postpartum doulas work shifts and charge by the hour. Look around a bit and see what other doulas in your area are charging to get a feel for the market. Then, position yourself comfortably in that market. You don't want to feel you have to make excuses for your fees or that you don't really deserve to be paid what you are charging. When it comes to fee setting, it may feel like you are simply guessing at the start and that is to be expected. Remember, you will be tweaking this as you go. Considerations include:

- Decide how and when you want to be paid. A retainer fee of some sort (recommended)? At the end of each week of services? Half up front and half at the end? All at the end (not recommended)? Most birth doulas collect all their fee at least a couple of weeks before the birth, while most postpartum doulas collect weekly for hours worked.
- Specify a timeframe for services provided.
- Do you want to offer a sliding scale for families who cannot afford your full fee?

Keep everything concrete and as simple as possible. There is a saying: "a confused customer does not buy." If you offer several choices, from your perspective, you may be thinking that you are demonstrating flexibility and willing to customize your services to the family and that this is a good thing. However, too many choices are confusing and hard to sort through. Keep it simple.

5. What is your Backup Doula Policy?
As a birth doula, you will need to decide whether your lifestyle supports a 24-hour on-call schedule. Is this even an option? If not, then a partnership practice (or working for a doula agency) may be a better match for you. Regardless, all birth doulas need backup support. What does that look like for you?

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Values Clarification:
Setting Your Professional Boundaries

For each item on the list, consider whether this is something you are willing to do or not. Consider also whether you can truly provide non-judgmental support. If you have no problem with the factor mentioned, check "Yes." Other factors may be a hard "No." In other cases ("Maybe"), you may feel unsure or need more information before you can decide.

Item	Yes	No	Maybe
Serve as a "sibling doula"—your primary role being to provide support to the couple's other child(ren) during the birth.			
Provide free services to someone who is very low income.			
Mom is a smoker and is not interested in quitting. She reports she smoked through her other pregnancies and her babies were "fine."			
Family has strict religious/cultural practices very different from your own.			
High anxiety mom; talks and talks and talks.			
Mom is in an abusive relationship; not ready to leave.			
Your client tells you she intends to request an epidural; she doesn't want more information.			
Client's baby has been diagnosed prenatally with a lethal birth defect; mom prefers to let her body go into spontaneous labor.			
Moms wants an elective cesarean for non-medical reasons.			

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Item	Yes	No	Maybe
Mom doesn’t intend to breastfeed; she does not want information about it.			
Mom’s mother is coming to the birth and is opposed to doula being there.			
Mom thinks the doula will guarantee her chances of having a VBAC.			
Client can’t afford your fees but wants YOU.			
Doula does not speak client’s language, but an interpreter is available.			
Imagine that you agree to do a volunteer birth and the woman stands you up for your first prenatal visit.			
Mom giving baby up for adoption.			
Mom wants to dig in deep with questions about your spiritual beliefs and practices.			
Rigid anti-medical beliefs BUT is planning a hospital birth; wants doula to “save” her from medical interventions.			
Mom is planning unattended homebirth and wants a doula to be present.			
Work with family who is not vaccinated for covid.			
Work with family who requires you to be vaccinated for covid, other diseases.			
Work with family who requires you to wear a mask.			

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Guide to Creating a Doula/Client Contract

A Service Agreement or Client Contract is a tool for communication between you and your client(s). Its purpose is to clarify the *mutual expectations* regarding your working relationship, including the doula's role, services offered, timeframe for services, fees charged, terms of payment and client responsibilities, such as when and how to contact you. Conflicts and disappointment can arise from mis-matched expectations. A written Agreement of your understanding is an essential piece of the doula's approach to managing any liability associated with her/his role, including clarifying that *doula care is non-medical and non-clinical*. Think of your Service Agreement as a work in progress. You will, no doubt, continue to tweak it after each family served until you settle into a comfortable practice and working document.

Try performing a Google search for "doula contracts" and read through a variety of samples. Notice how each doula puts her own personality and spin on the presentation. You may want to consider having a lawyer review your Agreement/Contract.

Additional steps involved in risk management include: (1) ensuring that the doula stays within his/her defined scope of practice, (2) formation of a limited liability corporation, and (3) purchasing professional liability insurance.

Your agreement should include the following components.

The Doula's Role and Services

- General description (e.g., family-centered care, emotional support, information and support for informed decision-making, referrals and community resources as needed, non-judgmental support based on client's values and preferences, respectful collaboration with other care providers, etc.)
- List of services and their scope. Be as specific as possible, including definitions. Wherever than *can* be room for misinterpretation, there *will* be misinterpretation. Assumptions often lead to misunderstanding.
- Any limitations to services, including both scope of practice limits and personal/ professional limits, including clarification about what non-medical care includes. Here are some more examples.
    - Do you come to the client's home in early labor and provide support or is it by phone/text only?
    - What does early labor support look like? Spell it out.

  Try to think of other expectations or assumptions families may have and make sure you are all on the same page. One way to find out is to ask them!

How Services are Delivered

- Do you work with other doula partners or as part of a team? Specify.
- If in solo practice, what is your policy regarding backup for the times you cannot be available to the family? Under what conditions might you not be available to fulfill your commitment to the family?

- Do you offer consultations? Work shifts? Provide overnight respite care? Take emergency calls? Agree to be "on-call" for the family? Spell out exactly what they can expect from you.

Responsibilities of the Client

- The primary responsibility of the client is to pay you according to the terms of the Agreement. List how and when payments should be made.
- You may also want to address notification regarding their need for services (if not starting immediately) and your response time/availability. How do they activate your support? How much lead time do you need? Do you want regular updates? How should they contact you (text, phone, email)?

Timeframe for Services

- When do services begin/end? How long will visits be?
- Do you offer any type of ongoing support or connection? A client Facebook Group or support group? Phone consultations for a fee? Classes?

Fees and Terms of Payment

- How much do you charge for services? When is payment due? Are you offering a package of services at a set fee? Or do you bill for services rendered weekly? Do you collect a retainer fee to be "on-call" or hold time in your schedule? Spell it out.
- Refund policy. If a retainer is collected to remain available to the family, most doulas will consider this retainer non-refundable. Be clear if it is non-refundable or state circumstances under which it might be partially or fully refunded.

How to Handle Conflicts or Complaints

- Most doulas prefer that if the family is not satisfied for some reason, they contact the doula directly as soon as possible. Explain your preferences. Mentioning this in the Agreement helps open the lines of communication in the hope of preventing problems becoming insurmountable.
- Consider mentioning that if you find that you are not compatible, or cannot meet their needs, you will provide them with a referral to someone else. This prevents abandonment.

Contact Information

- Include the doula's preferred method of contact. You may want to include instructions for the middle of the night (if they are welcome to call you then). Do you always take your phone to bed with you? Is there a better way to reach you at 3 am?
- Identify emergency contact numbers and circumstances under which they should be contacted.

Signatures

- Key decision-makers, responsible parties on the client side

- Doula and doula partner(s) (if any)
- Dates

Have two copies of the Agreement available for signing by both parties. One copy is for you to keep and the other should be given to the client.

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Birth Doula Contract Sample

Services Offered

I see my role as providing support to you through your pregnancy, birth, and immediate postpartum experience. My goal is that you feel well cared for, that you are supported in your choices, and that you make the transition into becoming a mother as smoothly and joyfully as possible. I am especially careful that my role is not to take the place of your partner or others whom you have invited to your birth, but rather to facilitate everyone's optimal involvement. The following services are included in my fee:

- Initial consultation/interview (no obligation)
- Two prenatal visits in your home, lasting approximately 75 minutes each
- On-call availability beginning two weeks before and up to two weeks after your estimated due date of [fill in date]
- Continuous support during your labor and birth in the hospital or birth center of your choice, or for your homebirth
- Support in early labor is provided by phone
- Support after your baby is born during the immediate recovery phase (approximately 2 hours)
- One postpartum home visit, typically on the third or fourth day (can be earlier if needed or preferred)
- Phone consultations as needed, up to six weeks postpartum

Limitations on Services

As your doula, I am committed to supporting you and your partner to make informed choices regarding your experience and care. I will not make decisions for you nor directly interfere with your health care providers on your behalf. My role is to provide nonmedicalized care focused on emotional, informational, and physical support, including hands-on comfort measures, during labor and birth. I do not perform clinical tasks such as monitoring fetal heart tones, nor do I provide in-home support in early labor, except if you are having a planned homebirth and the attending midwife is present in the home.

Backup

I promise to be available for two weeks on either side of your due date, except for any dates I provide to you up front at our initial interview. Should you birth outside of the on-call timeframe, I may very well still be available, but if I am not, a backup doula will be on call for me. This way, you can be assured that you are covered and will always receive excellent care. Please understand that illness, a family emergency or two births happening at once might also cause me to activate my backup doula.

Should your birth go long (over 20 hours), and I feel that I can no longer be an asset for you, my backup doula will provide relief so that I can get some rest. In the case of using backup, I will continue to provide as much of the care as possible, including the postpartum visit.

Fee and Timeframe for Payment
My fee is [fill in amount]. If you decide to hire me, a nonrefundable retainer of [fill in amount; perhaps 50 percent of the total fee] will be due upon hiring and signing of this contract to reserve space in my schedule. The balance owed is due at the second prenatal visit, which is typically scheduled three to four weeks before your expected due date.

Refund Policy
A partial refund of your birth fee will be given if you change your mind regarding my services, for any reason, and you give me notice at least two weeks prior to your due date. In this case, I will refund up to half of your total birth fee upon request. The retainer fee is non-refundable. A refund of your birth fee will not be given under the following circumstances:

- I miss your birth because you fail to contact me in time or your labor is precipitous.
- You change your mind regarding having a doula present, for any reason, within two weeks of your due date (i.e., after the on-call period has begun).
- Your labor results in a cesarean birth or otherwise departs from your ideal birth plan. Please understand that my presence at your birth is not a guarantee of success for any specific desired outcome. I can only support your strengths and help you to make informed decisions; the rest is up to you and your medical care providers.

You are responsible for:

- Keeping me posted on how you are doing and updating me on any significant developments related to your pregnancy. Please call me, at a minimum, within a day or two following each prenatal visit with your care provider.
- Calling me if you suspect that you are in early labor. If it is in the middle of the night, and you are still able to sleep between contractions, then you do not need to call, but I need to be put on notice by 7 am the next morning. The more notice I have of your impending need, the better prepared I can be to leave promptly when you need me.
- Communicating honestly about your needs. While I believe I am intuitive and empathic, I am not a mind reader and appreciate frank direction if there is anything I can do to adapt to your needs.
- Fulfilling your part of this agreement in terms of payment of fees and established timelines for doing so. If you anticipate a problem regarding a scheduled payment, please give me as much advance notice as possible so that we can problem solve the issue together.

I promise to:

- Return your nonurgent phone calls within 24 hours (unless it is a weekend, in which case, I will return your call on Monday).
- Maintain availability to respond promptly to all urgent calls.

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- Notify you when my backup doula is taking call for me, for any reason.
- Provide all services as described in this agreement.
- Do my best to help you to have the experience you are hoping for.

Agreement
This agreement is between [Your Name] and [Clients' Name(s)] for the purpose of providing non-medical birth doula services. We have read this Letter of Agreement and agree that it accurately reflects the discussion had by all parties. In signing this Agreement, we are promising to pay for the services described above. I promise to provide the services as described and look forward to helping your family.

[Insert signature lines and dates for all parties.]

Initial Client Contact

It is essential to have your "ducks in a row" before you begin receiving referrals for your services. You want to set a tone of calm, competent professionalism, right from the start. So, take your time to work your way through the Five Key Questions for Start-Up Doula Businesses and commit your answers/decisions to paper. Now you are ready to have the conversation!

Initial Phone Inquiry

The initial inquiry might also come in the form of an email or form that they submit from your website.

- Initially, you should screen for the basics like location and due date to determine whether you are even available to serve them, and then take it from there.
- Your primary goal on this call is to *establish rapport* and learn what type of assistance the person/family is seeking. Ensure that you can give them your undivided attention. If you are driving or have small children competing for your attention, set up a time to call them back asap.
- You will find that some folks want to take the lead on this call and are well educated about the role of the doula. They may even have a list of questions for you. They may be planning on calling several doulas. Others may be pre-disposed to hire you because their friend/sister has recommended you. Still others will be rather clueless. Perhaps someone recommended they hire a doula, but they really don't even know what questions to ask. You can simply follow their lead, meet them where they are at.
- Be curious about them and their needs.
- Give a brief description of your services and fees.
- If you feel you can help this family and they are interested, set up an in-person consultation to explore further. If they are not ready to take that step, you can let them know that you book time in your schedule on a first-come first-serve basis, and that you hope to hear from them.
- If you are not a good match for what they need, make referrals/share resources.
- It should not be necessary to spend more than 10–15 minutes on this call. Help the caller keep moving through the screening questions to the next step in the process. This takes practice. In the beginning, you are likely to error on the side of being too generous with your time. However, you are not really doing folks a favor and you are setting a bad precedent with poor boundaries around your time on the phone. *Be purposeful (professional).*

Initial Visit/Consultation/Interview

- Think of this as a mutual interview designed to discover whether you are a good fit for their needs. No one is committed prior to this interview and most doulas do not charge for this.
- Since COVID, many doulas are doing the initial consultation/interview on Zoom. That is certainly an option that saves time and effort. However, postpartum doulas may want

to consider the value of conducting the visit in the client's home because that is the setting where services are to be delivered and it will give you a better feel for the family.

- Based on the initial inquiry phone call, research any topics you may not know much about before you meet in person. For example, if your prospective birth client is hoping for a VBAC or shares that she has gestational diabetes, it's time to learn more about these topics. Gather any needed resources and have them available for the consultation. This helps to establish your value right away.
- Use a Client Intake Form to guide your interview (see instructions below).
- Ask open-ended questions and listen more than you talk.
- Provide them with a copy of the Client Contract and go over it with them, allowing for questions.
- This visit should take between 30 and 60 minutes.

Intake Form Guidelines

Your form will reflect the type of practice and services that you intend to offer so we cannot offer a one-size-fits-all form for you to use. Rather, I recommend that you create a unique form that reflects your practice. I have provided an editable template you can use as a jumping off point. Think in terms of "why am I asking this question?" "Will the answer(s) provide guidance for meeting client needs?" The goal is to collect necessary information without being overly intrusive.

Remember, the purpose of the form is to guide you through your initial conversations with clients. It would be helpful to have your form on hand to capture key information during a phone inquiry, from first contact. That way, you will have some of the information and won't have to ask the same questions again. It will help you to build trust and demonstrate that you are interested, that their story matters. Here are a few points to keep in mind as you create a form that will function well for your practice.

- This form is for the doula/doula team's use only. It doesn't matter how pretty or formal it is; it should be functional.
- It is best to fill it out in person by asking the questions rather than giving it to the client to fill out.
- Client confidentiality is essential. Don't let anyone else see the form or leave it lying about. Never share confidential client information on email or social media.
- Don't be overly medical with your questions. Since doulas don't provide medical care, we don't want to give that impression, even when the doula happens to have a medical background. Think to yourself, "What am I going to do with this information?" before you ask the question (e.g., "Do you have a history of kidney disease?"). If the answer is nothing, then don't ask. Otherwise, it gives a mixed message about your role.
- Personalize the form for your purposes—your unique doula practice—in any way that helps you gather key information, assess the family's needs, and determine how you can help them. Think of the form as a work in progress. As your practice evolves, so will your forms.

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Sample Intake Form

Name: ____

Partner's Name: ____

Siblings' Names & Ages (if any): ____

Due Date: ____

Intended Place of Birth: ____

Doctor/Midwife: ____

Home Address: ____

Phone Numbers for Mom & Partner ____

Email Address for Mom & Partner ____

Preferred method of contact? ____

How did they learn about you?

- Referral? If yes, who?
- Website?
- Social Media?
- Other? Describe …

Pregnancy History

- What number baby is this?
- If this is not their first pregnancy, then ask about past experiences, what went well, what might have gone better. Include both the birth and postpartum periods.
- Any special health or other concerns in relation to this pregnancy that they would like to share with you?

Expectations of the Doula

- Special concerns regarding their birth?
- Educational needs or need for resources (provide list of topics)?
- Goals for birth or postpartum period?
- How do they view your role?
- Resources / referrals needed

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Supplies for a Doula Bag

Self-care items

- Change of clothes
- Sensible shoes (no open toes)
- Layer for warmth (hospitals are cold); something with a hood can be useful as a shield against air conditioning blowing on you or withdrawing from the environment when/if there is an opportunity to nap
- Toothbrush, toothpaste, deodorant, comb/hairbrush
- Phone charger
- Foods to snack on such as trail mix, nuts, fruit, instant protein drinks, etc. (so you won't be at the mercy of vending machines when the cafeteria is closed)
- Cash/change for vending machines, parking
- Your meds if you take any

Doula supplies

There are no necessary supplies that doulas need to be good at their jobs. "Stuff" will not make you a better doula. However, you might find yourself frustrated at times for lack of a specific item and decide to add it to your birth bag. Here are a few suggestions.

- Rebozo (You can also use a hospital bed sheet for all the same things you might do with a rebozo.)
- Birth ball (I love birth balls. Most hospital L&D units have them these days, but some hospitals only provide peanut balls. I like having both options. If you take a tour of the hospital, check out what they have available and whether they have enough to go around when they're busy.)
- Massage tools, lotion (find an unscented lotion if you want something available for massage)
- Hair ties, lip balm
- Hand-held fan (a magazine works too)
- Small inflatable pillow for use in the bathtub
- Medium-size plastic bowl (to keep hot or cold compresses within easy reach bedside; you can also scrounge around in the cupboards in the birthing suite to see if there is a small tub or container available)
- Masking tape and highlighter or magic marker (for posting of birth plans in a couple of different spots around the room; highlight most important information so it can be seen at a glance; very helpful if birth goes long and you have a rotating series of hospital caregivers)
- Favorite reference book: *The Labor Progress Handbook*, by Penny Simkin and Ruth Ancheta (This book is expensive but worth it!)

Don't forget! Bring your client records, birth plan

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Safety Strategies Checklist for Home Visitors

- ✓ Have sufficient gas in your tank whenever you are on-call; fuel up on your home turf rather than on someone else's.
- ✓ Keep your vehicle in good repair.
- ✓ Have reliable directions and know where you are going; double check online directions with your client, especially during road repair season.
- ✓ Have a fully charged cell phone with you in case of emergency; keep a charger in your car.
- ✓ Avoid highway rest stops; choose a well-lit restaurant or gas station if you need to stop (or, better still, use the bathroom before you head out).
- ✓ If the neighborhood is unsafe, have your client's partner or a family member escort you; call from your car when you arrive; ask that they observe your departure until you are safely on your way.
- ✓ Park in well-lit areas. You may even want to walk a little further to stay in a well-lit area, compared to parking closer to a building entrance but off to the side in a dark corner.
- ✓ When using parking garages at hospitals in the late night or early morning hours, ask a security guard to escort you to and from your vehicle.
- ✓ If approaching your car alone at night, have keys in hand. Most key fobs have a built-in system whereby pushing "unlock" once opens the driver's side and pushing it twice unlocks both sides; use this safety feature to unlock only the driver's side. You can also hit the alarm button if feeling threatened.
- ✓ Lock all doors as soon as you enter the vehicle and drive away promptly. Many women make themselves a target as they sit for several minutes, tending to business, talking on the phone, distracted, and observed. Drive to a safe place before checking phone messages, etc.

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At 10:00 a.m. your client calls
Labor seems to be starting!

What will you wear?

Describe what plans you'd have to make to meet your family's needs for the next 36 hours.

Do you have food prepared to take along?

Can you be easily reached by your clients?

Are you free of all scents and perfumes?

What if Labor Started Right NOW?

Is what you need to take with you ready?

Describe what changes you'd have to make to your work schedule for the next 36 hours.

Describe what personal plans you'd have to change for the next 36 hours.

Is your hair clean and styled neatly? Have you showered recently?

Whoops! False alarm!
They call back at 11:30 p.m.
How do your answers change?

Questions and concept
by Carolyn Ogren, BDT(DONA)

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APPENDICES

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Appendix A

Perinatal Loss and Grief: Bereavement Support Guide for Doulas

Compiled by Patty Brennan

Overview

There are several different types of loss that may be experienced during the childbearing year.

We expect parents to grieve:

- Miscarriage
- Fetal or neonatal death
- The less than perfect or wished for child
- Giving a child up for adoption
- Less than perfect birth or traumatic birth

Parents may also be grieving:

- Loss of the pregnancy state
- Loss of the pre-pregnancy state, loss of relationship(s)
- Loss of identity
- Loss of income
- Loss of intimacy
- Loss of breastfeeding
- Infertility
- Loss of peer group

Miscarriage =
fetal death prior to 20 weeks gestation or under 500 grams; an estimated one in five pregnancies are lost to miscarriage

Perinatal loss =
fetal death after 22 completed weeks of pregnancy up to 7 days of life for live born children

Still birth =
fetal death after 22 completed weeks of pregnancy and prior to birth

Neonatal loss =
any infant death, including stillbirth, up to 28 days after birth

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Supporting the Family after Perinatal or Neonatal Loss

What Not to Say

In general, avoid saying anything that downplays or diminishes the family's sense of loss including:

- You can have others.
- You have an angel in heaven.
- This happened for the best.
- Better for this to happen now, before you knew the baby.
- There was something wrong with the baby anyway.
- Calling the baby a "fetus" or "it."
- I know how you feel.

What Not to Do

- Don't pass judgment on how long they should be grieving.
- Don't avoid or abandon them.
- Don't change the subject.
- Don't give advice.
- Don't suggest that baby received inadequate care.
- Don't leave partners out of your support efforts.
- Don't make it be about you.

What to Say

In general, a willingness to be a sympathetic witness will be helpful. Let parents know that you are sad for them.

- It's tough for you right now.
- Offer specific help.
- I'm sorry you are suffering.
- You must really miss them.
- I can imagine how you are feeling.
- Share a remembrance.

Ways the Doula Can Help a Grieving Family

- Be genuine and caring; don't abandon them.
- Allow them to express feelings without being judged.
- Validate. (Don't try to "fix"—<u>you can't</u>.)
- Ask/offer whether there is anything you can do for them. Special requests?
- Avoid overwhelming the grieving person(s) with too many choices and decisions. Keep it simple.
- Answer questions and make referrals.

- Refer to baby by name and talk about special features of the baby (if you got to meet the baby).
- Encourage them to be patient with themselves.
- Ask about and include other family members.
- Ask about the funeral or memorial service and attend if one is planned.
- Help form a healing community.
- Coordinate helpers; encourage tasks to be designated to others.
- Make a list of specific tasks to have available when someone offers help and let them self-select a task from the list (or organize a Meal Train; see below).
- Stay in touch; reach out and acknowledge their loss.

Physical Support for the Grieving Postpartum Mother

- Provide reminders and support for self-care. She is still a postpartum mother with the same physical needs for rest, nourishment, and healing.
- Be aware that grief will sharpen when milk comes in and no baby is there to take it.

Remembrances You Can Give the Family

- Baby ring
- Planter/flowers in a baby vase
- Original poem
- Tree or rose bush as a living memorial
- Donation to a memorial fund
- Needlework
- Photographs (Birth doulas can offer to take pictures if they are present for a still birth or the baby dies shortly after birth.)
- Keepsakes

When a baby is still born or dies shortly after a hospital birth, the hospital will put together a package of mementos for the family. This typically includes a picture, lock of hair, footprint, baby blanket, etc. It is offered to parents when they are being discharged from the hospital. Some parents who decline the package end up regretting their decision later. Hospitals are aware of this phenomenon and typically hold onto the packages for up to a year.

Keep in Mind

The family may need you a lot or may not need you at all. Your role has changed completely. Follow the lead of the family. Do not impose your services on them. Gently reassure them that you are there when they need you. Touch base with them periodically—leave a message. Support from family and friends will diminish over time. That may be the time for you to be there for them.

Leave your own baggage at home. Do not impose your own opinions, religious beliefs, etc. on the family. Sadness and tears are okay but imposing your own grief on the family is an

added burden for them. If your tears cause the grieving family to comfort you, then you have crossed the line.

Organize a Meal Train

Meal Train, Meal Train Plus, Care Calendar, and similar online Care Coordination websites are designed to organize meals and other forms of support for someone in need. Perhaps you have been on the receiving end of a Meal Train or participated in one for someone else? If so, you already have a good feel for how the systems work and the value they bring. If you are unfamiliar, the system can be activated on behalf of another in need of some extra support, such as after a loss, after having a baby, while undergoing cancer treatments, and so on.

Once the Meal Train is set up, see if there is someone in the circle of support who is willing to undertake any ongoing coordination that may be required. Then invite folks to participate through email and social media networks. Supporters simply link to the profile and choose a task/date. The system will send them confirmation and reminder. For an under-resourced person, the doula can help brainstorm potential sources of support such as the person's faith community and other social circles they may be a part of.

For meals, I recommend that you choose specific days of the week when it would be helpful to have a meal delivered. Likes and dislikes, prohibited foods can be listed and instructions for drop-off included (e.g., use of a cooler on the front steps; timing preferences, etc.). Some services enable more than coordination of meals, for example, running errands, driving/picking up kids from events, rides to doctor visits, and so on. It is best to be specific about when help is most needed. It can be a bit overwhelming to the support person who sees weeks of empty

days where meals are needed. Limiting your ask to specific days makes it easier for the helper to decide where to plug in and make a difference.

One new postpartum mama I was supporting had just brought home her newborn who had been born prematurely and spent a couple of weeks in the NICU. We set up a Meal Train for her. Instructions were nicely worded to the effect, "Please drop off your meal by 6pm in the cooler on the front porch. On your way, feel free to text me and, if I am awake and ready for company, I will invite you in briefly to see me and meet my baby." This gave her permission to turn her phone off and sleep undisturbed when the opportunity arose. It also sets clear boundaries for visitors.

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Exercise for Doulas

If you have never participated in a **Meal Train, Care Calendar,** or similar online service, check it out. Note prices associated with the various systems and which ones strike you as the most user friendly. Ask others for their favorite recommendations. Add to your Resource List.

What about that Breastmilk?

Years ago, if a woman suffered a loss or chose not to breastfeed her baby, a drug was given to help dry up her milk supply. This drug was found to cause dangerous side effects and has since been discontinued. Now, the only remedy recommended by medical health professionals is to wait it out and use a pressure binder on the breasts to help the mother be more comfortable. Since breastmilk supply is biologically based on the concept of supply and demand, lack of stimulation of the breasts from the baby suckling will gradually lead to reabsorption of the milk and a cessation of the supply. This process usually takes about two weeks.

Donation of Breastmilk

Breastmilk is in high demand and can be life saving for sick infants whose mothers are unable to nurse them or provide their own milk. Breastmilk Banks will screen donors for communicable disease and provide a means of safely collecting, storing, and donating breastmilk. I have heard testimonials from mothers who suffered a loss and felt comfort and healing in pumping their milk and donating it to another family. This choice can be gently presented to the mother as an option.

Exercise for Doulas

Identify the Breastmilk Banks in your region and how to become a donor. Add to your Resource List.

Herbal Tea Recipe to Dry up the Milk

The mother may speed up the natural reabsorption process, if she is so inclined, by drinking Sage tea, known for its ability to dry up the milk supply. Doulas can share the following recipe with their clients as INFORMATION rather than PRESCRIPTION, and at the same time, encourage them to check first with their midwife or doctor about its use.

Ingredients
Dried organic or wild-crafted sage from a reputable source.

Dried herbs (including all culinary herbs) have a shelf life of one year. After that time, all the essential oils in the herb become dormant. Exposure to heat and sunlight will cause the essential oils to deteriorate more quickly. This is the reason herbal tinctures are packaged in amber glass bottles (to block sun rays) and herbs are best stored in a cool cupboard (rather than above the stove). So, that sage you might have in your kitchen herb rack, in those cute little glass bottles, that was given to you as a wedding gift, is not going to cut it.

Sources
Check out your local health food stores for a good supplier. Some sell herbs in bulk. Ask how fresh the herbs are and what the turnover rate is for the Sage in particular. Older herbs that have been sitting packaged on a shelf for a long time can become moldy, so use your eyes too. If you don't have a good local source, there are several companies that will ship herbs directly to your client. These include Frontier Herbs, Starwest Botanicals, Herb Pharm and many others. If you have access to fresh sage that you can harvest yourself, you will just need larger quantities to make the tea, as fresh leaves are much bulkier than dried herbs.

Exercise for Doulas

Identify reputable sources for organic herbs in your service area and online. Add to your Resource List.

Directions
Make a strong herbal infusion of sage tea and drink 3 Cups daily.

- Use 1 TBSP of dried herb to 1 Cup of water.
- Add 3 TBSP of sage to a 1-quart mason jar.
- Boil 3 Cups of water and pour it over the herbs.
- Put a lid on the mixture and let it sit for 1–4 hours at room temperature.
- Strain the mixture and toss the herbs.
- Add a sweetener or anything you choose to make it more palatable, if desired.
- Refrigerate the remainder, spacing your 3 cups through the day.

Caution: Beware of abruptly discontinuing the tea once the milk supply appears to be drying up. Some women experience a rebound effect and are devastated to have the milk supply return. This effect was noted with the now-discontinued drug as well. Rather, slowly wean off the tea, cutting back to two cups per day for a couple of days, and then one cup per day for a couple of days, and so on. If any increase in milk production occurs, then take it more slowly.

Comfort Measures

- A breast binder or sports bra may be used.
- Fresh, cold green cabbage leaves can be placed on the breasts. These will relieve swelling. Wilted leaves can be replaced with fresh ones until a degree of relief is achieved.
- Visualization may help. Encourage the mother to imagine her breasts to be non-lactating and their normal size. Hold that vision and tell your body to stop making milk.

Children and Grief

Children grieve from infancy on. A child's grief may look the same as adult grief or it may look different, including the following:

- Often in and out of grief
- Don't react the way we think they should
- Say and do unexpected things
- Set aside to deal with later
- Revisit at different ages or stages

Children's biggest fears:

- Abandonment—Who will take care of me? Will my parents die? Reassure family will survive.
- Own mortality—Will I die too?
- Was it my fault?

Children need:

- Time to ask questions
- Simple, honest answers that are age-appropriate
- Special support person(s)
- Routine
- Reassurance
- The option to say "no" and to be included
- To express grief
- Understanding
- Preparation for the death and the events afterward, such as the funeral and graveside ceremony
- Help to commemorate their deceased loved one

Speak in simple terms:

- Use understandable words.

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- Be clear and truthful; if you don't know the answer, say so.
- Don't say anything that will need undoing later.
- Tell the child before they hear it from someone else, preferably in familiar surroundings.
- Explain what "dead" means (X's body stopped working and it couldn't be fixed).
- Don't say "asleep" or living somewhere else.
- Normalize feelings.
- Provide an opportunity to ask questions.
- May repeat, need reassurance

Hospice Bereavement Groups for Children
All hospices offer grief support for the loved ones of someone who has died. A family does not have to have used a hospice's services to access bereavement support. Many hospices offer special age-appropriate groups for children.

Exercise for Doulas

Explore grief resources available for children in your service area.
Add to your Resource List.

When is professional help needed?

- Support is lacking.
- Circumstances prevent grieving.
- Grief threatens survival, trauma.
- Biochemical imbalance is present.
- Spiritual despair is experienced.
- Someone is suicidal.
- Griever takes on the identity of survivor or victim.
- Activities of daily living are overwhelming.
- Relationships are in conflict.
- Panic is experienced.
- Health habits are out of control.
- Mediation for forgiveness is necessary; loss is interpreted as punishment.

Remember that not all people need to talk about their grief nor benefit from grief support counseling or groups. Most people do well on their own.

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Exercise for Doulas

Explore the mental health service providers in your area. Are there folks who specialize in grief counseling? Are there agencies who offer a sliding fee scale for low-income families in need (e.g., Catholic Social Services)?
Add to your Resource List.

One Final Note for Doulas

Witnessing another's devastating grief up close is painful. It can bring back our own experiences of loss or trigger past trauma. It requires willingness, courage, and good self-care.

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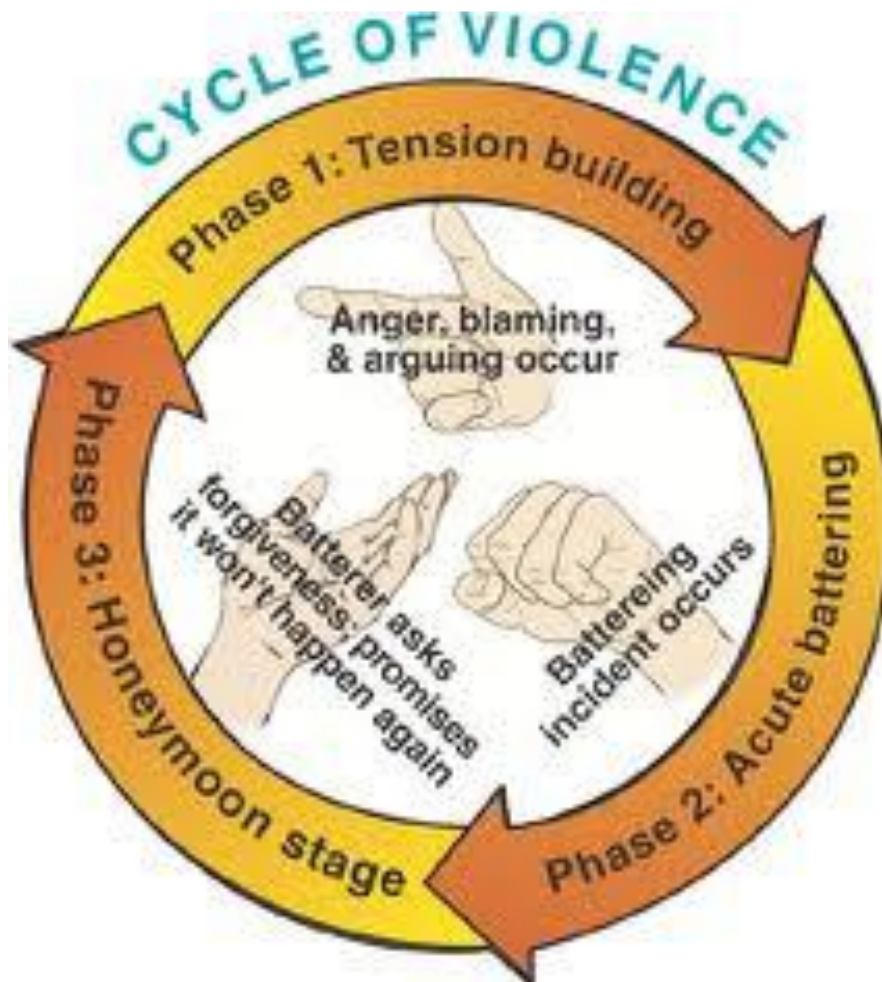
Appendix B

Domestic Violence Awareness for Doulas



Compiled by Patty Brennan

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Domestic Violence and the Doula

Excerpted from The Doula Business Guide, 4th Edition by Patty Brennan

Note: Because most victims of domestic violence are women, we are using the term "woman" throughout this discussion. However, it is important to keep in mind that anyone can be a victim of domestic violence.

Doula Observations

Following are some of the signs of an abusive relationship that doulas might observe:

- Pattern of injuries with incompatible explanation (e.g., objects that leave an imprint, but she says that she fell)
- Repetitive psychosomatic complaints
- Prone to "accidents"
- Depression and suicide attempts
- Multiple injuries in various stages of healing
- Any injury during pregnancy
- Inter-relationship between the couple; their demeanor is "off."
- Woman may be evasive, ashamed, avoid eye contact.
- Woman defers to her husband; he does all the talking, makes all the decisions.
- He's overly concerned, demonstrative and protective; sits too close to her; has his arm around her.
- He never leaves the doula alone with the woman.
- He ensures that the doula does not have independent access to her client; the woman doesn't have her own phone, is completely dependent upon him, etc.

Power and Control Wheels: A Great Visual Aid

Just do a search online and you will find several variations of the image. There is a version for immigrants, and the tool has been translated into multiple languages.

Barriers to Leaving the Relationship

A woman may have good reasons for staying in relationship with a batterer. She may love him and want the relationship to work out. She may rightly fear he will follow through on his threats to harm her, himself, her children, or her family if she leaves him. The most serious assaults occur when a survivor has left her batterer, called "separation violence." This makes sense if we think about it. If the batterer's agenda is about exerting absolute power and control, then the woman who has decided to leave is the biggest possible threat to that agenda. When he feels he is losing control, he is quite likely to escalate his efforts to regain it.

Additionally, she may be afraid of losing her children through custody battles or she might believe that she cannot parent her children alone and that they need their father/father figure. She might be financially dependent on her abuser and not have sufficient job skills to support herself and her children. Cultural and/or religious beliefs might dictate that she stays in the

relationship. The woman's self-esteem may have been so severely damaged from years of abuse that she believes him when he tells her she deserved or caused the abuse. She might feel too ashamed to tell anyone. The daily exhaustion from dealing with his abuse might leave her feeling unable to make a major change.

Signs of a Lethal Situation

- Threats to kill survivor, himself, the children, or a member of the family.
- Threats to use weapons to harm or kill the survivor.
- The survivor states she has told him she is leaving.
- Separation has occurred (survivor has left the batterer).
- Stalking behavior (numerous messages/calls to her, following her, letting her know he knows where she is at all hours and who she sees, calling her work or school to make sure she is there, etc.).
- The survivor tells you he is obsessed with her.
- Depression or recent losses (jobs, death of loved one, accidents, etc.).
- History of assaulting her while he is intoxicated.
- Mutilating or killing a pet.
- Recent dramatic change in behavior.

Immigrant survivors have another whole range of reasons for staying. She might fear that if she reports him to the authorities, he will report her status and she will be at risk of deportation. She may not know where to access services. She might believe that agencies will not be able to help her because of language barriers and/or staff who are unfamiliar with her cultural beliefs. Or she may have a general distrust of the government in any form.

Appropriate Doula Responses

Things to avoid saying to someone you suspect might be living with domestic violence:

- *Are you a victim of domestic violence?* Most survivors will respond negatively to this question. It is better to ask, *"Have you ever been hit, punched, kicked, pushed, strangled, threatened or otherwise hurt by your partner?"*
- *What did you do to make him hurt you? What were you doing right before he attacked you?* These kinds of questions imply she is to blame for the assaults. She is never to blame, nor does she deserve the abuse.
- *Why haven't you left him? Why did you go back to him?* Because of all the reasons for her to stay, she might be reluctant to leave, or she may have left and returned. We know that leaving a relationship, for anyone, is a process. *On average, a survivor will leave her batterer seven times before the relationship is over.*

Strategies that work well to facilitate disclosure and discussion of domestic violence in a survivor's life include the following:

- *Listen to her.* This may be the first time she has talked to anyone. She might not talk again about the violence she is experiencing. Just listen to her without judging or telling her what to do.
- *Empowerment vs. intervention.* Avoid telling her what to do next or trying to solve her situation. She is the authority in her life and knows how to survive in her situation. Telling her what she should do only results in one more person having control over her life.

If the woman does disclose that she is being abused, let her know:

- Battering is a common problem that happens to many, many people.
- She is NOT alone.
- The abuse is not her fault; she doesn't deserve to be treated like this.
- "I am concerned about your safety and the safety of your children."
- "I am here for you if you want to talk, regardless of whether you are ready to leave the relationship" (nonjudgmental).
- Listen, provide empathy, try to understand, validate.

The goal is to provide knowledge and support to the woman so she will do something about her situation. Listening allows her to identify what is happening and hopefully experience enough safety to take the next step. She needs to know her options. Leave the door open for her. **When she is ready to take the next step, she needs a safety plan.** Ask her what she has done in the past that worked (remember, she is a survivor). It is time to get a professional involved, such as a safety shelter!

Do not feel that you need to be the one that rescues her. Doulas must guard against the desire to rescue the woman. If we see ourselves as rescuers, we continue to victimize her. *Rescuers need victims to rescue.* Be honest with yourself if you notice you are experiencing any of the following classic signs of rescuing behavior:

- Obsessive worrying
- Desire to take her children home with you
- Lending her money
- We're on pedestal and now she's angry that we let her down
- We hear what we want to hear; she lies to us
- Making excuses for her
- Daydreams of revenge on her assailant
- Feeling that she's not grateful enough for all you do (Can she do more for herself?)

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Being Responsible *TO* Others Versus Being Responsible *FOR* Others

With permission, from Polly Perez's book, *Doula Programs* (2010)

When you feel responsible *to* others:	**When you feel responsible *for* others:**
• You show empathy, encourage, share, confront, level, are sensitive, listen. • You feel relaxed, free, aware, high self-esteem. • You are concerned with relating person to person, feelings, and the person. • You are a helper/guide. • You expect the person to be responsible for themselves and their actions. • You can trust and let go.	• You fix, protect, rescue, control, carry their feelings and fail to listen. • You feel tired, anxious, fearful, liable. • You are concerned with the solution, answers, circumstances, details and being right. • You are a manipulator. • You expect the person to live up to your expectations.

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"Safe House" or Shelter Policies for Battered Women

- Assign an advocate.
- Keep all information confidential.
- Provide services in her language.
- Provide services regardless of citizenship status.
- Provide emotional support for her decision to stay with or leave her abusive partner.
- Refrain from pressuring her to enter the shelter.
- Work with others in the community to help keep her safe, *only if she requests this and after she has signed releases.*
- Domestic Violence Response Team—emergency intervention available.

Child/Elder Abuse and Neglect: Are Doulas Mandated Reporters?

Child/elder protection laws are enacted to protect the health and welfare of vulnerable people, especially in instances where parents or other immediate family members are unwilling or unable to do so. To this end, statutes identify certain professions whose members are legally required to report abuse or neglect or suspected abuse or neglect. Those listed are the only professionals identified as having a legal obligation to report abuse. The standard statutory interpretation is that when a list is affirmatively delineated, that list is complete and omissions from it are intentional. Therefore, if doulas are not specifically mentioned, then they are, by definition, not considered to be mandated reporters. Statutes vary from state to state so you will need to research the wording of your state's law.

Although doulas are unlikely to be identified as mandated reporters, there is no prohibition against doulas making a report. So, while a doula is not legally liable for failing to report suspected abuse or neglect, she certainly may—and hopefully will—report it.

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Bibliography & Resources

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Special Mention Books

These two books make a great addition to your doula supplies as reference books to have on hand at a birth or postpartum visit:

- *The Labor Progress Handbook*, 4th Edition (2017) by Penny Simkin and Ruth Ancheta.
- *Breastfeeding Answers, 2nd Edition (2020),* by Nancy Mohrbacher. There’s a pocket guide version of this book which fits easily in the doula’s bag for a quick reference guide on the job.

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Favorite Online Resources

- MDHHS Doula Initiative. This is the hub for Michigan doulas to join the Doula Registry and become eligible for Medicaid reimbursement for their services to low-income families. Free ongoing continuing education programs are also offered.
- Lifespan Doulas. Professional certification for birth doulas; online doula business development support includes training, mentoring, and Patty Brennan's books.
- AllSourcePregnancy.com. Recommended, evidenced-based information.
- Aviva Romm. This website is a reliable source of information on safe use of herbs in pregnancy and while breastfeeding from an MD-herbalist.
- KellyMom.com. Popular breastfeeding website with great information.
- LactaLearning. Professional lactation courses and continuing education programs; book groups; free resources. From Barbara Robertson, MA, IBCLC.
- La Leche League International. Peer-to-peer breastfeeding information and support.
- Lamaze International. Read "The Six Healthy Birth Practices." Provides training to become a childbirth educator.
- Sarah Buckley. Great information on hormonal physiology of childbearing from Australian OB; author of *Gentle Birth, Gentle Mothering;* and more.
- SpinningBabies. This website contains useful information for turning babies who are not optimally positioned prior to the birth. Great continuing education workshops for doulas.

Facebook Groups for Doula Networking

Doula Connection—Upper Michigan
Michigan Doulas—Medicaid Enrollment and Claims Support

Mentoring

Lacy Anderson
Upfamily.doulacare@gmail.com
UPFamilyDoulaCare.com

Melinda Britton
doulasofmarquette@gmail.com
Doulasofmarquette.com