contents

2 YOU WANT TO GIVE BIRTH WHERE?
A father chronicles how he came to believe that homebirth is safe.
Issue 140, January–February 2007
BY MICHAEL ROBERTSON

7 FUMBLING TOWARD FATHERHOOD
A first-time dad’s lighthearted take on trying to be an effectual birth partner.
Issue 140, January–February 2007
BY JUSTIN SCHAMOTTA

8 HOMEBIRTH IN HOLLAND
Dutch midwives help an American to trust herself and her body.
Issue 144, September–October 2007
BY MAURA KIKSTRA AND SANDRA GAFFIGAN

14 KEEP YOUR BIRTH AT HOME
Strategies for steering clear of the maternity ward
Issue 150, September–October 2008
BY LORA SHINN

Cover: Photo of Karen Hultgren Bruce holding her newborn, Finnegan, was taken by Allison Kuznia. Story begins on page 14.
you want to give birth

where?

At first critical of homebirth, a thoughtful expectant dad comes to understand why women choose to labor at home.

It was 1999 when my wife, Windy, told me that her pregnant friend Mirm planned to give birth at home. I responded with a rhetorical challenge that she justify this lunacy: “At home? Why? Why in the world?”

We had no children at the time, but we talked that night about our plans, and affirmed our intention that our own baby would someday be born in a hospital, of course. Having babies at home seemed nonsensical, a rebellion against hundreds of years of hard-earned medical experience and technological development, a rebellion that would put two lives and a family at risk for the sake of some crunchy, organic experience. Before modern obstetrics took charge, didn’t women and babies regularly die in childbirth? No one can force you to accept an epidural, but you should at least be where a team of doctors can intervene immediately, if required. Otherwise, if something went wrong—if you were at home, the baby halfway out, waiting for an ambulance—how could you live with yourself? Who would take such a risk? For what? Mirm had clearly gone over the edge.
Four years later, I was in a car with my mom when I casually mentioned that Windy and I had decided to have our first child at home. “No, no doctors. Just a midwife and a birth assistant—and me.” Her response was restrained, but echoed my own of four years prior.

In the intervening years, Windy and I had completely changed our perceptions of childbirth. For most of that time I hadn’t given a second thought to where Windy would give birth—we’d bought a fixer-upper of a home in Washington, DC, and I was consumed with my efforts to make it habitable.

However, owning a home meant that most of our neighbors were no longer university students or single professionals. For the first time, we were surrounded by people our age and older, who either had children or soon would have. At potlucks and chance meetings, we learned that many of the families in our progressive neighborhood had begun with an out-of-hospital birth. It surprised us to see that none of these people seemed to have gone over the proverbial edge. These families included a lawyer, a World Bank manager, a political chief of staff, and a father with a PhD in physics from MIT. In each case we heard their stories firsthand, and in some cases we shared with them our prejudice against home-birth and asked for more information. Along the way we learned that the Washington, DC area has cesarean-section rates that are among the highest in the nation. Windy began reading. My wife is one of the most independent-minded people I have known. She will latch on to an issue affecting her and study it relentlessly, with a scientist-like curiosity and impartiality, until she reaches a reasoned conclusion. At some point, it became clear to me that Windy was no longer comfortable with our assumption that a hospital birth was best.

Windy began learning about the midwife model of care available at home, at birthing centers, and at some hospitals. Knowing that any decisions to be made regarding pregnancy and delivery were largely hers, trusting her decision-making approach, and knowing that this approach was often circuitous, I tried to give her plenty of space. She did her best to relate what she was learning. “You don’t have to read the whole thing,” she would say, “just the part I marked.” Off I would go on my morning Metro commute with a book by Henci Goer in my work bag. And another week of “Did you read it?” and “No, not yet” had begun.

I soon sensed a shift in Windy’s thinking and tried to head it off. “Our insurance probably won’t cover an out-of-hospital birth.” “Yes, they do,” she said. “I checked.” It was time for me to start paying attention.

In a short time, I came to understand something important: All of my perceptions about childbirth were rooted in a commonly held belief that we could not know until after the birth whether
the hospital emergency services we wanted to be close to would be required during the birth. This perception was the biggest obstacle I had to overcome in understanding and accepting out-of-hospital labor and delivery.

I learned that a normal pregnancy in a healthy woman is a reliable indicator of a birth that can be categorized as “a normal physiological event.” A midwife would not consent to deliver our baby outside a hospital unless she was satisfied that Windy was healthy and that her pregnancy was progressing normally. If Windy’s pregnancy exhibited any of the risk factors midwives screen for, she would give birth in a hospital. Those risk factors include heart disease, high blood pressure, polyhydramnios (too much amniotic fluid), prematurity (delivery before 37 weeks), postmaturity (delivery after 42 weeks), multiple births, baby not positioned to deliver head-first, and placenta problems such as previa (the placenta covers the cervix) or abruptio (part of the placenta separates from the uterus).

Statistically, both of the following are true: 1) If Windy’s pregnancy proceeded without complication, the chance that she or our baby would encounter a difficulty during birth that required hospital care was extremely low; and 2) The likelihood that the hospital setting and routine hospital procedures and interventions might result in a C-section was relatively high.

About the time we were ready to conceive and our fixer-upper was nearly fixed up, we attended preconception information sessions at a reputable birthing center in Bethesda, Maryland, 20 minutes from our home. When Windy became pregnant, we stayed with this midwife practice through the first 20 weeks of pregnancy. We drove there for Windy’s prenatal appointments and would often wander upstairs, wondering in which of the three home-like rooms our baby would be born. Everything seemed to be in place. I was happy and looking forward to meeting our first child. Meanwhile, Windy continued reading.

We were in the car. “We could have our baby at home.”

“Why?”

“It would be more comfortable.”

The homebirth thing still retained for me an association with the wacko fringe. Because birthing a child is an exceptional human experience—a rite of passage into parenthood—birthing a child at home is an exceptional departure from our societal norms. It’s not the same as declaring yourself a vegetarian or leaving the barbershop with a Mohawk. Windy was preparing to birth another human being—one incapable of defending its own interests—not only our child, but the grandchild, great-grandchild, and niece of others. Our home did not seem suited to having a baby. “Wait—I thought they don’t do homebirths.”

“They don’t. We’d have to switch to BirthCare in Alexandria.”

“Why? No, wait. We know all of these midwives, and you’re 20 weeks along. Why change now?”

Windy explained that it wasn’t just the physical comfort of our home she anticipated; it was that, combined with the psychological comfort of being at home and not commuting during labor. It was about how being comfortable contributes to a labor that progresses steadily and naturally.

Still, it seemed too radical a change to make halfway through this thing. “Our lives are going to be more complicated already, just having a kid. Have you thought through all of the . . . ” I didn’t continue.

She explained that the only practical difference between delivering in a birth center (detached from a hospital) and at home is the commute to and from the center, at a time she would least feel like getting into a car and driving someplace.

“What about the deep Jacuzzi tub you were looking forward to?”

“We can rent one for $200.”

Once we’d decided on a homebirth, we had entered the fringe group I had derided. According to the Centers for Disease Control, from 1989 through 1999, only about one in 200 babies was born outside a hospital with a midwife attending. Because this number combines birth-center and homebirths, the number
of babies born at home is likely much smaller.

While some family and close friends expressed concern and apprehension at our decision, the response of strangers or acquaintances was often neither concerned nor supportive, but some variation of “Oh my gosh, you/she must be brave; I/we could never do that.” This response was maddening because it negated the only important reason for our decision to have a homebirth: We had decided that it was the safest approach for Windy and the baby. Our decision had nothing to do with bravely forgoing anesthesia or making a political statement. But it seemed that any response I might make, however polite, appeared to be a critique of the other person’s choice of a hospital birth.

When it came time to sign up for a birthing class, we chose the Bradley Method on the strong recommendation of a trusted neighbor. The first Bradley class began with a graphic video of a natural childbirth. Neither of us had ever seen anything like it. Every subsequent class began this way, and what we’d first perceived as shocking and gory became interesting and clinical. By the fourth session we’d learned enough to watch for the fluid expelled from the baby’s mouth as it emerged, squeezed, from the birth canal. We noted that no woman delivering outside of a hospital chose to give birth lying on her back. By class twelve, the birthing videos were anticipated and . . . beautiful. At some point during this class, out-of-hospital labor and delivery became, for us, conventional wisdom—our new reality.

Reading the anxious look on my mom’s face, I recalled my own point of view four years earlier. I told her what I had learned about the risks of a hospital birth. I listed the all-too-common sequence of unnecessary medical interventions that lead to cesarean deliveries. I recalled statistics about the prevalence of homebirth in other developed countries. I spoke about the books Windy had read and the classes we had attended. I assured my mom that it wasn’t about being at home as much as it was about being away from the hospital. I emphasized the trust we had in Eileen, our midwife-to-be—a calm, capable woman who had successfully delivered hundreds of healthy babies.

Like me four years earlier, my mom had no reference for this kind of thinking. She had not read Ina May Gaskin or Henci Goer. She had not seen numerous films of women giving birth outside of hospitals, or the accompanying pre-labor, in-labor, and postpartum interviews. She hadn’t heard women relate firsthand how being on their backs, prohibited during labor from eating or drinking as they pleased, tethered to an IV, and subjected to incessant fetal monitoring, impeded their labor. She hadn’t yet seen enough to question the use of medieval-like stirrups.

While she accepted our conclusions, I knew that she could not help but retain some apprehension. At the same time, I found an unexpected value in our conversation. It was not unlike dating a woman for a while, then bringing her home to meet the parents. Invariably, no matter how much time I might have spent with this person alone and in the company of friends, on that evening I would see her in an entirely new context that was often illuminating. In the case of presenting our homebirth decision to my mom, I felt for the first time the gravity of the matter and, despite the confidence I felt in our reasoned decision, I worried at first that at some point Windy and I had become biased and were giving undue weight to evidence that supported an appeal-
ing aesthetic over the conventional wisdom and reality I had embraced all of my life. I didn’t come from a family of home-birthers. I considered this for weeks, but ultimately affirmed and reinforced my convictions. 

Months later, having labored all over the house, Windy delivered eight-pound, two-ounce Eleanor Lee in our bedroom. My mom was overjoyed and flew out to meet her granddaughter. She was relieved that everything had turned out OK despite our atypical choice. Our experience did not completely sell her on homebirthing, but it developed in her an awareness—and a degree of acceptance—she did not previously have.

Looking back, my transformation from homebirth skeptic to homebirth advocate seems unlikely. In most communities, we are taught from birth that babies are born in hospitals. And because nearly all American babies are born in hospitals, alternatives are marginalized.

Surprisingly, hospital-based obstetrics is a relatively recent concept, but one that has a stranglehold on our culture. Every pop-culture birthing reference I have ever been exposed to assumes—and celebrates—hospital births. Bill Cosby’s Dr. Huxtable never woke tired after spending the night delivering babies in people’s homes. The only TV show I can recall in which an out-of-hospital birth was successfully depicted is CHiPs, and then only because we knew the mother was in that car because she was en route to the hospital—or was it the episode in which labor came on suddenly, on the disco floor? Regardless, we knew that this character had not intended to give birth anywhere but in the hospital. Oh yeah—in *Little House on the Prairie*, Doc Baker delivered babies at home in Walnut Grove. But the inference was clear: That was how they did it back then, when they had only oil lamps and no cars. So prevalent is the culturally inculcated link between hospitals and childbirth that many healthy women with low-risk pregnancies are better suited to a hospital delivery because that is the only place they can feel comfortable.

Hospitals are essential places for addressing human physiological problems and damage. But this fact does not make the hospital environment ideal, preferable, or even adequate for a childbirth in which no physiological problems or damage are anticipated. An increased prevalence of out-of-hospital childbirth requires cultural awareness, acceptance, understanding—and, ultimately, cultural preference. Windy and I are fortunate to live in a neighborhood with a microculture that straddles the phases of acceptance and understanding, a neighborhood that has prompted us to learn more. There are surely other communities like ours across the country.

Windy homebirthed another member into our community this past spring. This time, undaunted by first-time trepidation, I took it all in much more carefully. Frances Ann’s arrival was not radical or brave, and should not be so rare. On the night of her birthday, for the second time, I watched the miracle of human birth unfold unhindered.

*Michael Robertson is a husband to one woman and father to two girls. At home in Washington, DC, he works on the house, writes, and dreams of sailing.*
My first mistake had been to confuse the words natural and easy. Sitting smugly in prenatal classes as the teacher described the unspeakable things done to pregnant women for the sake of a rapid labor and an empty bed, the choice of a drug-free homebirth had seemed the simple (and only) one to make.

Strangely, it was only with the long-anticipated arrival of the birth pool that I realized that I had, in fact, mistakenly based my whole idea of birth on third-rate hospital dramas featuring Dick Van Dyke. This mess of unassembled plumbing was to be the vessel into which new life was to be delivered—the replacement, however brief, for the miracle of the womb. I looked at it, and the instruction book looked back mockingly. “Man build pool” flashed across ancient ape neural pathways, and my hand groped for the nearest wrench.

Hours later, it was time to turn it on. My wife, Linda, looked on expectantly. The pool shuddered into life like some great relic of Victorian plumbing. It was a little unnerving. Even more unnerving was the jet of water the pool was now happily discharging between the floorboards. Rapidly turning the thing off again, I felt like a failure. The one thing I, a man, could help with practically had already gone wrong.

The pool shuddered into life like some great relic of Victorian plumbing. It was a little unnerving. Even more unnerving was the jet of water the pool was now happily discharging between the floorboards. Rapidly turning the thing off again, I felt like a failure. The one thing I, a man, could help with practically had already gone wrong.

Throughout the pregnancy, I had been unsure of my role. Males seem to inhabit a strange sort of netherworld, destined to roam the fringes of sacred femaleness, forever trying to catch up with knowledge that women seem to have been born with. The support networks that erupt beneath the feet of the expectant mum seem to collapse into crumbling ravines for the expectant dad. Perhaps, lacking any alteration in our physical appearance, we are thought to remain unchanged.

As the due date drew nearer, I sat night after night, the now-working pool bubbling away in the corner, and felt increasingly nervous. What would the birth be like? Would I cope? Would I do the right things? Was too much trust being placed in me? Support and love I can give, but what if . . . ? What if I crumbled at the sight of Linda in pain? At the sight of bodily fluids? What if my clumsy maleness imposed itself on a fragile serenity by loudly demanding some attention? What if the combined weight of five people and a ton of water sent us crashing through the floor of our third-floor flat? What if the police are summoned following reports of screaming?

As so often happens, these concerns amounted to nothing. When Linda’s contractions began at 3 a.m., it was as undramatic as it was special. Making tea, giving Linda a massage, informing relatives, the morning passed in a breeze. As her contractions drew closer together in the afternoon, so did we—in an intimate intensity that was both marvelous and draining.

Rain lashed at the window glass where the pool sat, and outside, the wind rocked trees to their roots—perfectly offsetting Linda, who looked to be deep in the throes of some sort of spiritual ecstasy (or should that be Ecstasy?). I’ve never seen anything look more right, and felt humble and privileged to be a part of it. Staring into her occasionally wild and unseeing eyes, I finally grasped my purpose: It was simply to be. To try to be most fully the thing that (I hope) Linda loves about me. The present was all that mattered.

Justin Schamotta is based in Brighton, UK. He was editor of Bulb magazine. Now he’s a slightly bewildered freelance writer.
homebirth in holland

Dutch midwives teach an American just how safe birth can be.

by Maura Kikstra, as told to Sandra Gaffigan

“You know, they're medieval here,” a Swedish friend told me. We were both from other countries, had Dutch husbands, and were pregnant in Holland. My friend ended up scheduling a cesarean section in a hospital, something that is increasingly available here. I chose the traditional Dutch model of homebirth under the care of midwives.
A year before, I and my husband, Dirk, had moved to Utrecht, an ancient university town near Amsterdam. Our daughter, Chloe, who was three when we moved, had been born in a New York City birthing center. But the system in the Netherlands, I found, goes a step further. Under the care of Dutch midwives, I birthed my son in my own bed.

Before Chloe’s birth, I read Ina May Gaskin’s *Spiritual Midwifery* and was hooked. I’ve always been interested in natural living, alternative medicine, and yoga, and am not wedded to the American system of medical care. I don’t even mind that some people call me “hippy-dippy.”

But that first time around, I was so busy learning that I didn’t make time to enjoy the process of pregnancy and birth.

This time I did. I found the Dutch singularly supportive of new families. They allot a week of state-funded home care for mother and child. The Dutch call the first week following birth *kraamzorg*, and the woman who cares for the mother during that week the *kraamvrouw*. My kraamzorg turned out to be the most perfect week of my life. Much of my enjoyment was made possible by the way the midwives of Utrecht delivered their care.

At first I was nervous—the year before, in the US, I had miscarried. But over the months of my pregnancy, the *vruchtvrouwen* (midwives) of Holland taught me to trust myself, and convinced me that it was I who needed to take responsibility for the birth of my son.

**MY FIRST INKLING THAT I WAS NOT IN AMERICA**

When I was about two weeks pregnant, I made an appointment with a Dutch general practitician to confirm that I was pregnant. He took my word for it, recorded my name and address, and recommended a midwifery practice in my postal code. I never needed to visit him again.

I selected the Vroedvrouwenpraktijk Breedstraat practice, a short bike ride from our home in St. Martin’s Hof, a square of 18th-century townhouses surrounding a gated courtyard in the Binnestad district. During the interview, the Breedstraat midwives, too, took me at my word when I said I was pregnant. I was never given an internal examination. All they did was take careful notes—there was no examination at all. My American eyes
wanted the reassurance of technology, but they didn’t even weigh me. Without tests, how was I to know that everything was all right?

In New York, I’d had regular internal exams. But the Breedstraat vruchtvrouwen seemed to be doing nothing. They were so unmedical—no white coats, no important-looking machines. When I asked about a scale, they had to search the office for one. They would weigh me if I insisted, they said, but in their opinion it wasn’t necessary. The same was true for measuring my belly, which they didn’t do. “It doesn’t change the outcome,” they said. “We can see that your belly is growing.”

In New York, I’d always had to pee on a stick when I came in for an examination. “Why no urine test?” I asked Hedwig Pesgens, the midwife who would eventually help me deliver.

“A rise in your blood pressure will alert us to check your urine for protein. Your blood pressure is normal. We don’t do tests that are not necessary.”

Then it hit me: Oh. Pregnancy is a natural condition.

During a later visit, a midwife said to me, “We don’t open doors that don’t need to be opened.” Those words helped me to understand the Dutch attitude toward kraam (childbirth): If my pregnancy showed any abnormal signs, they would refer me to an obstetrician for pathological care. As long as everything was going along normally, they would help me, but this was my job: it was I who would be giving birth. I felt liberated. And scared.

In Holland, office visits are less frequent than in the US. I was shocked that the midwives didn’t want to see me again until I was eight or nine weeks pregnant. After that, I would see them every five weeks until I was 20 weeks along. The visits were then scheduled gradually closer together until week 37, after which I was to come in once a week. The standard procedure during these ten-minute visits was a blood-pressure check, a Doppler check of the baby’s heartbeat, and questions about how I was feeling.

My recent miscarriage drove me to ask for a sonogram (called an echo in Holland) early in my pregnancy, and my desperate need to know that this new baby was alive convinced the midwives to write a letter of request. Letter in hand, I arrived at the hospital for my test, expecting to be reassured by hearing my baby’s heartbeat. When I heard nothing, I panicked. The technician, a kindly older woman, pointed to the baby’s heartbeat on the monitor and cautioned that the noise of the echo itself was not good for the baby. Her thoughtful explanation set my mind at ease.

During a visit to Breedstraat in my seventh month, I remarked that I was experiencing frequent Braxton Hicks, the pre-labor “practice” contractions. Immediately, the midwives gave me an order for a urine test, and I better understood the importance of communication. Braxton Hicks contractions can be caused by a urinary-tract infection, and they needed to rule that out. My Braxton Hicks were perfectly normal; by paying attention, I found that taking the two flights of stairs to our apartment more slowly helped them subside.

Like the rest of the Netherlands, Utrecht is a bicycling city, and the midwives encouraged me to bike as long as I could. With Chloe in the ride-on seat, I rode the cobblestone streets.

I would drop her off at De Twijn School at Pieterskerk Hof, then cross the Oude Gracht (a canal) to shop for groceries at Hoog Catharijne. This was our weekday routine until the day before Luke’s birth, and it turned out to be the best way to keep me fit and to naturally open my cervix.

Several weeks before the expected date of our son’s kraam-tijd (time of birth), a Breedstraat kraam packet of all the necessary birthing supplies arrived at our door: bed pads, maxi pads, first-aid kit, alcohol, cotton—even a rag monkey for the baby. We had to pick up the blocks that were to go under the bed. The blocks address an occupational issue: The Dutch look out for the midwives’ backs, so the bed must be in a position higher than normal. This ended up being a little added adventure; from the time we placed the bricks above: The author’s daughter, Chloe, gives her new baby brother a protective hug.
under the bed until the birth, we felt as if we were taking a nightly voyage high on the North Sea.

THE BIRTH

By April 15, the bed had been up on blocks for five days. I took a 90-minute bike ride to Ikea. When I returned, I had increased vaginal mucus, but it was clear. We ate dinner and put Chloe to bed. As we watched TV, I remarked to Dirk, “It’ll probably be another two weeks.”

Around one o’clock the next morning, Chloe came into our bed. At about 4:30 a.m. I felt a punch in my vagina that woke me up. I went to the bathroom and found that my panties were wet and tinged slightly pink. I remembered what a friend had told me: “If it smells neutral or sweet, it’s fine.” It had no smell. I told Dirk, who said, half asleep, “Two days, go back to sleep.” I ran down two flights of stairs to the living room and fluffed the pillows on the couch. I have no idea why. Then I decided it would be wise to sleep as much as possible. I got back into bed, Chloe spooned behind me.

Around 5:30 a.m. I started having contractions and began to make low moaning sounds, remembering what Ina May Gaskin had said about keeping the jaw relaxed and the mouth open. I got up twice to use the bathroom and felt lots of pressure on my rectum. Chloe awoke. “Mommy, why are you making those noises?” I didn’t answer. Dirk asked me to get up, then remade the bed with the plastic sheets from the kraam packet. I lay back down on my side, feeling the heavy contractions coming constantly, with almost no breaks between them.

At 6 a.m., every bell tower in Utrecht began to ring in Easter Sunday. Their pealing made me moan even louder, deep and low. Chloe asked to leave—she preferred a neighbor’s quiet home to her moaning mother. Dirk and I wondered about calling a midwife on Easter morning, but decided we had no choice. Hedwig Pesgens answered and, from my noises in the background, immediately knew that the baby was on his way.

Hedwig picked up Herma Ebbers, a midwife-in-training, and they arrived at 7:16 a.m. Dirk ran down the two flights of stairs to answer the door. I was alone in the third-floor bedroom when I felt my son’s head come out of me—the most intense feeling ever, and beautiful. Mothers speak the truth when they say that, during childbirth, life passes through you. I felt like a hollow vessel, my son barreling through me on his way into the world. Because it all happened so quickly, my mind couldn’t catch up with my body. I thought, “Yes, that’s Luke coming out. But if it’s not him, I am splitting in two.” You could say that Luke birthed himself, and that I just opened up for him. We were such a team.

Hedwig and Herma scrambled up the narrow staircase to the third floor, to be met by Luke’s head. Both midwives were the essence of calm. Herma put on her gloves and said, “Don’t push. Turn on your back and grab hold of your knees.” I focused and did as I was told. Then she said, “When you feel the urge to push, do so.” My urge was to yell, “Come to Mommy, Luke!” With the next push, my ten-pound, six-ounce boy was born in all his perfection. It was 7:21 a.m.

Hedwig immediately placed Luke on my chest. We lay there skin to skin, my warmth mingling with his. Oxytocin flooded my brain and I fell in love. I couldn’t imagine my boy being taken away to be kept warm under a heat lamp.
The placenta was still inside me; I began to nurse Luke, which helped stimulate its birth. The after-contractions were intense. Hedwig said that this is normal when a birth happens so quickly. She joked that it was actually Luke’s twin, and for a second I believed her. She gave me a glass of water with a straw. “With each contraction, take a sip and the pain will diminish.” To this day, I don’t know if she gave me magic water or a magic straw. We couldn’t just throw the placenta away—it had been Luke’s first home. We kept it to bury later.

Hedwig and Herma cleaned me up with care. I felt complete love for Luke and Dirk and Hedwig and Herma. I wanted Chloe to join us, and Dirk went to get her. The four of us then lay together in our bed—a complete family. It was that simple.

Hedwig and Herma’s quiet observation of everything helped me to trust myself. Even Hedwig’s little trick with the water worked wonderfully. She read my body perfectly. I thanked Hedwig, and she thanked me for the pleasure of Luke’s birth. She and Herma taught me that silence and observation are the keys to successful birthing. If only I could carry those qualities into the rest of motherhood.

I’ll never forget the pealing of the bells from every church tower on that Easter morning. I was sure they were loud enough to drown out my moans as I pushed Luke into the world, but our neighbors in St. Martin’s Hof later told me that the bells hadn’t quite done the job.

Yes, they are medieval here. Like the bell towers of Utrecht, the midwife tradition in Holland is ancient and unbroken. On that Easter morning I joined the multitude of mothers who have given birth down through the centuries, listening to the same bells that welcomed Luke. They, like me, had caring and competent midwives.

Maura Kikstra is a full-time mom to Chloe and Luke. Sandra Gaffigan birthed Maura in a Washington, DC, hospital in 1971, and wishes that experience had been more like Luke’s birth. Sandra, a freelance writer, lives with her husband, James, in Columbia, Maryland. She keeps in touch with her faraway daughters—Maura of Utrecht, Holland, and Alison of Santa Rosa, California—by writing about her grandchildren, Bronte, Nolan, Phoebe, Chloe, and Luke.
Michele Zorn’s labor began at 3 a.m., and she was too excited to sleep. She felt confident in her ability to have a homebirth without too much preparation. “Birth is natural,” she reassured herself. Watching the clock, she timed her contractions, eager to meet her first child.

But 24 hours later, still in labor, Michele began to panic. She decided to transfer to a Seattle hospital for relief, where a cascade of interventions awaited her: fetal monitoring, a continuous drip of Pitocin, and epidural anesthesia. After another 14 hours, she finally gave birth to her first son, Ari. “I realized that birth is natural, but it’s not easy,” Michele says today. “I was shocked.”

She’s not alone in that discovery. Twice-homebirthing mom Tera Schrieber says birth can be difficult because, “In our culture, most women who are giving birth for the first time have never attended a birth and have no idea what to expect.”

— TERA SCHRIEBER

A large 2005 British Medical Journal study found that first-time homebirthers transferred to hospitals four times more often than second-time homebirthers; in both groups, women were transferred primarily for such nonurgent reasons as exhaustion or “failure to progress.” Once they’ve arrived at the hospital, laboring women may desire or require the interventions they’d previously hoped to avoid. And in states where homebirth midwives cannot legally practice, hospital transfers can be complicated, requiring the laboring woman and/or her care providers to skirt anti-homebirth laws.

No magic potion exists for ensuring an intervention-free, healthy homebirth, and each labor is as unique as the woman bearing the baby. But the personal experiences of homebirthers and care providers I spoke with can provide insight into successful homebirths. So think of the following suggestions as a buffet: Choose those dishes that meet your own hunger for connection, knowledge, and preparation. Check with your care provider regarding medical issues and concerns. And remember: This list should not substitute for expert medical advice.

Keep your birth at home

The right midwife, drug-free pain relief, and eight other things that will help you stay out of the hospital
1. Hire the right midwife.
To ensure the right match, interview at least three midwives. Midwives vary in the way they deal with overdue dates, length of laboring time, and emergencies that might occur during birth. Compare different midwives’ reasons for a hospital transfer, and ask what your options would be if a transfer were suggested. “Don’t feel bad about shopping around,” says Tammi McKinley, CPM, a homebirth midwife in northern Virginia.

Lisa Kaufman, of Seattle, Washington, had two births at home and appreciated her well-recommended midwife. “Our midwife and doula were very nonintrusive, and we trusted our team enormously,” she says. “But we were really looking for a personality fit.”

When interviewing a midwife to find out if she or he supports your approach to homebirth, pay attention to your gut feelings as well as to your logical side. “Ask yourself, ‘Is she someone I can work well with?’” suggests McKinley.

2. Hire a doula or other support person.
Studies show that doula support can decrease a pregnant woman’s labor time, need for pain relief, and likelihood of having a cesarean section. Leah Adams, of Seattle, wanted a homebirth after C-section (HBAC), and felt that her doula gave her mental and physical support. “I would encourage every woman to have a doula,” Adams says, adding that hers provided essential support before the midwife arrived. Adams gave birth to her 10-pound, 10-ounce son at home after a five-hour labor.

As with midwives, interview a variety of doulas—some offer massage, acupuncture, aromatherapy, or other specialized services. For her first homebirth, Lisa Kaufman hired a doula who photographed and kept a journal of Kaufman’s birth story. For her second birth, her doula doubled as a massage therapist.

If necessary, friends and family can substitute for a doula. Regina Iaccarino, of Long Island,
New York, says that her “secret weapon” in the homebirth of her third child was her best friend, “who knows what I am going to say before I say it.” Penny Simkin, childbirth educator and author of *The Birth Partner* (Harvard Common Press; third edition, 2008), tells of one woman who had nine family members at her homebirth, all rocking and swaying peacefully with the rhythm of her labor. The woman later reminisced that “she never felt so loved,” says Simkin. “Everybody was truly there for her.”

3. Exorcise emotional ghosts.
According to caregivers, unresolved emotional problems can sometimes prevent women from fully letting go during labor. Midwife Tammi McKinley feels that her low rate of hospital transfer attests to the efficacy of her unconventional approach: She asks all of her clients to go through a hypnotherapy session that, she says, allows the women to deal with “issues like sexual abuse or feeling violated from a prior birth.”

Women can also find healing in birth circles, where they can share painful memories, or at local meetings of the International Cesarean Awareness Network (ICAN). Leah Adams ordered copies of her hospital records and showed them to fellow ICAN members: “Armed with the play-by-play of my labor, I understood how the whole thing played out and when the slippery slope began.”

Adams and Michele Zorn both used art therapy to heal, relying on exercises from *Birthing from Within* (Parterra Press, 1998), by midwife Pam England. Other options include speaking with clergy, a supportive partner, and/or friends.

“It’s a lot of work ahead of time, but when you . . . give birth, you’re good to go,” says McKinley. “Whatever is going on, it’s got to be dealt with prenatally.”

4. Create a supportive community.
In some parts of the country, talking about your upcoming homebirth invites dirty looks and rude comments that can deeply affect a pregnant woman’s attitude and emotional health. To find fellow homebirthers for support, “ask your midwife for previous clients to network with, or look on the *Mothering.com* boards,” advises midwife McKinley.

An encouraging partner is also a key to a happy homebirth—you’ll want him or her cheering for you on the big day. Being involved in midwife visits and doula decisions will help your partner feel more comfortable with homebirth.

Lisa Kaufman’s husband, who works at a Seattle emergency-care hospital, was at first unsure about the safety of homebirth. But after meeting and speaking with homebirthing families, midwives, and doulas, he’s now a “big advocate,” she says.

5. Prepare physically and mentally.
Read, stretch, breathe, and learn. “The more you understand about the process, what is normal, and what is cause for alarm,” counsels Leah Adams, “the better you are able to participate in the decision-making process and advocate for the birth you want.” For some women, this includes creating a birth plan detailing desired laboring positions, hospital-transfer protocols concerning common complications, and newborn care.

Read positive homebirth stories and watch
films to familiarize yourself with the diversity of births. “I took it upon myself to read as much as I could about successful deliveries,” Adams says. “I read hundreds of birth stories, trying to get a sense of all the variations in human experience and empower myself with the notion that this, too, could be my experience.”

To build your relaxation response, try classes in homebirth-friendly childbirth, prenatal yoga, meditation, or birthing courses based in hypnosis. “Through yoga I learned to release tension in my body, to breathe through contractions, and to focus my mind on the present moment,” recalls Kaufman; during her birth, “yoga allowed me to stay relaxed and calm during some very intense moments.”

Midwife Ronnie Falcão runs Midwife Archives, an online source of information about natural childbirth. “Women really need to practice getting into a relaxed state during times of stress,” she says. “Reading about it or taking a course isn’t enough. They need to practice every day.”

6. Create your birthing space.

Gather nourishing foods and beverages and homebirth supplies (see the great list at www.mothering.com/community_tools/toolbox/pregnancy_birth/labor-supplies.html). Then put someone else in charge of knowing where to find these items during the birth—you don’t want to succumb to Hostess Syndrome during labor, and feel as if you’re throwing a party instead of giving birth.

“I suggest lining up your ducks ahead of time,” says Penny Simkin, who observes that a woman in the midst of childbirth can’t be responsible for telling people that the towels are in the hall closet. Instead, ask a friend or relative to help. “But you really have to let the hostess be in charge,” Simkin notes.

Avoid uninvited or unwanted guests in your homebirth space. “When you’re considering various people—doula, sister, friend—get selfish,” says Simkin. “Ask yourself, ’How can this person help me? What qualities that I want can she or he bring to birth?’”

Amber Berman-Ortiz, of Seattle, admits that it was difficult for her to exclude family and friends from her homebirth—until the progress of her birth began to stall. “We [didn’t] want to hurt anyone’s feelings,” she says, “but after I cleared the house, I was able to get down to business.” She successfully birthed her second son at home.

7. Optimally position the fetus.

“All babies would like to be in the proper place, but our current lifestyles make this hard,” observes New Zealand–based midwife Jean Sutton, who, with Pauline Scott, cowrote Understanding and Teaching Optimal Foetal Positioning (Birth Concepts, 1996). Fetal positioning can have a dramatic effect on labor length and ease, according to many midwives, doulas, and homebirthing women.

Gail Tully is a Minneapolis-based midwife, doula educator, and author of the Spinning Babies website, which approaches fetal positioning by focusing on the mother first. Attaining a symmetry of the uterus and surrounding anatomy will allow the fetus to settle into a position for birth that will reduce (but not eliminate) the chance of

Studies show that doula support can decrease a pregnant woman’s labor time, need for pain relief, and likelihood of having a cesarean section.

“Women really need to practice getting into a relaxed state during times of stress. Reading about it or taking a course isn’t enough. They need to practice every day.”

— RONNIE FALCÃO
back labor or labor lasting beyond 24 hours. “The mother’s job is to dilate, the baby’s job is to rotate,” Tully says. “When the baby is in an ideal position for labor”—that is, when the baby tucks the chin in flexion—“rotation has a better chance of proceeding smoothly.”

Spinning Babies emphasizes three principles that pregnant women can apply to daily life as well as to labor: relaxation, gravity, and movement. Jean Sutton’s mantra is “tummy down, knees down, and baby will do his part.”

During her second and third trimesters, Leah Adams avoided sitting on chairs and sofas. Instead, she leaned on her birthing ball to watch television or read, and complemented this with yoga, which can also have a beneficial influence on fetal positioning.

8. Plan for the long haul.
On average, first-time mothers have longer labors, but moms giving birth for the second or even the third time (or more) can be surprised. “Everyone wants the short birth,” says Seattle mom Marisa Corless, whose third child was born after 17 hours of labor. “What you need is patience, and realizing that that birth curve is silly, because every single birth is going to be different.”

Gloria Lemay, a birth attendant and lecturer based in Vancouver, British Columbia, says that factors that contribute to slow labor include “drama” from calling family members, entering a birthing tub too early, too many pelvic exams, and unsupportive comments. Other interviewees mentioned cervical scarring, the baby’s position before descent and in the birth canal, and a short umbilical cord as additional factors that can prolong labor.

But sometimes, a birth simply takes an indirect route. “Some babies need time to mold their little heads, get turned the ideal way, and make their journey into the world,” Lemay reflects.

Ask any midwife you’re considering hiring how she or he works with labors that exceed 24 hours. As long as the baby stays strong, it’s helpful for everyone at the birth—mother, midwife, birth support—to relax into the rhythm of that birth, and deal with possible problems only if or as they arise.

Every woman’s response to childbirth-related fatigue and pain is unique. While you’re pregnant, explore relief strategies that can be applied during labor, and keep an open mind.

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.

Here are a few more common comfort strategies:
- Acupressure or Acupuncture: “One thing that helped me relax was acupressure on my feet. My mom did that—my acupuncturist showed her how to do it,” says Amanda Quaid, a Seattle mom.
- Aromatherapy: Essential oils are popular with many women, Penny Simkin observes.

Above (left to right): Two-year-old Adelaide watches her mom catch her brother and pull him up out of the water, and then she helps cut the cord! Grover gets a peek at mom feeding Finnegan.

Tip: Read positive homebirth stories and watch films to familiarize yourself with the diversity of births.
But it’s not just the aroma of essential oils that women find comforting—one woman wore her husband’s T-shirt.

• Focus on the breath, or relax areas of the body: “You cannot be tense if your toes and mouth are relaxed,” says Marisa Corless.

• Herbs and Homeopathy: Consult with a midwife, naturopath, or homeopath to find herbal or homeopathic remedies for relief of pain and/or stress.

• Meditation, Prayer, Visualization: Seattle mom Sarah O’Brien was able to “visualize my baby’s descent through my birth canal. I think this helped me focus on the task of giving birth.”

• Movement, Music, Rhythm: Soothing tunes and moving the body are great tools. “I had a long pushing phase for my first birth, and changing positions and rooms was helpful,” Lisa Kaufman says.

• Vocalizing: During contractions, Tera Schreiber focused on keeping her jaw loose and her noises low: “I would shake my head and loosen my jaw—I imagine, something like a horse—and I could actually feel my body relax.”

• Combine approaches: Some midwives suggest using controlled breathing and meditation together.

10. Surrender to birth—and don’t forget distraction, rest, and food.

For her second birth, Maureen Carr didn’t try to control the process. “With those first contractions, I was stepping onto a roller coaster that I’d never ridden before,” she says. “I knew that I wasn’t in charge, so I’d best just sit back and let the ride happen.”

Penny Simkin contends that distraction is key in labor’s early stages. Some successful homebirthers are very productive laborers: Marisa Corless baked zucchini bread and went for a walk, Lisa Kaufman whipped up a birthday cake to welcome her new baby—and Julia Kaplan, of New York, went shopping for groceries. “During my contraction, I’d bend over and look at that can of peas very closely, like I’d forgotten my glasses,” Kaplan says. This provided her with a little levity: “It helped to not take each contraction so seriously, which can be

BE SURE TO ASK

Ask your care provider what her hospital-transfer protocols are (e.g., when does she transfer, under what conditions, and how long does transfer take?) for the following common situations:

• Labor lasting more than 24–48 hours
• Broken amniotic sac, more than 24 hours
• Fetal distress
• High blood pressure
• Meconium-stained fluid
• Surprise breech
• Retained placenta
• Hemorrhage
• Baby’s breathing problems

—LORA SHINN
mentally exhausting.” Nine hours later, her son was born at home (not in the canned-foods aisle).

Other women took a different approach, preferring solitude, quiet, and darkness during their labor. “I needed a sensory-deprivation tank for my birth experience—lights low and noise off,” says Schrieber. “I closed my eyes tight and wanted to be by myself.”

Although it sounds counterintuitive, rest was mentioned as one of the most important components of labor. Birth attendant Gloria Lemay warns that “the most common reason for [hospital] transfer is that the mother exhausts herself in the pre-birth.” Penny Simkin agrees: “When the mind is thoroughly exhausted, it’s not doing the body any favors, and vice versa.” Many moms nap through nighttime labor, conserving their energies for the next day’s work.

And don’t neglect nourishment: “When labor is longer, the mother nurtures her uterus by eating small and frequent meals, such as oatmeal with honey. Not eating enough will lower the blood sugar, increasing the likelihood of nausea, which makes it hard to eat without vomiting. Without food over time, contractions can lose their ability to progress labor,” states Gail Tully. So eat and drink during those early contractions, and again during pushing, if pushing takes a while.

Electrolyte drinks and protein shakes were often mentioned as fluid-based sources of energy.

**The best is yet to come**

Despite all the best intentions and preparations, some births include transfer to a hospital—for the sake of the life of the mother, the baby, or both. If this happens, it’s important not to feel...
guilty, or that you’ve somehow failed. “A lot of trauma can come from transfer,” Michele Zorn says; “try to find a way to make it OK.”

Create a plan with your care provider, designating the conditions for transfer, a preferred transfer hospital, and your desires if a hospital or interventions should become necessary. In other words, expect to meet your baby at home, but prepare a backup plan for a possible 3 a.m. trip to the maternity ward.

Michele’s second birth turned out quite differently from her first. She began labor in a dark, silent house, and when her eyes drooped, she slept. She turned to an experienced midwife and to her husband for support, and didn’t time her contractions or watch a clock. Her son slept in his bed, and a blanket of calm fell over the house. She ate a peach, and relaxed between contractions in a water tub. Six hours later, Michele welcomed her 6-pound, 2-ounce daughter, born at home. And in 2007 she earned her certification as a doula, to help other mothers successfully birth at home.

FOR MORE INFORMATION

Book

Articles Online


NOTE

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.


FOR MORE INFORMATION

Book

Articles Online


NOTE

FOR MORE INFORMATION

Book

Articles Online


NOTE

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.


NOTE

FOR MORE INFORMATION

Book

Articles Online


NOTE

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.


NOTE

FOR MORE INFORMATION

Book

Articles Online

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.


NOTE

FOR MORE INFORMATION

Book

Articles Online


NOTE

Water was the most popular pain relief and relaxation method mentioned by homebirthers. Midwife Tammi McKinley confirms that most women who try a waterbirth insist on using the technique for all their future pregnancies.


NOTE
For additional Mothering toolkits—as well as a wide variety of books and reprints, visit www.mothering.com/shop.