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Features

Rethinking Swaddling
By Nancy Mohrbacher .............................................................. 7

Help for Pubic Symphysis Pain During Pregnancy
By Heather Jeffcoat .................................................................... 13

The Birth of Sarah Grace
By Ashley Benz ........................................................................ 15

Columns

The Editor’s Perspective – Turning Over a New Leaf – By Robin Elise Weiss ......................... 4

Across the President’s Desk – Exciting News – By Jeanette Schwartz ........................................ 5

Executive Director’s Letter – A Busy Board – By David Feild ....................................................... 6

Growing Your Business – Starting Your Own Website – By Robin Elise Weiss ......................... 13

The Way I Teach – Teaching What is Possible vs. What is Probable – By Kim James .................. 16

Reviewed by Stacie Walker ...................................................................... 19

Announcements

Journal Submissions ........................................................................ 5

New Advertising Opportunity for ICEA Members! .............................................................. 17

Follow ICEA Online ........................................................................ 19

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Turning Over a New Leaf

It’s autumn and while we still have very hot days, I love watching the tree across from my desk as the leaves begin to change. It’s a relatively gradual process that starts slowly and picks up pace, until one day there are beautifully colored leaves! Just as the autumn brings changes, ICEA is turning over a new leaf. Hopefully, you’re enjoying the new ICEA logo and all it represents, as well as the newly tweaked mission statement.

This month’s International Journal of Childbirth Education brings you lots of exciting news and articles. Nancy Mohrbacher talks to us about how swaddling might not be the best practice. Kim James explores thoughts on teaching probabilities versus possibilities. And in discussing pregnancy discomforts, Heather Jeffcoat provides some help with pubic symphysis pain. All this and more awaits you in the upcoming pages.

I look forward to hearing lots of discussion about the Future of Birth Conference. Don’t forget to consider sending in your submissions. We have a team of editors willing to work with you to help you get published. Send your thoughts and ideas to editor@icea.org — Robin Elise Weiss, IJCE Editor

Brief Writer’s Guidelines for the ICEA Journal

Submitted articles should express an opinion, share a teaching technique or research, or describe an experience. References are usually not required because the writing is solely from the author’s opinions or experience. (Electronic submissions preferred. Minimum 500 words.)

Accompanying photographs of the people and activities involved will be published only with accompanying Photo Permission Form.

The title page should include:

• Title and author’s name
• Academic and professional degrees, institutional affiliations, and status
• Mailing address, phone and fax numbers, and e-mail address

Writers are asked to include a photograph, a two- to three-sentence biography, and a 50-100 word abstract of the article. If bibliography is attached, please use Chicago Manual of Style.
Exciting News

By Jeanette Schwartz, ICEA President

This month, ICEA is partnering with Lamaze to celebrate both organizations’ 50th birthday at the Mega Conference in Milwaukee, Wisconsin. Together we will honor the past 50 years of training/continuing education programs, quality educational resources and professional certification programs. This legacy sets the direction for our next 50 years.

Setting the stage for the future, the ICEA Board of Directors reexamined an issue regarding our mission statement that was presented to the membership in December, 2006. Jane Hanrahan, ICEA President at the time, wrote: “Our mission statement is as follows: The International Childbirth Education Association (ICEA) as a professional organization supports educators and other health care providers who believe in freedom of choice based on knowledge of alternatives in family-centered maternity and newborn care. Some members thought that this statement implied that we were pro-choice towards the issue of reproductive rights. That ICEA, in its mission statement, supports abortion. ICEA, as an organization, is neutral on the issue of abortion.”

This issue continues today, as we continue to receive feedback regarding our mission statement. With this in mind, the motion was made and approved to change the mission statement to read “… freedom to make decisions based on knowledge of alternatives …”

It is the Board’s intent to dispel any concerns regarding our mission as an organization. The second change I want to share with you is our logo. Members have raised concerns that our logo was “outdated,” reminded them of the singer “Prince,” and was offensive, in that the use of male and female sex symbols did not represent all types of families. The ICEA Board of Directors took this feedback very seriously, and after much careful consideration, accepted a new logo. The artwork keeps some of the old design, while incorporating new concepts of interconnected elements of family, mother, childbirth educator, doula, caregiver, etc., supported by the International Childbirth Education Association. I am excited to share it with you and look forward to your comments.

Journal Submissions

The International Journal of Childbirth Education welcomes your articles, research papers, essays, and photos for upcoming issues.

Deadlines
December 2010 ...................... November 1, 2010
March 2011 .............................. February 1, 2011
June 2011 ................................. May 1, 2011

The guidelines for submissions can be found at: http://icea.org/content/information-journal-writers

Please send all submissions electronically to info@icea.org.
A Busy Board

By David Feild, ICEA Executive Director

The Board of Directors for ICEA consists of four officers and six other members. The “others” are all chairs of the major ICEA committees: Convention, Education, Communications, International Relations, Lactation, and Public Policy/Marketing. The Board holds monthly conference calls for most of its business. They will meet face-to-face during the Mega Conference in Milwaukee.

There has been a significant level of activity at the Board level this year, and I would like to highlight some of the major new initiatives and actions:

Publications

The Board realized in 2009 that many of our educational pamphlets and other printed materials were aging. Some carried copyright dates in the 1990s and many (too many) were dated in the early 2000s. The Board established a revisions task force and recruited a large squad of members, with expertise in the whole spectrum of childbirth, to undertake revisions and updates. A large number of ICEA publications have now been reissued with 2009 and 2010 copyright dates. Although more work remains to be done, great progress has been made. The Board’s goal is keeping all ICEA publications within the JCAHO requirement that publications on hospital shelves be no more than five years old.

Committees

The Board reviewed ICEA’s major activity areas and decided to revamp the committee structure to take into account a shifting set of priorities. The International Relations, Public Policy/Marketing and Lactation Advisory Committees are newly-established, and the charges for Communications and Convention were revised. This realignment has helped better define the roles of the various Board members and has allowed greater focus on ICEA’s communications (the committee now oversees overall communications, the journal, the e-newsletter, the website and ICEA bloggers) and has given a focal point for lactation issues. For example, the ICEA was granted membership in the United States Breastfeeding Committee (USBC) as the first major initiative of the committee.

International

The International Relations Advisory Committee was set up to make ICEA’s international presence more than just a word in our name. The committee has already been able to become involved officially with educators and doulas in Guatemala, Costa Rica, India and Liberia. ICEA has appointed an International Development Director. An officer recently traveled to China to explore collaboration with a Chinese doula education group. Other outreach activities are planned. In addition, the committee is serving as a resource for individuals around the world (ICEA members and others) who have questions about childbirth research, practice, education and public policy issues.

New ICEA Guidebook

As an off-shoot of the publication revision process, the Board decided to work with Meadowbrook Press to produce a new book entitled *The ICEA Guide to Pregnancy and Birth*. This is intended as an inexpensive (less than $10) classroom book to supplement the work of our certified educators. We hope that the book may also find an audience with parents who don’t enroll in formal childbirth education classes. An expert author was hired to produce the first draft and Board members have been busily reviewing and editing. If all goes well, the book will debut in the first half of 2011.

Website

The ICEA website was completely redesigned two years ago. However, the ICEA Website Subcommittee (under the Communications Committee) is beginning an in-depth review of the current site and looking to make some improvements. The site is increasingly expected to serve a variety of users—members, non-members, expectant parents, internationals, etc.—and it was not designed to fill that expanded need. Look forward to some enhanced features that the Board will approve for addition to the website in the near future.

There are, of course, a host of other ongoing activities that the Board directs for ICEA, most in the educational area. However, I thought it was a good time to highlight a few new initiatives prior to the birthday/anniversary party in Milwaukee for the Mega Conference.
Rethinking Swaddling

By Nancy Mohrbacher, IBCLC, FILCA

Many of us think of swaddling as a useful way to calm and comfort small babies. For years, when I made home visits to new families as a lactation consultant in private practice, I used to teach mothers and other family members techniques for swaddling newborns as a way to keep their hands contained when they put them to the breast.

However, recently, I received an email from a parent educator whose friend had heard me speak at a recent breastfeeding conference. Her friend quoted me as saying that “swaddling is bad,” and as a Happiest Baby instructor, the educator was concerned. She said she believed that swaddling must be okay since it was “something other cultures have used for a long time.” She asked me to share with her the studies I cited in my talk.

I responded by clarifying that I had not actually said “swaddling is bad,” but that in recent years, my opinion on swaddling has changed. In my book, Breastfeeding Answers Made Simple: A Guide for Helping Mothers (2010), I note that, although swaddled babies appear calmer and sleep more, research has found that regular swaddling can contribute to negative breastfeeding outcomes. Routinely swaddling babies during the first few days of life is associated with a delay in the first breastfeeding, less effective suckling at the breast, decreased intake of mother’s milk and greater infant weight loss. Routine swaddling during the first few months of life is associated with a variety of other negative health outcomes. I emailed the educator some of the studies I described during my talk so that she could read them and come to her own conclusions.

When I read the studies cited at the end of this article for the first time, the question I asked myself was, “Are swaddled babies really happier, or does swaddling cause newborns to shut down?” There is no doubt that a calmer baby makes new parents’ lives easier and more pleasant, but I wondered from the baby’s perspective whether swaddling is a positive or a negative.

Swaddling and Early Breastfeeding

As the parent educator who wrote to me noted, swaddling—also known as bundling—has been practiced historically in many parts of the world. Research has found that swaddled babies arouse less and sleep longer (Franco et al., 2005). That may sound good, but in the early hours and days after birth this can lead to less breastfeeding, which has definite drawbacks (see below).

Although many studies have examined the effects of swaddling, in one review of the research, every randomized control trial compared swaddling with practices involving separation from mother, such as keeping babies in

continued on page 8
incubators or giving them a pacifier or massage (van Sleuwen, Engelberts et al. 2007). None of the studies compared swaddling with being held or carried by the mother.

Swaddling Delays the First Breastfeeding and Leads to Less Effective Suckling

In a U.S. study of 21 babies after a vaginal birth, researchers compared two groups (Moore & Anderson, 2007). Immediately after birth, one group was laid tummy down, skin-to-skin on the mother’s body, removed for a short examination, and then returned to the mother’s body where these babies remained in skin-to-skin contact for two hours. The other group was shown briefly to the mother after birth, examined, and swaddled with hands free and returned to the mother. The group that was swaddled during their first two hours showed delayed feeding behaviors, suckled less competently at their first breastfeeding, and established effective breastfeeding later.

Combining Swaddling with Other Newborn Stressors

When swaddling is added to other newborn stressors, there are more negative repercussions. One study of 176 mothers and babies done in Russia with a team of Swedish, Russian, and Canadian researchers was designed to measure the effects of postpartum practices and resulted in several published papers (Bystrova, Matthiesen, Widstrom et al., 2007; Bystrova, Matthiesen, Widstrom et al., 2007; Bystrova, Vo-rottsov et al., 2007; Bystrova, Matthiesen, Widstrom et al., 2007; Bystrova et al., 2003). These researchers compared outcomes in four groups of newborns, who were
1. kept in skin-to-skin contact with mother for 30 to 120 minutes after birth;
2. held in mother’s arms wearing clothes;
3. separated from mother at birth and returned to her after two hours;
4. taken to the hospital nursery at birth and returned to mother for breastfeeding seven times each day at regular intervals.

In each group, some babies were swaddled and some wore clothes. The researchers reported that skin-to-skin contact reduced “the stress of being born” and found the babies kept skin-to-skin after birth had the highest body temperatures (Bystrova et al., 2003).

Swaddled babies separated during their first two hours lost more weight. Among the babies taken to the nursery for the first two hours after birth and then returned to their mothers for the rest of the hospital stay (group 3 above), the swaddled babies had a significantly greater weight loss on their third and fifth days (Bystrova, Matthiesen, Widstrom et al., 2007). This significant difference in weight indicates that the first two hours after birth may be a “critical period” during which mother-baby separation can undermine infant stability and growth.

Swaddled babies kept in the nursery were colder and consumed less milk. Among the babies in the “nursery group” (group 4 above), some were swaddled and some were not. Those babies in the nursery group who were swaddled had the lowest foot temperature of any of the babies in any of the study groups. Overall, the babies in the nursery group consumed 37% less mother’s milk on their fourth day compared with the babies kept with their mothers. Newborns who were both separated and swaddled consumed less mother’s milk overall than those who were not swaddled. Their mothers also produced less milk on the fourth day and they had a shorter duration of breastfeeding overall (Bystrova, Matthiesen, Widstrom et al., 2007).

Swaddled babies in the nursery lost more weight despite consuming more formula. In addition to separation, supplementing with formula (another physiological stressor) was found to produce greater weight loss among the swaddled newborns. The only study babies to receive formula were some of those in the nursery group. The supplemented and unsupplemented babies in the nursery group consumed similar amounts of milk daily, but the
supplemented newborns who were also swaddled lost significantly more weight on their third and fifth days as compared with the newborns who were either not swaddled or not supplemented (Bystrova, Matthiesen, Widstrom et al., 2007). The researchers suggested possible reasons for this greater weight loss among the swaddled, separated, and supplemented babies:

- By severely limiting baby’s movements, swaddling causes stress, which contributed to the greater weight loss.
- Swaddled babies receive less touch, which was found to compromise growth in one study of preterm babies (Ferber et al., 2002).

This research indicates that swaddling may be physically stressful for babies.

Alternatives to Swaddling

After Birth

Common sense tells us that wrapping a baby in a blanket should help keep him warm. However, research has found mother-baby skin-to-skin contact to be far more effective at maintaining a newborn’s body temperature. If the room is cool or there are other reasons to be concerned about the baby’s temperature, a much better strategy than either swaddling or putting baby in an infant warmer is to keep baby on mother’s body, putting blankets (either warmed or unwarmed) over both mother and baby (Galligan, 2006; Ludington-Hoe, Ferreira, Swinth, & Ceccardi, 2003; WHO, 2003). If the mother is not willing or available, skin-to-skin contact with the father is an excellent second choice.

Mother-baby body contact is also important for other reasons. In addition to keeping baby warm, it also releases baby’s inborn feeding reflexes (Colson, Meek, & Hawdon, 2008), which leads to more breastfeeding. This has been found even among late preterm babies (Colson, DeRooy, & Hawdon, 2003).

Postpartum practices associated with more early breastfeeding should be encouraged, as more feedings in the first 24 hours of life have been associated with lower rates of exaggerated newborn jaundice on baby’s sixth day and less weight loss and greater milk intakes on the third and fifth days (Yamauchi & Yamanouchi, 1990).

Regular Swaddling During the Early Months

But what about swaddling after hospital discharge? Once a baby is breastfeeding well, is there any reason to avoid swaddling? Many who advise new parents promote swaddling as a way to soothe fussy babies. While swaddling may be helpful when used occasionally, research from around the world has found negative health outcomes associated with routine swaddling during the first months.

- **Greater risk of hip dysplasia.** When babies are swaddled tightly and their legs cannot bend and flex, this creates a greater risk of hip dysplasia, sometimes called “developmental dysplasia” (Sahin, Akturk et al. 2004; van Sleuwen, Engelberts et al. 2007).
- **Greater risk of SIDS in prone sleeping positions.** One Australian case-control study that compared 22 babies who died of sudden infant death syndrome (SIDS) to 213 babies who did not find that swaddled babies laid face down (prone) to sleep were at 12 times greater risk for SIDS than babies laid face up (supine), compared to a three times greater risk in babies laid face down who were not swaddled (Ponsonby, Dwyer, Gibbons, Cochrane, & Wang, 1993).
- **Greater risk of overheating.** If also in warm surroundings, swaddled babies are at risk of overheating, which in rare cases has been fatal (van Gestel, L’Hoir, ten Berge, Jansen, & Plotz, 2002).

Changing Perspectives

After looking into the research, my own opinion of swaddling has changed. Rather than assuming babies should be swaddled after birth to keep them warm, I understand that in most cases a mother’s body is her newborn’s best “baby warmer.” My opinion of swaddling during breastfeeding has also changed. Rather than recommending mothers turn their babies into “baby burritos” to prevent waving arms from making latch more difficult, now I

continued on page 10
understand the role of “arm cycling” and other inborn feeding reflexes in helping babies get to the breast and feed (Colson et al., 2008). Instead, I suggest mothers simply lean back into semi-reclined, “laid-back” feeding positions. With baby tummy down on mother’s body, gravity makes these same inborn reflexes work for rather than against breastfeeding.

Although swaddling may sometimes be helpful, in light of this research, it may be best to limit its use and suggest parents consider alternatives during fussy times, such as skin-to-skin contact and baby carriers.

References


Nancy began helping breastfeeding families as a volunteer in 1982, becoming board-certified in 1991. From 1993 to 2003 she founded and maintained a large private lactation practice in the Chicago area, where she worked with thousands of breastfeeding families. She still lives in Chicago, where she works as Lactation Consultant for Ameda Breastfeeding Products. In 2008 the International Lactation Consultant Association (ILCA) officially recognized Nancy’s contributions to the field of breastfeeding by awarding her the designation FILCA, Fellow of the International Lactation Consultant Association. Nancy was one of the first of 16 to be recognized for their lifetime achievements in breastfeeding.
Teaching What is Possible vs. What is Probable: A Mid-Career Educator Examines Her Childbirth Philosophy and Values and Challenges You To Do the Same

By Kim James, CD(DONA), CD(PALS), ICCE, LCCE, DONA-Approved Birth Doula Trainer

“Well that’s a nice idea, but I can’t imagine that working.” Three years ago, I remember saying these words to a class member, and while I can’t remember her question, I still remember my reaction of disbelief towards what she wanted to do; it just didn’t seem possible, given her choice of birth place and care provider! You see, I was having a mid-career “crisis of faith.” After teaching childbirth education for six years, I was increasingly coming face-to-face with the fact that what I considered possible in childbirth wasn’t likely to happen for most of my students. I had attended over 30 reunion classes by that point, and my class members weren’t returning with the glowing stories of empowered birth with low-intervention outcomes. One reunion class even had a 50% cesarean rate. I was feeling like a failure as an educator. What hurt wasn’t the actual birth outcomes—for the most part, mothers and babies were healthy and families were intact and functioning—instead, it was the emotional reactions of class members, the “I didn’t know THAT could happen” statements. I felt like my students hadn’t been properly prepared for the likelihood of their actual experiences. Few had envisioned the paths their labors took and the decisions that had to be made along the way. Where had I gone wrong?

In my disappointment, and perhaps disillusionment, at realizing that not all families will seek or make choices that lead to empowering, low-intervention outcomes, should I minimize disappointment and only present the options that are standard fare and easy to receive? What is a mid-career educator to do? How does one move forward with enthusiasm and zest without becoming cynical to the realities of the average labor and delivery experience?

Alexandra Smith, in Nolan and Foster’s 2005 Birth and Parenting Skills: New Directions in Antenatal Education, loosely describes three educator personality types:

Dorothy: Tells women what to expect. She believes her best role is to prepare families for what to expect so that there will be few surprises. Dorothy is concerned with telling women about the “reality of the situation.” She doesn’t want women to worry unnecessarily or be set up for disappointment. She provides carefully selected information aimed at allaying fears and encourages women to trust the experts who are caring for them. Dorothy believes giving women too many choices, especially when the likelihood of achieving those choices are low, will breed confusion, lack of confidence and plant the seeds for “a bad birth experience.” Dorothy feels safe from both criticism of hospital staff and care providers and class members’ admonitions of “you never told me...” Her teaching is safe, but not empowering for herself or her students.

Paula: Tells women what they should do. She is a promoter for her cause. Paula has strong views about which she is passionate. She wants women to know how it could be. The strength of her convictions are infectious, and she can be very inspiring to the women in her class to make changes. Even though Paula’s ideas are sound and research-based, because

continued on page 12
they aren’t always part of routine hospital protocols, she is sometimes stigmatized as a troublemaker or an extremist by some of her peers. Paula is empowering, but her class members aren’t always cognizant of the realities they’ll face.

Sarah: Tells women to trust their own judgments and to seek the information they need to do the best they can. She enables women to identify and meet their own particular needs. She is a facilitator, enabler, advocate and friend. She is an excellent listener and responds to the individual needs of her group. She believes in informed choice and understands that for learning to be important, it has to be matched to the needs of the learner. Sarah provides impartial, research-based information on a variety of childbirth methods and options, as well as a framework for her class members to evaluate and judge those options for themselves.

I aspired to be a Sarah, but as a mid-career educator who started out as a Paula, I could feel the pull towards becoming a Dorothy. As a dear mentor and one of my first CBE trainers, Barb Orcutt, RN, MN, IBCLC, recommended to all her CBE students, I decided to examine my own philosophy and values about birth, as well as the pros and cons of being a Paula, Dorothy and Sarah.

Over the next 18 months, after observing seven different educators in different teaching venues and attending two national childbirth educator conferences, I had new clarity regarding what I believed about childbirth education and adult learners: I am here to educate. The adults in my class have come not just to learn about childbirth in general, but also to do better for themselves. That clarification has made a profound difference in the language I choose and the way I ask my students to grapple with the content of our classes. It has also led me to the perfect combination: teaching what is possible with the likelihood of it being probable. Here’s how I do it:

I find out what the current needs of my class members are before the first class. I do that with a quick learner assessment through email before we meet for the first time. This allows me immediately to engage with class members at their level of readiness for learning and making choices. As class members grow their knowledge and curiosity, I expect learner needs to change. Midway through our series, I’ll ask learners again to assess what they need to know. I’m clear about my intention to educate on the range of choices, some of which they won’t have ever considered before, and some that may make them feel uncomfortable or may not be readily available at their place of birth without great self-advocacy. I quickly follow up with several stories from previous class members who were “squeaky wheels” and got what they wanted, or families who completely changed their plans as a result of finding a care provider or birth place that was a better fit. I tell my class members that hearing choices that sound good, and are readily backed up by good research, but still might not be completely welcomed by their chosen care providers may be troubling, but will create realistic expectations. What WILL boost our class members’ confidence is the exercise of choosing: either choosing to align their expectations to their care providers’ protocols, or deciding to be a squeaky wheel to get what they want, if their expectation and their care provider’s protocols are very different. Neither choice is right or wrong, but the conscious decision of seeking information and deciding how to use it can have a lifelong impact on women and their families’ self-confidence to face all sorts of parenting decisions.

There are a couple of key aspects to making this approach work:

- Give class members the responsibility of deciding for themselves what choices to make based on their own values and what works best for their families.
- Give class members ample opportunity, at least three separate occasions, to practice making informed choices in class. Use storytelling, role-play, and other learning techniques so that class members can practice saying the words they’ll use, as well as hearing the words their care providers will use.

Penny Simkin, PT, childbirth educator and doula, sagely discusses how long it sometimes takes for new knowledge to “trickle down” into usual practice and being sympathetic to hospitals and caregivers for whom even a tiny change means lots of red tape and changing many routines. A word of caution: if the dissonance between class members’ wishes and their birth place or care provider is too great, they may decide to change venues or care providers. Of course, if we take on the task of creating that dissonance, we are obligated to be prepared for offering referrals and a lot of patient, active listening as class members dissect and successfully make their changes.

And so, with renewed enthusiasm, I return to my classes inspired to be a “Sarah.” As you approach, or move beyond, your career mid-point, who will you aspire to be?
Help for
Pubic Symphysis Pain
During Pregnancy

By Heather Jeffcoat, DPT

Pubic symphysis pain, or anterior pelvic girdle pain, is one of a myriad of musculoskeletal pains that women may experience during pregnancy. This pain can be debilitating, requiring some women to use crutches or a rolling walker to alleviate the pain while allowing some mobility. Some studies report that up to 50% of pregnant women have some type of pelvic girdle pain prior to 20 weeks gestation. Additionally, this pain negatively affects perceived health and sexual life during pregnancy (Mogren, 2006). It is defined as mild to severe pain over the pubic symphysis, and can extend down into the groin and medial thighs (unilateral or bilateral). It generally presents clinically as pain with standing (especially on one leg), prolonged sitting, or with transitional movements such as going from a sitting to a standing position, rolling over in bed, or going up or down stairs. In some women, there may be a clicking in the joint present. Oftentimes, this pain is present along with other types of pain, most commonly with lower back or sacral pain. One study pointed to additional physical and psychosocial factors that may increase risk of this type of pain during pregnancy, such as increased weight and less job satisfaction (Albert et al, 2006). Risk factors that are associated with prolonged pelvic pain at six months’ time include increased BMI and pelvic joint hypermobility (Mogren 2006).

A study published earlier this year looked at pelvic girdle pain (including anterior) and disability reported in pregnant women in the first trimester and again at gestation week 30 (Robinson et al, 2010). Clinical examinations were also performed. The results showed that self-reported pain locations in the pelvis, a positive posterior provocations test and the sum of pain provocation tests present in early pregnancy are statistically significant with disability reports at 30 weeks gestation, but the number of pain sites is not. Another study looked at hormonal contraceptive use and the occurrence of all types of pregnancy-related pelvic girdle pain (Kumle et al, 2004). It found that the use of hormonal contraceptives was only significant with regards to pelvic girdle pain for the first pregnancy. The most significant determinant of pelvic girdle pain in subsequent pregnancies is the presence of pain in a previous pregnancy. Studies have looked at several factors to identify risk in developing various types of pelvic girdle pain, but there is no single factor that appears to play the biggest role. Once the pain occurs, there are some exercises your client can perform that may alleviate her symptoms.

Modifications in your client’s daily activities are an essential first step to

Exercises

**Abdominal Stabilization:** Instruct your client to gently pull her navel towards her baby.

**Kegels:** Instruct your client to contract her pelvic floor gently, like she is closing the openings.

**Gluteus Squeezes:** Instruct your client to gently squeeze the buttocks. This can be done while standing.

**Lat Pulls:** Instruct your client to grasp a door handle and gently pull it toward her.

**Adductor Squeezes:** Instruct your client to place a small, soft ball between her knees and squeeze gently.

*continued on page 14*
alleviate pain and pressure in the pubic symphysis. Instruct her to keep her legs together when she is rolling over in bed or getting out of the car, like she is wearing a tight mini-skirt. Also, it is generally more comfortable for her to get into bed “on all fours” and then lying on her side, rather than sitting in bed and lifting her legs up.

Additionally, there are some exercises your client can perform, which have been shown to reduce pubic symphysis pain (Depledge et al, 2005). [See sidebar on page 13.] All exercises should be held for five seconds, repeated five times, and performed three times per day and in a seated position.

The good news is that this type of pain usually resolves on its own after birth. However, if the pain worsens or these initial exercises do not work, there are additional exercises and treatments your client can learn or receive from an experienced Women’s Health physical therapist. To locate one in your area, go to www.womenshealthapta.org or call (800) 999-APTA extension 3229.

References


Heather Jeffcoat, DPT is a Doctor of Physical Therapy and owner of Consultation-based Women’s Health Physical Therapy & Fitness Practices in Los Angeles, CA; Ph: 310.871.9554; email: heather@thepilatespt.com
The Birth of
Sarah Grace

By Ashley Benz, CLC

On Monday, I had a biophysical profile, and the baby looked good. My doctor talked about inducing on Friday, which would have been 42 weeks. After the appointment, we went to my dad’s house for lunch. The contractions started right after I finished lunch, around 12:30. We left there and went to the grocery to pick out foods to eat in labor. The contractions continued irregularly through the night, but they kept me awake all night. Around 7:30 a.m., I called Robin, our doula, and told her that the contractions were painful, but irregular. She suggested some things to help make them more regular. The next contractions were 15 minutes apart, then ten, then five, and they stayed that way. By 9:30 a.m., I was having trouble dealing with them and called Robin again.

Mark was helping me relax, and I decided to get in the tub. Mark washed my hair while I was in the water, and it felt really good. Robin arrived around 10:00, while I was still in the tub, and put one finger on my forehead to relax it. For the next eight hours or so, my contractions remained five minutes apart. Robin suggested many things, including bouncing on the birth ball, rocking in the glider in the baby’s room, walking outside, and standing in the shower. When I had trouble dealing with a contraction, I flapped my hands until someone reminded me to relax. Mark and Robin reminded me to eat and alternate periods of rest with periods of activity. Mark massaged my feet and hands and brought me cool cloths. That felt so good!

Around 6:30 p.m., I hit a wall. I was so frustrated that the contractions were still five minutes apart that I started crying. Mark held me while Robin told me that the crying was a good thing. She suggested I get in the shower. While I was in there, the contractions got closer together, around three minutes apart. After I got out of the shower, I thought maybe it was time to go to the hospital. We got ready, got in the car, and peeled out of the apartment complex parking lot. When we got to the hospital, a triage nurse checked me. She said I was only 3 cm dilated, but 100% effaced. I had three contractions while she was prepping and checking me, and she said they were going to keep me because of my dates, not because of my regular contractions. We laughed about that. Robin reminded us that contractions sometimes space out as your body gets acclimated to a new environment. Meanwhile, a nurse put a saline lock in my arm. They moved us to a labor room, and I made a joke about how they put us at the end of the hall because we planned a natural birth.

continued on page 16
We met our first nurse, who was very nice, but very hardcore about the fetal monitoring. Every time the baby moved and the monitor lost the heartbeat, she came in to fix it and insisted on 15 consecutive minutes of monitoring, which was a real bummer, to say the least. She got much better as time went by, though. The contractions became regular again, about five minutes apart, and Mark and Robin helped me relax by saying, pretty much exclusively, “Relax.” I got in the shower again, and one of the nurses wrapped the arm with the saline lock so it wouldn’t get wet. They continued to monitor me for 15 minutes of every hour, and those were the most uncomfortable times of my labor. All night, the contractions remained the same, and my cervix remained at 3 cm. We walked the halls, bounced on the birth ball, and sat on the toilet. While on the birth ball, I kept falling asleep, so Mark helped hold me up so I wouldn’t hurt myself. One nurse, Stephanie, helped me immensely by allowing me to stay on the birth ball while she held the monitor on my belly for 15 minutes. It felt so much better than lying on my back in the bed.

At 5:00 a.m., one nurse decided I was 3½ to 4 cm. The contractions slowed down to 12-15 minutes apart. Mark and I were starting to lose our cool because of the lack of progress and lack of sleep, and we discussed all of our options, including an epidural, Stadol, natural induction techniques, and medical induction techniques. We decided that my body probably had decided that it wasn’t going any further until I got some rest, so we opted for a half dose of Stadol. I was worried about being caught off-guard by the contractions while under the influence of the medication, so Robin said that she or Mark would rouse me before it was time for each contraction. It turned out to be a non-issue, though, as I slept for two hours with very minimal interruptions.

When I woke, my contractions resumed their five-minute pattern. We continued to walk the halls and shower. Around 10 a.m., we came back to the room from walking to find Dr. P sitting on the couch with Robin. We were concerned that he would want to use medicine to expedite the process, but he said, “I’m not worried. You’re 3-4 cm, so who cares?” For the next several hours, I dealt with the contractions with much help from Robin and Mark. Every time I said, “Ow,” Robin would remind me to turn it into “Open.” When I complained that I wanted the baby out now, Robin would tell me to make it positive, like, “I want to meet my baby.” When it was just too hard, I cried. We were all exhausted and ready for it to be over.

During my next exam, around 6:15, the nurse said that my cervix had dilated to 7 cm and my membranes were “paper-thin.” While her fingers were in there, my water broke “spontaneously.” For the next couple of hours, I walked around with a towel between my legs as I toggled between the toilet, the birth ball, and the bed. All day we had talked about one of our friends and fellow doulas coming to give me a massage and offer Robin a break. When the time came for her to come down to the hospital, I yelled, “No! No one else is coming in.” Thankfully, she understood and Robin did, too. After dealing with some more contractions, I got the idea to listen to a comedy routine on iTunes and we sat and listened and laughed. As I hit transition, I became pretty clock-obsessed and at one point yelled, “You said everyone gets the same amount of transition!” This was a difficult time in my labor and I couldn’t have gotten through it without Mark’s help. He was so calming and soothing to me.

Around 8:45, I felt like pushing, so we called the nurse in to check me. All that was left of my cervix was a lip, which meant I was just about ready to push! The nurse called Dr. P and told him I was ready. For an hour, I pushed with Mark and Robin, nurses and doctor nowhere to be found. Dr. P finally arrived around 10:00 p.m. We had laughed with the nurses about how Dr. P has a tendency to make somewhat inappropriate comments and started taking bets on how many he would make during our birth. He walked in and said, “This is going to be one big-ass baby,” and we all cracked up. Thankfully, he didn’t say anything about the fact that I was lying there with my gown wide open, having lost my modesty hours before. He put on the paper scrubs and came to look at me. Robin said, “Ashley would like to try spontaneous bearing down instead of coached pushing,” Dr. P took off the paper gown, assuming it was going to take longer than expected. I had a contraction and pushed a little bit, with the baby’s head peeking out. He said, “She just might blow this baby out!,” as he put the paper back on.

As my baby’s head started crowning, Robin was snapping pictures. Dr. P kept making her take pictures with his fingers in them. He posed for pictures with Mark and the nurses and generally made a fool of himself. One nurse said
multiple times that she was excited to find out the sex of the baby (she had walked in at the beginning of her shift and said “I’ve never seen a natural birth before. I’m scared.” She annoyed me from that moment forward.) Robin reminded me to reach down and feel my baby inside of me one more time. During the next push, she told me to look down at my baby. I told her I couldn’t see anything, but when I looked, I saw the baby’s head between my legs. As the shoulders came out, I reached down and helped pull the baby up to my chest. Mark and I cried our eyes out as we looked at our baby, thinking how miraculous it really was. After a few seconds, Robin said, “So, Mark, are you going to tell us what it is?” He laughed and said, “It’s a girl!” The nurses asked to take her for the newborn exam, and I declined. She tried to breastfeed a little, with no success, but at least she tried. When we finally gave her up for the exam, Robin asked me to guess the weight. I said 7½ pounds. They put her on the scale and told us she weighed 9 pounds, 2 ounces!

Sarah’s birth was challenging, no doubt. 58 hours of labor was not what I had planned. Honestly, though, it was the most wonderful experience of my life. Mark and I bonded in a way we never could have otherwise. I couldn’t have made it without his help and Robin’s. Their reminders that I was “doing beautifully” and that they were proud of me really gave me strength to keep going. Even though I declared “I am not doing it this way next time” (meaning without an epidural), I have definitely changed my mind and look forward to the birth of our second child in early 2011.

Ashley Benz, CLC is working towards her certification as a childbirth educator while finishing her Masters in Maternal Child Health: Lactation Consulting. She and her family are expecting their second baby in Louisville, KY. You can find her on the web at: www.louisvillebreastfeedinghelp.com

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Reviewed by Stacie Walker, MA, LCCE, CD(DONA), LMT, NCMT

The fourth edition of Pregnancy, Childbirth, and the Newborn is a comprehensive, almost encyclopedic guide to its title topics, with expectant and new parents as its obvious target audience. Written and newly updated by some of the “mothers” of the modern childbirth education, doula, and lactation professional movements, the information is not only wide-ranging in its coverage, but also evidence-based and accurate, while remaining straightforward and accessible for most any reader.

A detailed table of contents offers a nice thumbnail sketch of the 19 chapters and their subsections, and the book is logically arranged to cover almost every facet of normal pregnancy, childbirth, and postpartum experiences, with additional chapters devoted to complications and potential challenges during each of the three stages. For example, chapter seven, “When Pregnancy Becomes Complicated” covers such issues as preterm labor, placental abnormalities, and high blood pressure. Other than the usual topics one might expect from a book about expecting, the authors give a fair amount of attention to important subjects that may or may not be covered in the typical childbirth education series (especially hospital-based classes), such as how to choose a care provider and place of birth, how to switch care providers, what to do in the case of a prolonged second stage labor, improving the chances for a successful VBAC, selecting a pediatrician, and caring for the intact vs. circumcised penis, among many others. The appendices contain useful resources recommended for additional reading; helpful charts summarizing the benefits, risks, and alternatives of different medications used during labor; and an easy-to-digest table explaining what to anticipate during a normal labor without pain medications, including physical and emotional signposts, as well as coping and comfort measures for mom and her partner and/or doula.

In this newest edition, not only have the statistics and discussions been updated to reflect current evidence-based research, but there are also plenty of great features to appeal to a wide range of reading audiences. For the type-A parents who start reading and researching their options from the moment they see the + sign on a home pregnancy test, this book offers a comprehensive, almost step-by-step guide for engaging in an informed decision-making process throughout the pregnancy, childbirth, and postpartum journey. Other parents will merely skim the book for major topics of interest (sort of like cramming just before the final exam), and those folks will likely enjoy the sidebars, topic boxes, and photos highlighting the salient points from each chapter. Each chapter also has very clear subheadings and includes a “Key Points to Remember” summary at the end, which makes it easy for parents to determine where they’d like to stop and spend a little more time, and which parts they might prefer to skip. There are unique sections devoted to yoga positions during pregnancy, caring for a premature baby, preparing older siblings for a new arrival, and facing relationship challenges during pregnancy or in the postpartum period, along with many other topics not always covered in pregnancy books. In addition, there are regular sidebar features like “Two Views,” which feature personal stories from two different parents, as well as

continued on page 19
“Fact or Fiction?,” “Advice from the Authors,” and “Common Q&As,” which are fairly self-explanatory. The section on comfort measures for labor offers an overview of Penny Simkin’s ever-popular “Three Rs: relaxation, rhythm, and ritual,” and the doulas among us will recognize many of the positioning guidelines and illustrations from Simkin’s *The Birth Partner*.

As a childbirth educator and doula, and especially as a natural birth advocate, I like the authors’ focus on what’s normal, with complications and challenges presented separately, but completely and accurately. I also appreciate how impressively inclusive the authors are, giving some attention to same-sex couples, single mothers, the mother whose partner is not a biological parent, and other non-traditional families and their unique considerations, as well as devoting sections to the varying concerns of parents with a history of abuse or trauma, miscarriage, stillbirth, or infertility, as well as those who are planning an out-of-hospital birth. For me, just reading it was a worthwhile reminder of the variety of backgrounds and potential “baggage” expectant parents might be bringing into their births, and I intend to keep this volume in my lending library and as a refresher for those times when I might be asked an uncommon question about a circumstance or issue with which I have no experience, either professionally or personally.

While the book does address families expecting or parenting multiples, I think those parents will likely still find the need for additional reading in a volume tailored more specifically toward preparing for twins, triplets, or more. For most parents, however, while a book cannot replace the interactive, dynamic experience of a well-planned and thoughtfully-executed childbirth education series, it would be difficult to find another single volume that covers pregnancy, childbirth, and the immediate postpartum period so comprehensively and in such an approachable, user-friendly manner as this one does—all without falling into fear-mongering or compromising the accuracy of the information presented for the sake of trying to convince parents that there’s a right or wrong choice. As a bonus, the book’s companion site, www.PCNGuide.com, offers a really nice selection of additional resources and worksheets for families wanting more information or guidance on a particular topic, and it is accessible to everyone, not just folks who purchase the book.

In *Pregnancy, Childbirth, and the Newborn*, Simkin, Whalley, et al., emphasize informed decision-making, rather than a natural birth agenda. I believe this emphasis is a goal they share with most birth and postpartum professionals in their work with new parents, and I think this is definitely a worthwhile addition to any recommended reading list for students, clients, and teachers alike.

Stacie Walker, MA, LCCE, CD(DONA), LMT, NCMT, is a Lamaze Certified Childbirth Educator, a DONA-certified Birth Doula, and a licensed and nationally-certified massage therapist, specializing in prenatal and postpartum massage and newborn massage instruction. She is also a WAHM of two children and owner-operator of Fannies Diaper Service, a cloth diaper web-store and diaper laundering and delivery service. Stacie can be reached at herbodyworks@gmail.com, or online via www.herbodyworkslouisville.com.

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Starting Your Own Website

(This is the third in a four-part series about childbirth professionals and how they can use the Internet more effectively.)

By Robin Elise Weiss, BA, CLC, LCCE, FACCE, ICPFE, ICCE-CPE

Building a website has many advantages for the childbirth professional, the obvious one being advertising in a way that was previously out of reach for most childbirth educators and birth professionals. It wasn’t that long ago that your phone number was the most important thing to have on hand when you met a potential client or student. Now, more often than not, it seems that when you meet a potential client, she’ll say, “What’s your URL?” when trying to find out more about your services.

The Advantages of a Website

Having a website means that clients can find you 24 hours a day. They can get information about your services and read whatever information you have on your website so that they can get a sense of who you are and what you offer, all without calling while you’re having dinner or standing in line at the grocery. The web allows the consumer to do some basic comparison shopping for childbirth professionals, contacting only those who best match their needs.

As the manager of the information that is displayed, you have the unique ability to list exactly what you want known. You can add pictures of your classes, schedules and your biography. You can even have fun areas like a recommended reading list or a section of testimonials from previous clients. If your site is technologically capable, you can even take registrations and payments for services.

The Disadvantages of a Website

As with all good things, websites come with some potential drawbacks. The two biggest are not knowing who is there and how to reach out to them, and not using the technology wisely.

While you would hope that if someone viewing your website had a question, she would contact you for clarification, there is no guarantee. You also lose the ability to ask potential clients/students questions that would help you tailor your website’s content to that particular person and her needs. This can be managed with the amount and type of information you include on your site.

Mismanaged technology is probably the larger issue. Not understanding how best to design a website, getting bogged down in too many gadgets and “clutter” on your site, and not responding to inquiries or having bad information will also bring your business down. For these reasons, a website needs to be seen as a responsibility, not merely inexpensive advertising.

Wise Websites

In the process of designing your website, whether you or someone else will do the actual design, look around at other websites that you like. These do not need to be childbirth-specific for the design portions. What elements do they have that attract you? What color schemes? How do they use pictures and images to draw you in? What annoys you when you look at a website?

continued on page 21
Now step back and make a list of how you would like your website to work for you. Do you want it to function only as a brochure? Do you want to have a schedule of classes or services listed? What about prices? Or would you like to have the ability to register students for classes?

Think about how potential clients will learn about you. Will you have a biography? Will you post information about your philosophy? Can potential clients call or email you? Will you have a blog accessible from your website? What about a Facebook or Twitter feed?

Who Will Build Your Website?

Once you have a good idea of what you want, you need to decide if this is something that you can realistically build on your own. There are many free sites that allow you to build a website, as well as programs that will help you. If this is something that is fun for you or that you have always wanted to do – go for it! The beauty of a website is that you can change it every five minutes if you want or need to do so. Forget the static brochure!

There is also the option of hiring someone to help you. This often makes a nice bartering project for a client if you know someone who has that skill and needs your services. Other inexpensive sources of website help include a local high school or college student who needs to build a site for a web design class, past clients, or your own children. Do let me say that web work is often underappreciated and even if someone agrees to work for free, it is best to offer them something in return, even if it’s a gift certificate for iTunes or for a favorite restaurant. This will help you build a relationship anytime you may need help in the future.

There are also paid services you can use that will take you through every step of the design process. This can cost you as little as $100 to as much as $10,000. You do not need a $10,000 website. For the average childbirth educator, this is not worth the money spent, so when gathering estimates, that one should be dropped from the list.

Doing your homework ahead of time will make this process easier. You should go into this process being able to say nearly everything that you will need:

- How many pages do you need? (Home page, schedule page, bio page, etc.)
- Do you need a logo designed or just scanned and cleaned up?
- Do you want your own domain? (ex. robineliseweiss.com, yourcitycbeclass.com)
- Do you need any special items added? (blog, Twitter or Facebook feeds, etc.)
- What contact information do you want to have listed?

Having a website should not be your total marketing venture, but a good website will bring you people that you may never have reached any other way, regardless of how great your marketing plan was without the internet. Be sure to avoid these small but costly mistakes on your website:

- **Check your email or voicemail regularly.** Swift callbacks are important to your business success.
- **Be professional.** Don’t try to mix business with pleasure. You don’t want to have something silly or unprofessional as your email address. Ex. mombuysjunkcars@aol.com
- **Keep schedules up to date.** There is no bigger turn-off for a potential student than finding last year’s schedule when she wants a class now.

10 Sites to Help You Design Your Website

- [http://webdesign.about.com/od/beginningtutorials/a/aa060198.htm](http://webdesign.about.com/od/beginningtutorials/a/aa060198.htm)
- [http://webdesign.about.com/od/strategy/a/hire_web_design.htm](http://webdesign.about.com/od/strategy/a/hire_web_design.htm)
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- [http://www.noupe.com/design/ten-most-common-design-mistakes.html](http://www.noupe.com/design/ten-most-common-design-mistakes.html)

Robin Elise Weiss, BA, CLC, LCCE, FACCE, ICPFE, ICCE-CPE, CD(DONA) is a childbirth educator, doula and trainer in Louisville, KY. She lives there with her husband and eight children. You can find her on the web at [http://robineliseweiss.com](http://robineliseweiss.com) and on Facebook at [http://facebook.com/robineliseweiss/](http://facebook.com/robineliseweiss/) and on Twitter @RobinPregnancy.
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David Feild, Executive Director/ICEA

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