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ABOUT THEIR
SEXUAL HEALTH

How body literacy can teach us confidence, and so much more!

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Read back issues of Birth Issues magazine, visit www.birthissues.org

UPCOMING THEMES & SUBMISSION DEADLINES

Send us your birth stories, articles, and photos at any time during the year (or by the deadlines if you want your article to fit the upcoming theme). If you have a topic or a story that is dear to you, and does not fit the theme, please submit it anyway—we want to publish those too!

Fall 2019 Postpartum Care: The Fourth Trimester Send submissions by June 1. On stands September 2.


Spring 2020 Happy Birthday ASAC! 40 years Send submissions by Jan 3. On stands March 2.
Speaking to Youth about their Sexual Health is definitely a topic that is far from our usual fair. I am both nervous and excited to present this issue, wanting it to be both interesting for adults to read and one that parents would feel comfortable sharing with their own teenagers. We gently challenge our current concept of sexual education, and offer several raw stories of teen pregnancy. I am proud of these mothers for sharing their stories, and for what they have accomplished. I hope this is not seen as ASAC supporting teenagers rushing to become parents, but rather allows our readers to see that if they have been trusted by a teenager facing pregnancy then they are in a very powerful position to affect both the teen’s life, and that of the next generation. I hope that our readers will see some of the barriers that young teens may face: things like needing an alternate method to continuing education, not being respected by peers or adults, not being given all of their options during pregnancy or birth, or not being treated as though they are capable of full consent.

For me, my children are still rather young. Discussions of sexual health have begun with consent. This may be honouring that a child does not need to share their own toys, only communal toys. Perhaps it begins by not making suggestions for our children, “Go kiss Grandma goodbye” rather wording things to our children with the acknowledgement that they have ownership over their own bodies, “Do you want to kiss Grandma goodbye?” If a friend or loved one really wants a hug, it is still our child’s right to say no. We can show them that it is valuable to have bodily integrity by helping them stand up for their own consent as very tiny humans. “Sorry Auntie, she does not feel like a hug right now, and that is okay, right?”

I know this is not always an easy feat. I have wondered to myself how to fully accomplish respecting a child’s consent as a parent, while running late for an appointment with a toddler who refuses to put their shoes on, or does not want their hair brushed. Sometimes for us it looks like a kid in a shopping cart with no shoes, or unbrushed hair, or me reminding myself that strong-willed and confident will be traits I am proud they have as adults. Sometimes it is reminding my child that I respect their opinion but I, as the adult, have made a decision about something. Every situation and child is unique, and no one else will know your family as well as you.

It can become particularly difficult when we consider neurodiverse children and adults. Two of my children are highly sensory seeking, with physical touch as an important love language; I have seen both of them devastated when someone else does not want to hug or hold hands. I can admit there are times when I have hoped others will be patient with them for not understanding body cues or subtle hints that a hug has gone on too long. Does it mean that I do not bother to teach them consent because it is difficult? Absolutely not. It just means that I hope as a society that we understand some children may struggle with the concepts of personal space and body language; some may need more time to learn these concepts, some may continue to struggle with it through adulthood.

Another way we have begun healthy sexual education in my household is by increasing basic body literacy. All children, starting as a baby, hear the proper naming of body parts: breasts, nipples, penis, testicles, anus, and the good old vagina
It is important to name body parts properly so that children gain an appropriate level of respect for that body part (not thinking of it as silly or a joke) and to increase the child’s safety by ensuring they can properly identify and discuss any inappropriate behavior they could potentially encounter.

All of my children have witnessed menstrual products in the house and any of them who ask will find out what they are for and, if they want to know, how they are used. If the kids walk in on me in the washroom and notice menstrual blood in the toilet or on my underwear they will get a conversation on female anatomy and menstruation. I do not hide it from my girls or complain about menstruation to them. Nor do I shy away from including my son if he happens to be around or ask questions about my blood; perhaps if boys have a better understanding of the menstrual cycle from an early age they will be more sympathetic to women’s ‘moods’, and less likely to make offensive ‘period’ or PMS (premenstrual syndrome, which is actually before the blood is flowing) remarks or jokes.

My nine year old daughter has already begun showing signs of being within a big physical and hormonal shift. Our conversations deal a little more around the hormonal changes of menstruation and how the cycle fluctuates through the month from a really outgoing energy to a reclusive and sensitive one, and that it is okay to take time to ourselves and focus on self-care during that second half of the cycle. I have already begun planning a unique gift of useful items for her first menstrual cycle, and a way we can celebrate that says both, “I am excited you are growing up” and, “Do not be afraid of your period.” Although not widely popular, I have seen celebrations to honour women’s cycles from, “Period parties”, to women’s circles or, “Red tent” celebrations.

At the same time, I am wondering if the same type of thing exists for my sons: a non-religious (as my family is not practicing any) boy-to-man class. I know that this can exist, in a sort, through sports and hobby classes like outdoor survival or debate club: opportunities to challenge oneself, rise after defeat, gain independence, increase confidence, or improve team building skills. Yet I have not found something that really takes on the topic of anatomy and physiology of male puberty in a way that addresses typically male stigmas.

For instance as a young male one will learn testosterone is a major hormone responsible for puberty, while also experiencing that the pubescent period is commonly a time of emotional uncertainty and even moodiness or outright anger; many times I have heard males in my life refer to their angry mood as caused by raging testosterone. However, one might be surprised to learn that testosterone actually plays a bigger role in bone strength (even in women) than it does in anger. Anger is actually a near instantaneous cascade of neurotransmitters (such as catecholamines) and hormones (including adrenaline and noradrenaline) designed to increase energy, narrow your focus, and heighten interest: so you can get ready to run or fight! The fact that it happens quicker than our minds can stop, and judge if fight-or-flight truly is necessary, does not excuse our anger; rather, it simply means none of us are born knowing how to stay calm when triggered. It is only through learning about neurodevelopment, the physiology of anger, and by practicing calming and self-regulating techniques that we can become masters of our anger (regardless of our gender).

It is time we stop excusing, “Boys will be boys” mentality and we teach males appropriate ways to deal with feelings of anger, loneliness, failure, and depression. Now imagine this ‘boys-to-men’ class also acknowledged, head-on, male privilege and did not shy away from sharing the shocking statistics of male-perpetrated violence on women and members of the LGBTQ+ community. Imagine what it might mean for society if we taught young prepubescent males that masculinity involved diversity for what, “Being a man” looks like, if we taught tolerance for other individuals’ choices and autonomy, and if engrained within the language of this class or discussion was the framework of respect for people’s differences, gender diversity, and all women in general.

When it comes to birth options we owe it to the next generation to pre-emptively share all of the available options in our province, including midwives. Even if we do not believe they are ready for the knowledge, they deserve to know about midwifery care before becoming pregnant; people seeking a midwife late in their first trimester are often denied care, particularly if they live farther from an urban center. Women deserve to know midwifery care exists, even if they are not planning on becoming pregnant for a decade or more. Under new legislation, midwives’ scope of practice is expanding, and girls and young women can seek a midwife to assist with vaccines and contraceptives as well as maternity care.

Again, it is important to teach boys and men about midwifery care, home birth options or birth centres, waterbirth, and
instinctual birth (both the physiology of birth, and coping techniques). This would help break down stigmas surrounding these topics, increase understanding for why the birth giver may want these options, and help the partner support their loved one in pregnancy, birth, and the postpartum period.

One last concept I would like to touch on is that of continuing to mother the mother, or I should say continuing to parent the pregnant child (regardless of the age of that child, and if they are now an adult). The importance of a present mother, or a supportive parent or parental figure, for teen pregnancies can make the difference between continuing success in education, developing career potential, and improving parenting skills. Without support teen pregnancies will often face many societal challenges that make it common to struggle with continuing education and poverty; this can even create a cycle where the teen’s child is also susceptible to poverty, lower levels of education, increased chances of drug or other abuse, increased likelihood of trauma, and increased rates of teen pregnancy. However, Sarah Rivera’s story also shows us how important the concept of, “Mothering the mother” can be at any age; it may not be right for everyone to have their mother or other parent attending during birth, but for some it can be a priceless chance for bonding and support. If you are considering asking a parent to attend your birth, know that this has been a perfectly normal occurrence through much of human history. Why not want someone there that loves you unconditionally, knows all your favourite comfort measures and coping mechanisms, and is wholly invested in the health of the mother and baby.

Midwifery News: Savings and Funds
Midwives are primary caregivers that deal primarily with pregnancy, birth and the first six weeks postpartum. They are paid for by the provincial government and do not require a referral. To request a midwife use the following link: https://clientcare.alberta-midwives.ca/waitlist/register.

Low intervention rates among midwifery clients, along with the option of out-of-hospital birth, offer significant savings for the Alberta healthcare system. Based on the Maternity Care in Alberta report (2016), published by the Association for Safe Alternatives in Childbirth (ASAC), out-of-hospital births with a midwife offer a savings of $2055/birth and in-hospital births with a midwife offer a savings of $540/birth when compared to maternity care with an obstetrician. Midwives currently
attend approximately 54% hospital births and 46% home or birth centre births. Nearly 60,000 babies are born in Alberta a year, and statistically only 7% of those pregnancies will be high risk (out of the scope of midwives). These numbers can build a solid case for the cost savings of midwifery services, particularly if it were allowed to grow unfettered to reach a potential as high or higher than other provinces (BC currently has 22% midwife attended births). **The Alberta government could save millions of dollars by changing the funding model and utilizing Midwifery to its full capacity.**

Midwives currently attend 5.5% of provincial births, saving the healthcare system $3.76 million a year. By 2020 (potentially delivering ~9% of the total provincial births, which would put us closer in line to the national average of 10.8%) it will save our province an additional $3 million. Increased education for midwifery and homebirths could encourage a greater need for midwives, and greater job security and a living wage would encourage more trained midwives in the province: we could aspire towards the leading provinces in maternity care (towards 20% of births being attended by a midwife) and be looking at another $8 million in additional savings.

In 2015 Alberta had 77 midwives and 19 midwifery practices. As of the summer of 2019 we will have 137 midwives and 28 practices (with another three on the way). Since 2015 Red Deer saw an increase in one midwifery practice, Calgary gained four new practices, and five much needed rural locations opened up (which previously had been losing maternity care options in rural hospitals).

A lot of work over the last few decades has gone into securing all Albertan midwives have the ability to receiving funding for a full case-load. This will finally be achieved as of 2020, and is not a point Albertans are willing to go back on. If the funding model is not changed indefinitely it will continue to be a struggle to ensure enough funding. The funds need to follow the mother and baby, not the caregiver. This can be achieved by paying for midwifery services under Alberta Health as other primary caregivers in maternity care are paid, instead of through Alberta Health Services with a set budget and ‘cap’ on the number of women that can be attended a year.
Birth Issues invites our readers to send in the letter template, found on page 56, to your local MLA to help bring awareness to our government of the issues surrounding maternal care within Alberta. To locate the online version of the letter template go to: https://birthissues.org/mla-letter/.

How to look up your MLA
You can find your riding here:
www.assembly.ab.ca/lao/mla/mla_help

With your constituency you can then find your local MLA:

Meet your MLA in person
If you are able, add impact to your request, and story, by meeting with your MLA in person:
1. Call/email/go to your MLA’s office and make an appointment with his/her assistant.
2. Explain that you would like to meet your MLA to increase access to midwifery care.
3. Mention you will send briefing notes via email to prepare MLA for the meeting.
4. Mention the names of others who will be part of the meeting. Give their contact info. There is always strength in numbers!
5. Send a follow up email with contact info, time and date of the meeting, a fact sheet and your personal story (story and fact sheet in an attached document).
6. When writing your story, include your address, date, caregiver’s name, hospital name and the details of the birth. Write a paragraph that outlines what you suffered through, or how midwifery care made a difference to you, and another explaining what your solutions would be. Solutions are important!
7. Do not email multiple MLAs and Ministers or use CC. Send individual emails or BCC them.
8. Always include your phone number, full address and legal name.
9. Provide MLA with a complaint they can act on and solutions that they can use.

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Happy Summer everyone! The big change I would like to talk about is the new government. We received a lot of questions and activity in our Facebook group about what to expect under a UCP government and what their commitments were. The UCP’s platform said they would, “Lift the cap on midwifery services”; what this means we do not know yet, but I encourage all of you to reach out to your MLA and ask what they are going to do and how they plan to, “Lift the cap”.

Recently, the Alberta Association of Midwives worked with Alberta Health Services to negotiate a new contract for midwives. As part of these negotiations, Alberta Health Services agreed to continue increasing the funding for midwives each year. They also increased the capacity for each midwife.

Previously, midwifery clinics were given a fixed number of courses of care and had to decide how to distribute the courses of care between the midwives at the clinic. Under the new contract, midwives themselves will have up to 40 courses of care each a year and can take their clients with them if they move between clinics, as long as they stay in a geographic region or zone. This is great news and something we should make sure the UCP continues with. There is also a new “Midwifery Alternative Relationship Program” that will use a different funding model for midwifery practices working with Indigenous, rural, remote communities and targeted populations in urban areas such as single or teen parents, and newcomers.

Another very important piece, that was not agreed to in the new contract for midwives, is an increase in their cost of living; midwives have not received a cost of living increase in over ten years. If you do contact your MLA, please encourage them to increase the cost of living for midwives, as they cannot continue to make a living with wages from a decade or more ago.

I would like to thank all of our current board members and volunteers, especially those who work so hard on our Birth Issues magazine. These amazing individuals work tirelessly to keep ASAC running smoothly and are so dedicated to educating families about their birth choices. We are continuing to work on improving Birth Issues; look for details soon about our upcoming new website launch, and a future redesign for the magazine! Remember, if there is a topic you would like to read about, please let our Editor-in-Chief, Erin Mayou, know by sending her an email at bi_editor@asac.ab.ca.

I hope you enjoy this issue and the stories in it about, “Talking to Youth About Their Sexual Health”. As always, please feel free to contact me if there is anything you want to talk about. ✶
In 1991, I was 17 years old when I found myself pregnant. I had been dating my boyfriend for over a year and a half at that point. We had met at school. While our relationship did not last very far into my pregnancy, I was determined to be a good mom to my baby and faithfully went to my doctor’s appointments and took my prenatal vitamins, all while keeping it a secret for as long as I could and carrying on with school. Finally around my fourth month of pregnancy I told my parents and friends. I tucked money away from baby-sitting for families in my community, which I had been doing since age 12.

My pregnancy was uneventful, except for being sick 24/7. I got very good at being sick quietly. I saw an obstetrician in Edmonton, where I was living, and trusted her immensely. I relied the most on my obstetrician for advice because I knew very little about pregnancy and birth, and although my mom was supportive in some ways, I never really talked to her about my pregnancy. My mom did attend prenatal classes with me at the local health unit. I felt out of place, but I wanted to do all I could to be a good mom.

I stopped going to school in the second trimester and started doing my school work at home. My school was very preppy and I while I did want to continue my classes, I did not want to have negative comments made about being pregnant. I was very lucky that my school was accommodating and allowed me to continue my work at home. I even had a teacher who would drop my school work off to me. My baby was due August 11, so it was good timing to finish the school year off.

August 17, I went to the doctors’ and she looked at me and said, “Oh, you are still here.” She had been away for a week on holidays. I laughed and said, “Yup.” She told me she was concerned because in an ultrasound my baby had been in a frank breech position,1 and in an x-ray they did (yes, they did an x-ray while I was pregnant) they determined the baby was still breech and I would not be able to deliver the baby vaginally.2 So she asked me to go to the hospital for 7 a.m. and they would do one more ultrasound. If the baby was ‘big’ they
would do a caesarean section that day. I happily agreed and went home to pack.

This was mid-summer, and I was so very hot and done. I had spent many days lying in my parents’ basement with the air conditioner on, or in the backyard in the kiddie wading pool. Now I knew it was finally going to end. There was no discussion about what to expect. I did not know anything about caesarean births, except what my mom had told me about the birth of my sister. That had not been a pretty picture. My mom had given birth to my sister via caesarean, and she told me they both nearly died due to complications. My sister has arthrogryposis multiplex, which was not found out during the pregnancy, and they ended up doing an emergency caesarean section (with a median incision, which cuts up and down the belly, sometimes referred to as a classical caesarean). My mom ended up with a bad infection at the incision site. You would have thought that would have made me ask questions about the procedure, but I trusted my doctor. I do not remember ever asking any questions about it. I just knew I was going to meet my baby soon!

The next morning my mom, the baby’s dad, and I were at the hospital bright and early, around 7 a.m. I had an ultrasound and the technician said she figured the baby was 8 lb, 15 oz. I knew that was big. Oh, and still bum first. I knew I was having a caesarean so I asked if she knew what it was, as I had never found out. She looked at me, held a finger up and she said, “It has one of these.” I took that to mean it was a boy. I felt dizzy and excited.

Upstairs we went to wait for my turn. I remember watching Days of Our Lives at 1 p.m. with my son’s dad in a patient lounge area. My mom had left by this point and so it was just him and I waiting to meet our baby. There were other people in there too, talking and watching TV. I had not eaten since the night before and I was excited, scared, and impatient.

Finally it was my turn to have my baby. I do not remember any risks being explained to me about anything. I was still happily going along with everything. I also remember being rolled down the hallway and I just cried. I think it was the unknown; I was alone and scared. I did not have anyone with me who I knew at that point and I knew I would not see my baby for a while as I would be in recovery.

At 4:05 p.m., on August 18, 1992, my baby was born! Yes, he was indeed a boy. Since, in 1992, they used a general anasthesia for c-sections, I was not awake for the birth. I do remember waking up in the recovery room. It was bright and I do not remember any other patients being in there, just two nurses across the room at a desk talking and making notes. My stomach felt like there was a pile of bricks on it and I called out. The nurses stopped talking, looked over at me, and said, “She thinks we are touching her!” Then I was out again. It was scary because I did not know what was going on when I woke up initially, and I felt like the nurses in the recovery room were mocking me instead of coming over to comfort me or to say congratulations.

Next time I remember waking up was in my hospital room. I asked where my baby was and my mom told me he was down the hall somewhere with my dad. I was so upset! Everyone had held my 9 lb, 1/2 oz baby before me! Finally I got to hold my baby when he was around four hours old.

He was a dream baby. He breastfed easily with no issues, he slept well at nights, and I loved being a mom. He really was my everything. I easily fell into parenthood and when I turned 18 years old, six weeks after Troy was born, I moved out of my parents’ house into my own place. When Troy was a year old I went back to school and graduated one year behind my class. Which I was totally okay with. I was very proud of myself for graduating while raising a baby on my own.

I do wish I had known it was okay to ask my care provider questions. There are many I would have asked, had I known what to ask. Questions like: “Will this affect future pregnancies?”; “What is recovery like?”; “Are there risks with a caesarean birth?”; “Do I have any other options that we can look at?” That is always the issue, we do not know what to ask. No one explained the risks to me of a caesarean, the impact on future pregnancies, offered to try turning my baby, or ever mentioned a vaginal breech birth. Back then we also did not have the internet and I did not have any friends to talk to about pregnancy. I think resources are widely available now and much more accessible for everyone, which is such a great thing!

Editor’s Notes:

1. Frank breech refers to when the baby is sitting bum down within the womb, with the feet high around the baby’s head. This is one of the safest positions for a vaginal breech birth, as long as the head of the baby is not tilted backwards. This is because the presenting part, the buttocks, is approximately the same circumference as the head; which means the baby is less likely to begin descending through the cervix before it is fully dilated, or that the cord could slip through, called a prolapse, thus risking cord entrapment and oxygen restriction to the baby.

2. In 2001, The American College of Obstetricians and Gynecologists (ACOG) put out a position paper recommending all breeches be delivered by caesarean. Two years later a critical review of the study uncovered that the initial conclusion was incorrect. However breech practices had already changed around the world. It would take three years after the critical review, in 2006, to have ACOG revise their recommendation for breech birth, and then another three years later for The Society of Obstetricians and Gynaecologists of Canada (SOGC) to follow suit by changing policy to once again promote vaginal breech delivery. For more information read Suzi Martin’s article titled, “Bringing back breech – Empowering moms through choice” from our Empowered Birth – Spring 2018 issue of Birth Issues.

3. Arthrogryposis multiplex congenita refers to the fusing of more than one joint, either bent or straight, prior to birth.

Christine Catherall is a birth doula and childbirth educator living in Red Deer. She is passionate about educating others so they can make informed decisions for their pregnancies. She also loves taking photographs, going to scrapbook retreats, and travelling.  

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By Danielle Johnston

My birth stories are not of a negative or positive birth story experience. Both were so much different than I expected. I am sure that this thought is a normal one for most moms.

My fist pregnancy looking back we on the normal range, but being that it was my first it felt like a gong show. I had bad morning sickness longer than what they say you are going to have it for. I had about two months of feeling pretty good, and then I was just sore and ready for that baby to come out. I had an obstetrician who worked out of the Royal Alexandra Hospital in Edmonton. With me was my close friend who also was my doula (defiantly recommend this for your first baby), her baby who was just four months at the time (this was not as chaotic as it might sound), and my husband. I had an induction at 41 weeks. The night before the induction I had a bit of a cry while I thought about going in to the hospital the next day, and if I was making the right decision. I knew what my options were, refusing the induction and waiting with possible stress tests, and had truly taken some time to feel the weight of responsibility for making such important decisions for my daughter who had not yet even been born. In the end I trusted my doctor who was advising me to begin the induction process. Once I had made the decision to proceed forward with an induction, I felt some relief knowing the baby would be coming relatively soon, and that I would be cared for in the process.

Everything was pretty normal for an induction. I arrived at the hospital for 10:30 a.m. After the process of admittance and a little waiting, I had a cervical exam in the early afternoon. The doctor came in and discussed the induction process. I felt confident at that point about the choice to move forward with the induction, and the Cervidil was inserted. I then had some paperwork to complete but was sent home fairly shortly, in the late afternoon.

My water broke around 10:00 p.m. that night. I had no labour pains on the way to the hospital. They got me into my room before midnight, and within an hour or two they had started me on Pitocin; I began having contractions right after. They were instantly powerful. I remember sitting and rocking on a birth ball, and finding comfort in the shower under hot water for quite a while. I needed my husband close and was comforted by his steady presence. My husband and my doula took turns napping through the night. My memory is mostly of hours of these very intense contractions.

About 12 hours after the Pitocin had been started I was beginning to have a harder time coping on the birth ball or in the shower. I wanted to lay back in an upright position on the bed. Shortly after getting on the bed, around 3:00 p.m., my daughter’s heart rate began to drop. My husband pressed the emergency button to call nursing staff, and we found several nurses and a doctor were already on their way to the room after being alerted to my daughter’s heart rate at the nursing station. The look on their faces was very concerned, yet they all acted quite calmly and professionally to quickly turn me onto my side. After a position change or two my daughter’s heart rate returned to normal and the staff left my room. One of them told me that I was lucky that doctor had attempted to turn me and not taken me directly for a caesarean.

By dinner of the second day of the induction process, labour pains were becoming excruciatingly difficult and I was screaming at the top of my lungs. The nurse on-call performed
a cervical exam and said, “You are only 2 cm dilated.” They asked if I wanted an epidural. With tears in my eyes from the pain I looked at my very close friend and husband and asked if I should get the epidural. I did not know if I could make a good choice at the time. I was worried I may fall asleep or feel out of control. I also worried I would not feel anything at all, which again felt out of control and removed from the birth process. They both encouraged me that I had done so well, and laboured strongly, but that if this was what I needed to get through the next phase of labour that was okay as well.

Throughout my stay at the hospital nurses had been having a very tough time finding and placing a vein for my IVs, and had needed several attempts. This proved to be true for an epidural as well. After three attempts to get the needle into my back (which is really hard to stay still for when you are in labour) the technician asked me, “Do you have spine problems?” I was annoyed he would ask me that and responded, “No... but my spine hurts now.” I felt I was regaining a little control over my feelings and labour, and was not so lost in the fog of labour. I was on to my next challenge: fatigue.

A couple hours later, my body started to push on its own. The nurse on duty (not my favourite one that night of course, ironic because she seemed to be one out of 20 staff members I met) told me, “Do not push.” I told her, “My body is not giving me a choice.” After arguing with her for a little bit she finally told me, “Well you can bear down a bit, but do not push.” That was all she needed to say in the first place.

The nurses and the doctor were ready to receive my baby and I was given the okay to fully push. After a while my doula encouraged me try leaning backwards over the head of the bed on all fours, but I found it more comfortable leaning back against the upright bed. It seemed the pushing phase was going on for a long time, and I was getting so tired I felt like I had no ability to push at all. It must have been obvious that I was struggling because they brought in their retired obstetrician who happened to be at the hospital. He said, “I do this just because I need something to do.” He was amazing! He took my leg, ordered my husband to take the other and bared down while telling me to push. I told him, “I cannot, I am too tired. Just order me a C-section.” He said, “That is too bad because I am not leaving until this baby is out.” That was settled, we were doing this. It took me what seemed 100 pushes and I yelled at my husband to be a little more aggressive with holding my legs and helping my hips open wider (bless his heart, he does not like being even a little hard on me).

Finally I pushed out my 8 lb 3 oz baby girl at 8:03 p.m., January 14, 2018. More than 30 hours since the whole process had begun, and yet neither of us cried at all. She was wide awake seeing the world for the first time, and I was so thankful that the birth was all done. The last thing I remember was them putting her on my chest and feeling the calmest I have ever been in my whole life.

My second baby, like the stereotype, was dramatically different. It was a gong show. I was puking for what seemed like forever. I had cold after cold, after cold. At 22 weeks I started to have gallbladder attacks; it feels like you are dying, and because I did not know what it was the first time I did feel
Like I was dying. My husband ended up calling the ambulance. Of course, as soon as I got into it the pain subsided, but we were worried about the baby so we went to the hospital anyway. My baby was doing great (this is not always the case, some people lose their baby because of this). So my Auntie (she is amazing by the way) picked me up, gave me socks and a house coat (I went to the hospital with nothing), and later she took me home. I promptly went to bed and cried.

My Aunt called me the next day and told me that she thought it was gallbladder related. After she told me that she had the same problem and had lost her baby because of it. After that, she got her gallbladder removed and she told me that it might be something I would have to do as well. So after my second attack I went to the doctors. The obstetrician tested me and found that I had gallstones (not to be confused with kidney stones). We decided to wait to deal with them until after I had the baby). So, for around three months, I had gallbladder attack, after gallbladder attack which became more frequent as the pregnancy progressed.

Looking back and talking it out with my sister I realized I was really depressed. I did not know it at the time as I was still functioning and getting out of bed (barley). Who would not be depressed, really? I was in pain all the time, me and my husband (although he is super supportive) were losing our connection to each other, I was doing the absolute bare minimal with my two-year-old, and I sat on the couch all day (hardly ever left it). I felt disconnected to the world and I felt I had no one to talk to about it. Yep, defiantly depressed, but I could not tell. I do not think most people are able to, especially if they have kids and a husband that need them.

Finally at 40+5 weeks, I had an inkling that I might be going into labour: having it wake me up at 9:00 a.m. from a dream about going into labour. I called my sister because I had never actually experienced this before with my first labour being induced: they are not the same. She was convinced that, since I was talking normally and seemed comfortable, it was most likely false labour (which is very normal). I had a midwife appointment that day as well, and she too thought it was not true labour. It felt really different from what I had experienced before with Braxton Hicks, for either pregnancy, yet it made me uncertain to have everyone else telling me this was not labour.

I had a pretty violent gallbladder attack the night before and am often a bit incoherent the next day, so my husband had stayed with me to make sure that I got to where I needed to be safely. He was planning to go back to work after dropping me off at my sister’s. I was feeling insecure about my ‘false’ contractions, so he stayed with me that day. I cooked lunch for my sister and our families and we joked about if I was in labour. We went home to put our toddler to bed for a nap and
I noticed things were changing.

By 3:00 p.m. I was sure I was in labour. My husband called his mom to come and pick up our oldest. Then I called the midwife; she was still unsure if it was active labour and time for her to get involved. She told us to meet her at the hospital around 5:00 p.m. At that time, I thought the midwife had seemed so casual about meeting us that it really must still be early in labour, and I had much more to go. However, by 4:45 p.m. I could not handle it and needed to be anywhere but where I was, so we got in the car and drive to the Royal Alex. Labouring in a car is hell. I had to keep reminding myself that my husband was driving, and I could not just grab on to him. I made jokes about how uncomfortable I was and about having a baby in the car.

We got to the hospital and I was thinking, “I am crazy; I should have got an epidural again.” The midwife got there at the same time my husband arrived at the door after parking our car. Apparently I was laughing and making jokes, but I will admit that, after getting to the hospital and seeing my midwife, my memory of this part is foggy and unclear. When we got to our room the midwife said, “Just let me know when you feel like you need to push.” So I responded soon after with, “I feel like pushing now.” She looked over at me in a kind way that also said I was being just a bit dramatic. Still being unsure that I was dilated enough to push she said, “Hop onto the bed,” and then she checked my cervix. She realized I was fully dilated and then she said, “We just need to wait until your water brakes.” Almost as soon as she finished her sentence, ‘pop’, my water broke. My husband walked in and asked where we were at in the labour process, and she said, “We are ready to go.” He had to call his boss to let him know he was having a baby that day.

In two pushes I had my baby at 5:19 p.m., on July 5, 2018, at the Royal Alexandra Hospital, and was suddenly a mother of two girls. One more push, and I delivered my placenta. In a whole 11 minutes I was done and in a shower, lightly giggling to myself about the earlier thought of me having an epidural. Likely a doctor would have just laughed and said, “You are shit out of luck.” In two hours we were out of the hospital and then at our home in 15 minutes. I am still in shock about how quickly that went.

It is funny to think about birth and parenting just two generations before me. My grandmother, and Gigi to my kids, does not remember much about giving birth to her three children, but does remember some of the superstitions and things she was taught about raising her own kids. She told me once that she found it strange that my sisters and I were cooing over my younger sister’s pregnant belly, hoping on the off-chance we might feel a kick. When she was younger you were not even supposed to acknowledge the pregnancy, let alone kiss and rub a pregnant belly; something to this day, after six great grandchildren, she is most likely still slightly uncomfortable with but sits there quietly as my sisters and I cluck away about our womanly problems, her only once and awhile reminiscing herself. There is, of course, many dramatic changes from her generation to my own as there will be from mine to my own children. Even both of my pregnancies were different from each other, as I am sure your own will be as well.

Editor’s Notes:
1. Pitocin is the synthetic form of the naturally occurring hormone oxytocin. It can also be called syntocinon. It is administered with an IV. It is used to contract smooth tissues in the body, which causes uterine contractions. Oxytocin is used in labour to increase the frequency and strength of contractions. However, it confers a risk for an increase in uterine contraction frequency, resulting in inadequate relaxation periods. This leads to an increase in the basal tone of the uterus, which may lead to a tetanic contraction - lasting over 90 sec - with the risk of decreased uteroplacental blood flow and fetal hypoxemia (lack of oxygen).

2. Women are more likely than men to have gallstones. Pregnant women are at an especially high risk because their bodies are making more estrogen. Added estrogen in the body can lead to an increased amount of cholesterol in the bile, while also reducing gallbladder contractions. Doctors call the slowing of gallbladder contractions during pregnancy cholestasis of pregnancy. This means bile doesn’t escape the gallbladder as easily. Cholestasis of pregnancy is associated with increased risk for pregnancy complications. Examples of these complications include: passing meconium (stool) before birth, premature birth, and stillbirth.

Danielle Johnston has been married going on five years, this fall. She has two beautiful daughters (three, and nearly a year) and loves all things arts and crafts. She is super excited about building a Montessori learning environment in her home and being an active teacher in her kids’ lives. ✯
Ten years ago I was fifteen years old, standing in the girls’ bathroom in my high school, staring down at a positive pregnancy test. I wish I could describe the emotions associated, but honestly it was just shock. Was I happy? Was I scared? Was I ready? No, to all of that. I was just in shock.

December 3, 2008: My mom was the first phone call I made. It did not matter what state my relationship was like with her, she was my go to. She was my safe place. She was my rock. Now fast forward ten years later, I am that person for my daughter, but this story is not about that. This story is about how I got to the point of being called Mom at such a young age.

My boyfriend at the time was my first love. I had given him my virginity. One month after this event (which was a big moment in my life at the time) I discovered that sex is not just sex. Sex is not just loving someone. Sex is not just satisfying those crazy hormones that take us over. Sex is not just about making yourself feel loved when you need it. The simple act of sex can alter your life forever... and create an entirely new one.

I found my best friend in the halls and we left school (with permission) to go to the clinic. I needed to find out what the next step was.

When I got there, being so young, the first set of pamphlets I was handed were all about my ‘options’. Did I want to give this baby up for adoption? Or the scarier option for me... abortion? I was presented these options like they were the only logical ones. It upset me. Looking back now, I understand. This fifteen year old girl walks into the medical clinic with no parents by her side or money in her pocket. Keeping this baby was not an option in anyone’s logical mind.

Now let me tell you the best, but weirdest, part of this experience: as the shock began to wear off, happiness and excitement set in. I thought I was crazy for being happy about this. Do not get me wrong, I was scared, but I was happy. So I knew immediately that neither of these options were for me.

Fast forward to me, nine months pregnant, living in my mom’s basement, trying to make a long distance relationship with my boyfriend work, and coming to terms with the fact that very soon I was going to be a mom. The pregnancy in itself was difficult: morning sickness, and the aches and pains of my body shifting to grow this little human. All in all, though, it was a healthy pregnancy. I was healthy and my baby was healthy. My baby. Just the words made me feel weird. I had trouble wrapping my head around it. I did not see myself being a mom. It was not until the moment I held her in my arms, that I truly knew what that felt like. You can try to prepare your brain and your emotions, but it’s nearly impossible to do so.

August 16, 2009, 7 a.m: I was laying on the hospital bed in the Wetaskiwin Labour and Delivery ward, with the monitor strapped to my midsection. I had been there so many times already since I was unsure about any little pain that came my way. Every little cramp, every sharp jab, every time a muscle tightened... was this it? It never was. On this morning the doctor was inducing me. I was 41 weeks and had been told by my doctor it was time for an induction. I was not given other options, and was too young to know they existed. I trusted my doctor. With my mom and my boyfriend by my side, I was preparing for my life to change forever.

8 a.m: The doctor came in and explained the Cervidil® process to me. I did not understand anything he said but I trusted him. He said it could take hours, or even days to take effect. I felt my heart drop. I did not want to wait anymore. I had already...
waited nine months. They inserted the gel ring and then left the room.

8:15 a.m.: I was in pain, real pain. I cried out to the nurse. I gripped my side with tears in my eyes. “I am in a lot of pain. Is this normal?” I cried.

“Yes of course. Your body must have been ready to go into labour. Those are contractions you are feeling.” She seemed slightly annoyed at my crying dramas. Yet, I was scared! She did not comfort me, she simply said it was normal and left. I cannot even explain the fear I felt in that moment. The doctor made me think I had more time. So I felt like the pain I was feeling was not typical and that something was wrong. I held my mom’s hand and let myself cry.

9:30 a.m.: The doctor came in to check the monitors and my progress. I was only 2 cm dilated, but baby was doing great. He told me to go home and get some rest. He instructed that I come back in the afternoon or when the pain got unbearable.

I went home and laid in bed with my boyfriend. The contractions were still painful but I was exhausted. I managed to sleep until 2 p.m. I woke from an extra painful one. I called out to my mom and she suggested a bath. I sat in the tub for about thirty minutes. It helped a lot. The warm caress of the water relaxed my body as the contractions came and went. It was not long until we all decided it was time to go back. By this time my Mom’s best friend (my auntie) showed up. So now it was four of us going back to the hospital.

3 p.m.: I was back in the bed and on the monitors. I was 5 cm dilated when the doctor checked. He said it could be quite a few hours before I was ready to deliver. The pain was so much that it really made me sad. I just wanted this to be over. The doctor then decided to break my water. I remember being in disbelief on how much water came out of my body. It was then that I also decided I wanted an epidural. I did not want to be in that much pain for hours.

3:30 p.m.: The doctor checked me one more time before leaving. All of us were quite shocked to discover I was already 8 cm dilated just minutes after breaking my water. They decided it was time to bring me to the delivery room. The anesthesiologist still had not come with the epidural. It was then that my sister showed up with her video camera. The delivery room was full of my closest people. I was contracting hard and praying for the doctor to show up with the epidural.

4:30 p.m.: When the anesthesiologist finally showed up, I was almost 10 cm. They still gave the epidural to me, surprisingly. It was the biggest relief I had ever felt. Now, it was time to push. I pushed for almost an hour. The doctor thought it best to try the vacuum as the baby seemed stuck under my pelvic bone. I did not disagree or argue with anything he suggested. After all, I was a mere sixteen year old girl and he was a professional.

5:23 p.m.: After the most exhausting hour of my life, my baby girl was placed on my chest. I remember looking down at her little crying face and thinking, “Wow. This is her? She is pretty funny looking.” I look back now and laugh at my reaction. I do not think I really knew what to expect at all. It was still such a beautiful moment. They cleaned her, weighed her, and wrapped her up. I felt her in my hands and kept thinking, “Man, I cannot believe she was just inside of my body minutes ago.”

I studied her face and soaked in the feeling. I cannot really describe what it was I felt. Shock again, maybe.

Within an hour the room was filled with family and friends wanting to meet her. She was the first grandbaby born on both sides of the family. I felt so much love in those moments.

Now ten years later, I watch my little girl load the dishwasher and help cook dinner. I watch her play with, and help take care of, her siblings. I look at her in awe and disbelief every single day, not believing that, at one point, she fit in my hands: a mother of five children. Her hobbies include: editing for Birth Issues magazine, crochet, yoga, and reading. She is fascinated with all things baby and birth! ☺️

Editor’s Notes:

1. Instead of an induction, a woman could choose to wait, likely with the recommendation for a non-stress test (NST) which is a type of monitoring. It is a simple, non-invasive test performed at the hospital. Although fetal risks are still very low, the Society of Obstetricians and Gynecologists of Canada recommends regular NST after 41 weeks pregnancy to make sure baby’s oxygenation is optimal.

2. Induction with Cervidil is when your labour is artificially started, using a synthetic gel to ripen the cervix and then synthetic hormone to make the uterus contract.

3. Breaking the bag of water, also called rupturing the membranes, is when the bag of water, which is the membranes surrounding your baby in utero, breaks. Since the artificial rupture of membranes (AROM) can increase the risk of infections and increase the intensity of contractions, some women prefer to keep their membranes intact as long as possible, or to squat during a contraction to naturally break their own membranes.

4. Epidural medication is a narcotic used to block the sensation of pain and can be used to help someone cope with the intensity of childbirth. It is associated with increased risks. Staff may taper the epidural off, or choose not to recommend one, near the end of the first stage of labour before pushing begins; this is because it may slow the contractions, relax the pelvic floor and impede the baby’s ability to rotate through the birth canal, and can hinder the mother’s ability to push effectively.
A CHILD’S-EYE VIEW OF BIRTH

By Jesslyn Bell

We were approaching midnight on February 6, 2019, in St. Albert, Alberta. My eight-year-old daughter watched as the midwives took turns breaking up the scar tissue on my cervix (a LEEP procedure1 years earlier had left some damage), and then broke my water with what looked like a long crochet hook. Speckled brown liquid flooded out onto our bed, and my daughter explained that she probably would not have to do this kind of thing once she became a vet, but she was glad she was getting to see it happen. Her little sister’s due date had come and gone. Contractions would pick up every evening and be gone by morning, and the 42-week mark was looming on the calendar. This was our last attempt at getting the birth we wanted before venturing into more medical inductions.2

I had been dreaming of a homebirth for years: delivering our baby, with my husband and our sweet midwives by my side; showing my daughter that birth could be both natural and safe. She did not think twice about telling everyone that we were having a baby at home, and she was unfazed when an adult at her school told my daughter that this woman would have died if she had a homebirth. Her dad and I had gone out of our way to normalize this kind of birth, and she did not have any concerns about it.

When it came time to deliver my own child, I asked my mom if she would film it for me. I wanted her there, naturally craving the comforting presence of the woman I was closest to. The video she shot is amazing and raw: my daughter crowns, there is blood and confused pushing, meconium in the fluid, suctioning, and the expulsion of a pink baby into the hands of an obstetrician. The video ends with the first cries of new life and the first cries of a new grandmother, overcome with seeing her grandchild being born. My daughter and I have watched that home movie many times throughout her life.

Now, thanks to Youtube, Instagram, and birth photography, we were able to watch birth videos to prepare my daughter for her sibling. As soon as she accepted our offer to have her present at the birth we made sure to see many different kinds of labour experiences. She felt comfortable with our midwives and helped prepare our home for the new arrival, painting a giant “welcome” banner to hang above the birth pool. Her involvement in things was voluntary, though, and once my water was broken she skipped out of our bedroom and booted up a computer game in the office across the hall. Our midwives left the room, and, in the dark, with just my husband there, things progressed quickly. Three hours later, I clawed at the floor, vocalizing loudly, feeling out of control. I worried that my daughter was anxious, but she was happily playing her game, totally ignoring the strange sounds I was making.

I entered the warm water in the birth pool and it was not long before my groans turned to loud growls and I was bearing down. I had been at 6 cm about 30 minutes earlier, and I thought it might be too early to push, but the midwives assured me, “Listen to your body!” My experience with this labour had been fairly out-of-body so far, and this stage was no different. I was not aware of my family or what any of the
midwives were doing. I was deep in the birth realm. At 2:06 a.m., three hours after my water was broken and 12 days after her due date, Clover joined us. I pulled her up out of the water and held her to my chest, and I heard her cries mix in with the loud, emotional crying of a new big sister. “Shhh,” I whispered to them both and kissed my oldest daughter.

The next day, as we lingered in the glow of birth and small new family members, we discussed the events of the night before. Big sister disappeared into her room and came back with her digital camera. She had filmed me giving birth—just as her grandma had eight years earlier—and, taking a cue from the midwife, she had put her camping headlamp on her head as well: lighting! We had loosely discussed filming the birth but had not settled on who would do it. The footage is a child’s eye view of a labouring mother and the birth of a sibling. It is fearless, focused and calm, and everything I hope for my daughters if they decide to have children. This home video is helping us to write new family legends and is just one example of what a child can contribute to a birthing space.

Editor’s Notes:

1. LEEP procedure uses a loop of heated electrical wire to remove abnormal cells from the cervix. It is used in order to screen and prevent cervical cancer.

2. Although fetal risks are still very low, the Society of Obstetricians and Gynecologists of Canada recommends regular non-stress test (NST) after 41 weeks pregnancy to make sure baby’s oxygenation is optimal. The Society of Obstetricians and Gynecologists of Canada (SOGC) recommends an induction ten days after the due date. Inductions pose their own risks and have been associated with an increased use of other interventions as labour progresses. To read more on this you can look for our Spring 2016 issue of Birth Issues: https://birthissues.files.wordpress.com/2016/09/1604-birthissues-spring2016-web.pdf.

3. Sometimes, even with a birth that is a family legend, it can happen that all the members of the family know the birth, yet no one really knows the details of the birth. In this case it is hard to say what drugs were offered to the mother, if it truly was an emergent need and if so what it was, or what exactly were the reasons for the forceps delivery and blood loss. Assumptions could be made, but they are not as useful without knowing the details of what was discussed between the medical staff and the ‘grandparents’ of this story, or how the labour and delivery progressed. Certainly not all posterior births are met with forceps and blood loss, but it can be true that they become longer labours with a more intense contraction pattern that can be harder to find relief or control through. Posterior babies – when the baby is head down and facing the mom’s stomach – can take longer to come down into the birth canal and can be seen as stuck if they enter in an unfavourable position, particularly if staff are not skilled in releasing this stuck position and encouraging a more beneficial fetal position. Impatience by medical staff could lead to an offer for Pitocin, or a worrisome bleed could lead to the same recommendation. Forceps or a posterior position could lead to a severe tear and blood loss, but a sudden need for “drugs”, a swift delivery, and fainting from blood loss could also be signs of placenta previa or an abruption (when the placenta covers the cervix and tears during dilation, or another tear or detachment of the placenta occurs).

Jesslyn Bell is a mother to two girls and wife to one handsome guy. She is currently certifying to be a doula and immersing herself in the birth culture of Edmonton, AB. Her hobbies include having children with a huge age gap (eight years), watching re-runs of Law and Order, and wiping up baby puke.
MOTHERS AND DAUGHTERS:
A MULTI-GENERATIONAL HOME BIRTH

By Kaitlyn Breederland

Leading up to my second homebirth, at the beginning of February 2019, I decided to allow both of my daughters into my birthing space. I have always loved the idea of having our girls getting to meet their new sibling right away and spending those first few hours together as a family. I also wanted my daughters to grow up knowing that birth is normal and not something to be feared. This choice was met by more than a few skeptics, who could not understand why we would want our children to be present and who feared that the birth would be traumatic for them. In my heart, I knew that it would be a beautiful moment for them to be a part of and that the positives would greatly outweigh any potential inconveniences.

This was the second time for my five-year-old, Zelena, who sleepily attended the birth of her little sister two years prior and who still fondly remembers the experience. It was, however, Aliza’s first time attending a birth and it was her I was most concerned about. I was mostly worried that she would be in the way and that she would disturb my birthing space. In the end, all of my worries were for naught, as she did amazingly.

We spent the weeks leading up to their baby brother’s birth by watching birth videos online and talking over what was likely
to happen again, and again. I prepared them about the noises that I might make, “It is okay if mommy makes lots of noises. I am not in danger, just doing some hard work.”

The girls also did their own preparation. They spent days talking to, and praying for, their little brother in my womb. Having Aliza, the two-year-old, kiss my belly and say, “Love him already!” is one of my fondest memories of this pregnancy. Leading up to the birth, I felt that the girls were well-prepared for what was to come.

My mom also attended my birth. This was also her second time attending one of my births and she knew that her job was to help take care of the kids, make sure everything stays tidy, and keep everyone fed. She also prepared extra this time by reading birth classics such as Guide to Childbirth by Ina May and The Birth Partner by Penny Simkin.

On the night of the birth, everything went as planned. I wanted early labour to be quiet and intimate, with just me and my husband, before everyone started to arrive. When contractions started picking up, my mom came over, helped me make the bed, and helped my husband set-up the birth pool. We let the girls stay asleep at first until my birth noises woke them up. Little Aliza waddled sleepily out to the living room to cuddle with her grandma on the couch.

Zelena, on the other hand, was much more down to business. She is very familiar with my work as a doula and with me leaving in the middle of the night to go support a woman in labour. When I would come back from births, she would ask me to recount the experience and tell her the new baby’s name. Throughout my whole pregnancy, she talked about being my ‘mini-doula’, and that she was. At some point during the labour, she donned a frilly white apron from her dress-up box and can be seen in my birth pictures holding my water bottle ready to step in when needed. I have memories of her sweet little voice saying, “Good job mamma, you are doing great.” Zelena has such a caring and compassionate heart. It gave me joy knowing she was there.

Eventually, Aliza warmed up to her surroundings. She would come over and stroke my face and kiss me in-between contractions, saying “It is okay mamma, it is okay mamma” over and over. She would then wander off to play with Duplo, coming back whenever she desired.

Never once were the girls an inconvenience or a burden. Instead, they were little reminders that I had birthed before and came out the other side with the loves of my life; I would do it again with the same outcome.

My mom remained bustling in and out of the background, reminding me of times gone by, as she boiled pot after pot of water to keep the birth pool warm. Having her there made me feel like a little girl being taken care of. She was a reminder that she too had gone through the birthing process and could empathize with me as she reflected on the memories from her own four births.
Then, just as suddenly as the times before, he was here. Our first boy, Augustine Wesley, was born in the early morning of February 7, 2019, with three generations witnessing the birth of new life and a new family member: grandma and sisters instantly in love with a tiny squishy new human.

I do not regret having my daughters at my birth. I drew strength knowing that I was surrounded in love by the woman who birthed me and by the future women whom I had in turn birthed.

Even if the girls do not remember this experience, it is my deepest hope that they know that birth is not something to fear and that they can carry that knowledge deep in their hearts when the time comes for them to have their own babies. I hope they pass that knowledge on to their daughters. I hope to create a family line of women who are not scared of birth, but enter into it knowing they are strong and capable and made to do this just like the women before them.

Kaitlyn Breederland is a wife, mother, and doula from Edmonton, Alberta. She has two girls, a new baby boy, a crazy black lab, and a nerdy husband. She is constantly going back and forth between her desire for minimalism and her love of thrift store shopping. ✿
In preparation for the birth of our firstborn son, my partner Jerome and I did so much research and preparation with the goal of an unmedicated birth. I raised the idea of hiring a doula, but my husband had some uncertainties about having a ‘stranger’ in the room. A few days later, he told me he had been thinking about it, and had come up with a perfect solution, “We should ask your mom to be there with us.” He felt that she knew me better than anyone else in the world, and that she brought wisdom and experience to the table, having birthed four babies herself. At first I was resistant to the idea. I felt like it meant I would also need to invite my mother-in-law into the birthing room, and I was concerned about my birth experience becoming a performance. Jerome was quick to reassure me that he just wanted it to be us, the midwife, and my mom. The more I thought about it, the more I realized I did really want her there. It stirred my heart to know that my husband wanted her there too.

The next order of business was to propose it to my mom. Although she knew we were under the care of midwives, and that we were planning a hospital birth, we had never discussed much about the concept of a doula, or her thoughts on being
present for the birth. Weeks passed as I mulled it over. Was it too much to ask of her? At the time, we lived in Calgary and she lived in Edmonton. I worried it was a lot to ask her to be ‘on-call’ to drop everything and rush to Calgary to be with us. I also knew she herself had not asked her own mother to be there for my birth, or the births of my siblings, but I had never asked her why. Was it because she thought birth should be private? Was it because she did not have as close of a relationship with her own mother as I felt I had with her?

I spoke with several friends about it and got all the same responses. “I would never want my mom there. What if I yell or swear? I would not want to be naked in front of her.” It came up at work, and two co-workers who were my mom’s age agreed that they hope their daughters never ask them to attend the births of their grandchildren because they would feel obligated to say yes, despite not wanting to be there. One said that she was too scared of the possibility of witnessing something go wrong and the other said she would rather wait in the waiting room and come meet the baby afterwards, because it would hurt her to watch her daughter experience pain. No one I talked to thought it was a good idea to ask my mom to be there for my baby’s birth, but I could not shake the feeling that I wanted her there.

Near the end of third trimester, I was visiting my family in Edmonton and on an impromptu trip to Winners together, I gained the courage to just outright ask her. We were sitting in the car together before going in, and my heart was pounding. I blurted it out much less graciously than I had planned. Without hesitation, her face lit up and she said she would be honoured to be there with us. To this day, I remember the relief I felt when she said yes.

In the weeks that followed, she asked me what she could do to prepare. I told her I had been reading a book I had borrowed from my midwife called Natural Hospital Birth by Cynthia Gabriel, so she went out and purchased it too. I flipped through her copy later and saw she had highlighted, underlined, and written notes in the margins. She would often tell me that she was excited to be there. She repeatedly insisted that I phone her the minute I think I might be in labour, even if it was the middle of the night. She came to Calgary on more than one occasion to attend midwife appointments with me and hear the heartbeat of our baby, who we had affectionately nicknamed Ducky.

On April 1st, 2016, at 39+ weeks, we drove up to Edmonton so my husband could attend my brother’s bachelor party. I tagged along to spend some time with my family, one last trip before the baby. I was convinced that I would be going into labour around 41 weeks, so when I awoke to cramping around 2 a.m. the next morning, I chatted it up to Braxton Hicks contractions and tried to rest. By 6 a.m. I could not sleep, and a hot shower had not resolved the cramping. I decided it was best if we packed up early and drove back to Calgary just in case true active labour started in the next few days. Still convinced it was pre-labour, I insisted my mom stay home and I would call her in the next few days when things really got going. By ultrasound, our ‘guess’ date was April 6, so I was sure I still had days or even weeks to go. We left Edmonton around 8 a.m.

The drive back to Calgary was uneventful. I drove to keep myself distracted and focused on the road instead of the cramping. When we stopped in Red Deer for a bathroom break around 9:30 a.m., I felt a significant leak of fluid when I got out of the car. I wondered to myself, could this be my water breaking? As I drove the final 30 minutes of our trip home, I could no longer talk to Jerome through the ‘cramps’, which I was now beginning to realize may be true labour contractions, and was vocalizing in what he graciously calls a, “low-pitched humming”. By the time we got home around 11 a.m., I abandoned the denial I had been in and phoned my mom to tell her I thought this might actually be the real deal. She literally dropped what she was doing and got on the next bus to Calgary. She was worried she would be too excited to drive, and thankfully there was a bus leaving shortly.

After arriving at our house and finishing on the phone with my mom, I phoned the midwife to let her know this might be the real thing. She encouraged me to try the shower or a warm bath and to try and rest if possible. We went upstairs and laid in bed and tried to watch a nature documentary to stay distracted and try to rest, but I was not comfortable lying down and found the contractions more difficult to manage in that position. I decided to try a shower where I tried numerous different positions to find what felt best. Being on my hands and knees worked briefly, but after a couple of contractions, I found that position too intense. I got out, dried off, and asked my husband to phone the midwife again. My contractions were definitely changing in intensity, but remained very variable in terms of length and frequency. Sometimes it would be a long 90 minute contraction with only a 30 second break. Then a brief 15 second contraction with a four minute break. The passing of time was immeasurable to me.

I remembered being told by my midwife that some people find sitting on the toilet comfortable during labour. She had said our bodies are so conditioned to being relaxed when we sit on the toilet. I decided to try it and found immediate relief. For the next few hours, I alternated between sitting on the toilet and swaying back and forth while leaning on the bathroom counter. My ever-present helping husband offered me pineapple juice and words of affirmation regularly. At some point, the exact time has disappeared from my memory, I stood up to change positions and Jerome noticed some blood in the toilet. Concerned, he phoned the midwife again. After asking him a few questions, she reassured him that it was likely related to cervical changes and should be seen as a sign of progress. She encouraged him to offer me something to eat to keep up my energy and said she would send the on-call midwife to our house to check on me, as she herself was just finishing up with another birth. I did feel hungry and asked him to warm up some soup, but when he brought it to me,
suddenly felt too nauseated to eat it. He sat on the ledge of the bathtub to be close to me and ate his soup.

An indeterminate amount of time passed, and I decided I should probably get downstairs at some point. Vaguely at the edge of my mind, I remembered being told by our childbirth educator that doing stairs can help open up the pelvis somewhat to help the baby ease into a desirable position. Once downstairs, I made my way to the main floor toilet for a few more contractions. The on-call midwife appeared in the washroom and observed me through a contraction, encouraging me quietly. She helped me back to the sofa and asked if I wanted a cervical check. Initially we had decided we wanted to avoid cervical checks, but I had reached a point in my mind where I was quite convinced I was not making progress due to the variability of my contraction lengths and frequencies. I decided that if I was less than 6 cm, a completely arbitrary number I landed on in my head, I wanted to go into the hospital and get an epidural for the remainder. I felt good about my efforts, but also was finding myself feeling like I was hitting a wall – feeling exhausted and like I could no longer continue on. I expected to hear that I was at 3 cm, maybe 5 cm if I was lucky. We were both shocked to hear the midwife say that my cervix was about 9 cm dilated with a tiny cervical lip remaining. She advised us to get in the car immediately if we were still set on a hospital birth, but gave us the option of staying home as well. I was unprepared to make changes to our plan in the throes of transitional labour, so we got in the car.

Throughout this labouring time, Jerome texted my mom on her bus ride to Calgary his questions and updates, and she replied with encouragements, prayers, and reassurances. He still recalls feeling so grateful for her support to him. She arrived in Calgary at about 3:30 p.m., just as we were leaving home to go to the hospital, so she took a taxi to the hospital to meet us there.

I was very deep in the end of transition when I arrived at the hospital around 4:00 p.m., but I distinctly remember how it made me feel to hear my mom enter the room a few minutes after we did. I had just been given the go-ahead by the midwife to push when I felt ready, and was feeling a combination of fear, uncertainty, and hesitation. My eyes were closed, so I did not actually see her, but hearing my mom’s voice made me feel grounded. I sat upright in the bed to push. She came to my side and encouraged me, offered me sips to drink between contractions, stroked the hair off my forehead. I only opened my eyes one single time during pushing, and it was when the midwife offered to show me my baby’s face using a mirror. I will never forget that crinkly purple face capped with a thick black head of hair. I closed my eyes again, ready to push out shoulders and find out whether we had been blessed with a boy or a girl.

My mom cried with us when Samson was born at 4:26 p.m., 7 b, 13 oz, and 20.5 inches long. Then my mom left to the waiting room to give us our “Golden hour” to bond together. When Jerome called her back in the room afterwards, he handed over her swaddled up brand new grandson and snapped the first photo of Samson and my mom together. It remains one of my favorite photographs of that day. Other than my husband and me, she was the first, and only, to hold him before he ever wore clothing. She was the first to wash his hair. The first to love the name we chose.

Over the next two weeks, she lived with us and helped us immeasurably. She did all of the laundry, cooking, cleaning, grocery shopping, pharmacy runs, and appointment rides. She took care of literally everything so that we could rest, and bond, and heal. I can confidently say, and my husband would
wholeheartedly agree, our experience was so much better with her alongside us. Shortly after Samson was born, my extended family drove to Calgary to meet him. One of my young cousins asked my mom why she was staying with us. I remember my mom’s response so clearly. “You know how Samson is Sarah’s baby? She is taking such good care of him, right? Feeding him and making sure he is warm and comfortable and doing lots of cuddles? Well, Sarah is my baby. So I am taking care of her too.” I have never understood the depth and breadth of my mom’s love for me, until experiencing that feeling towards Samson. It was in that moment that I suddenly realized that this unfathomable love I felt for Samson was exactly how my mom felt, and still feels, about me. She has told me countless times that she loves me, but until I experienced the feeling for myself, I did not truly understand. In every way, we are so grateful to have had her there with us as we welcomed our son into the world, and as we embarked on the journey of parenthood.

Almost two years later, we had moved to Edmonton and were preparing to welcome a second baby. There was no doubt in our minds we wanted her there again. After copious research and many discussions with our new midwife, we decided to plan a midwife-attended waterbirth at home. My husband and I are both healthcare providers, so we were met with significant questioning and disapproval from our peers about that decision. Even some extended family expressed disagreement. Some people were concerned it was unsafe to birth at home, others were concerned about the safety of waterbirth. We were always happy to share the research we had come across, showing that out-of-hospital birth is safe and has very similar outcomes to hospital birth1,2 and that waterbirth may be linked to lower incidence of perineal tears and has similar outcomes to land birth.3,4 My mom and dad, however, were quick to support me birthing wherever I felt safest and most confident.

On January 22, 2018, I was 39+ weeks with an early ultrasound-based guess-date of January 27, 2018. We decided it was a good day to test out setting up the birth pool so we would be ready when the baby decided to come. I wanted to have my Oma and Opa over for dinner that night, one last time before the baby came. After dinner, Jerome set up Rummikub, one of our favorite games to play with my grandparents, and I went upstairs to put 22-month-old Samson to bed.

Around 8:00 p.m., as I sat cross-legged on the floor in Samson’s room, I thought I felt or heard a distinct ‘pop’ near my pubic bone. I did not feel any kind of fluid gush, so I thought maybe my symphysis pubis had finally given out or that my hip joint had settled oddly or some other strange pregnancy-related phenomenon had occurred. I went downstairs after settling him in bed, and sat down to play Rummikub. After a few minutes, I stood up to go to the washroom and suddenly the fluid gush came. I calmly informed my grandparents that after this round of Rummikub, we probably would need them to head out as I thought my water had possibly broken.

I texted my mom, our midwife, and our doula (in that order) to let them know that I thought my water might have broken, but I was not having any contractions or cramping. No one could focus on the game, and within half an hour, the contractions came on hard and fast. My grandparents left, and I texted my circle of supporters again to let them know contractions had now started. Jerome lit some candles and put on some relaxing music, then cleaned the kitchen and set up the birthing pool.

My second labour was different from the first labour in some ways, but similar in others. I again craved pineapple juice. My contractions again never became ‘regular’ and remained variable in terms of length and frequency, though their intensity increased consistently. I again used low pitched vocalizing and swaying to work through contractions. I
again kept my eyes closed for the bulk of labour. The main difference was the intensity of the contractions. Our midwife theorized it may have been related to the fact that my water broke early in labour, so the amniotic fluid cushion between the baby’s head and my cervix was gone. My support circle included Jerome, my mom, our midwife, and our doula. We had first hired a doula, early on in the pregnancy, in case we needed extra hands to help with Samson around, seeing as you could never predict at what time you will go into labour or how long it will take. My mom arrived first, around 9:00 p.m., followed closely by our midwife and doula. Each contributed positively and uniquely to our experience.

My memory from about 9:00 p.m. onwards is vague and foggy. I felt somewhat disconnected from what was going on around me, buried deep within myself. I leaned against the sofa and swayed between contractions. During contractions, I got the most relief from Jerome squeezing my hips hard on either side. I got in the pool reluctantly at 10:25 p.m., not wanting to use the pool so “early” in labour. Just after getting in the pool, I heard Jerome say to the midwife something like, “It looks like we are going to be having a baby tomorrow!”

The midwife replied, “Actually, I believe we will probably be having a baby today still!” I remember feeling confused by that exchange, as my first labour was about 14 hours from first cramp to placenta being born, so I was sure that I still had quite a ways to go. The contractions had escalated significantly though, and I was desperate for the relief I hoped the birthing pool would offer. It was everything I imagined it would be. The water was warm and soothing, the pool bathed in candlelight and nestled near the fireplace. The contractions still came, and were still intense, but I found myself able to relax completely and rest between them once in the pool. I stayed on my knees in the pool, arms draped over the side. Everyone held quiet space for me while I laboured.

At 10:42 p.m., just over two hours after contractions had started, I suddenly panicked. I felt as though my body was involuntarily bearing down. I remember being scared and wanting to slow down, crying out to the midwife, “My body is pushing and I cannot stop it. I am trying so hard not to push!” She quietly told me to just let my body do the work and to do my best to just breathe. My mom reminded me that God had made my body to do just this. I remember a brief moment of stinging at my perineum, then incredible relief at 10:45 p.m. as Joel was born into the water, at 8lb, 2oz, and 20.5 inches. I felt bewildered and amazed as I reached down to pull him up out of the water. He came immediately to my chest and someone passed me a towel to cover him with. The placenta came on its own about 30 minutes later.

As in the birth of our first baby, my mom formed a vital part of the circle of support around us. She was a calming presence while I laboured, offering me pineapple juice when I needed it, encouraging me, quietly folding towels when I needed space to work through a contraction, brushing hair off my sweaty forehead. She was again the first to hold Joel, other than me and my husband: the first to love the name we chose, the first to share our joy.

I will never be able to express in words the strength and confidence I drew from having my mom with me when I birthed my sons. My husband echoes my gratitude and says it made him feel so much less anxious to have my mom there to offer support and reassurance. We both agree that if we are ever blessed with the opportunity to bring another baby into the world, we hope she will be there.

Editor’s Notes:

They would whisper behind my back, but just loud enough that I could hear them calling me a slut. They would give me dirty looks or, worse, not even look at me at all.

It was my fault. “Way to ruin your life” they had no problem telling me to my face. You see, at 18, I had already been living on my own for three years. Although I made some efforts to continue high school, I did not end up getting all my credits to graduate. I was working as a server in the restaurant and bar industry, which was a breeding ground for substance abuse for me; however, I thought I was being responsible. I worked hard and paid my bills, so it was okay to party. It seemed everyone else was doing it.

Exactly two months after my 19th birthday, I had a rude awakening into the train wreck my life was becoming. I was in a complete downward spiral. I got fired from my job, my roommate moved away, and the morning of July 5, 2006, after having missed my period, I took the test that changed everything... I was pregnant.

I was now a statistic, “Pregnant teen”: burden to society and, according to popular belief, I did not have a chance at being a good mom.

Teen Pregnancy Worldwide

16 million girls ages 15-19 give birth each year.

Global birthrate among girls 15-19 years old, is 49 in 1,000.

3 million girls age 15-19 have unsafe abortions every year.

The father, also young at only 21 years old, did not think we should keep the pregnancy. My friends and family talked of all the heartache and challenge it would be if I chose to go through with it. Of course, word spread quickly amongst our industry, and I became the one everyone was whispering about. I wanted to maintain my relationship with the dad and I knew keeping our baby would be the end of it. I felt like I did not have a choice. I called the Morgentaler Abortion Clinic in Edmonton and booked myself an appointment for August 29, when I would already be 14.5 weeks pregnant.

As soon as I hung up the phone, I grasped a bottle of Yellow Label cabernet sauvignon, tears streaming down my face and
Individual Risk Factors for Teen Parents

- Single parent home
- Living in a home of family conflict
- Early sexual activity
- Early use of alcohol and drugs
- Low self-esteem
- Being the victim of sexual abuse
- Negative attitudes towards using contraception
- Poor School Performance

Within minutes of falling asleep, my body started revolting against me. I quickly ran to the toilet and, quicker than I got it into my system, the wine was back out of me. I laid on the checkered linoleum floor, my body still abruptly trying to rid itself of any of the last poison I was trying to feed it. My stomach pain was so intense and did not subside for hours, forcing me to realize that I was torturing my own flesh and blood.

Was that a mistake? Was that really what I wanted? I knew I needed to get out of the world that I had created for myself and find some time to breath and really contemplate what I wanted for my life.

I packed my bags and booked a bus ticket. I woke up early the morning of August 6 to catch my Greyhound bus to British Columbia to meet up with my sister at a music festival nestled in the Kootenay Mountain range. Removing myself from my own reality, surrounded by mountains, trees, and water was exactly what I needed.

As we set up our camp for the weekend, I met a friend of my sister’s: Charlotte, a beautiful blonde 23-year-old woman, who had her daughter, Cora, at my age and was a single mom, raising Cora all on her own. She told me how everyone said it would be so hard, but she reassured me that it is easier than ‘they’ say and even more worthwhile. “Being a mom has given me more love than I could have ever imagined. I often cry as I watch her, so overtaken with love I cannot contain it” she told me. It was music to my ears.

I realized then that age does not determine our capacity to love our children.
That weekend, I dreamt of her, my baby, and it really was her in my dreams. I would wake up each morning, walk down to the edge of the sparkling Salmo River where the music festival was located, and I would journal and imagine my life with her. On the last day there, I threw a stone into that river and I wished. I wished that my baby would grow up to be happy, healthy, and free. I knew right then and there that she was mine, and we were going to do this together, that I would get my life back in order and, against all difficulties, I was going to be a good mom.

The odds were stacked against me.

According to stats,

“Nearly one million teens have babies every year and of these almost seven out of ten will drop out of school before completing high school. Less than 2% of teen moms go on to get a college degree. 80% of women who have babies when they are teens spend at least part of their life dependent on welfare, and they have serious disadvantages in achieving financial success and independence in life, largely due to their lack of education. Their children are also less likely to succeed in school and financially.”

I wanted to be a good mom. I knew I would have to get a job. In fact, I got two. I was a receptionist at a tanning salon by day and a server by night. I also knew I would need to get my high school diploma to have any chance of a financial future. So, with the help of my mom and sister, I started researching options for that. I got a new roommate to help me with my bills. I started to realize the relationships that were harmful in my life and those that were supportive, and I began to choose a little more wisely the ones I kept. I was finally feeling like my real self and back on track.

As my belly got bigger, I really noticed the stigma against young mothers. “Are you even old enough to be a mother?” strangers would ask. My only logical response being, “Obviously” and I would gesture to the belly that they clearly already knew existed. Statistically speaking, I barely had a chance, but the rest of society was not helping make it easier.

At my seven month appointment with my obstetrician, after fighting off stares for three hours in the waiting room and finally sitting in my own private room, my doctor came in, barely removing her hand off the door knob, because, well, she really did not seem to have any time for me. I told her that I was going back to school the following month to work towards getting my high school diploma. She looked at me with pity in her eyes and said, “Oh? You will not be able to do that. You really have no idea what this is going to be like, do you?” Then she quickly rushed through the rest of our appointment, brushing off any questions I had. Frustrated and angry, I left her office.

“She does not even know me” I thought. “Why does she think I cannot do this?”

That was the kind of situation I was becoming more, and more accustomed to.

Despite it all, I did start school the following month at Braemar School. I was waking up at 6 a.m. to take the bus for an hour across the city to a school for teen moms, being sure to hide my belly in my big winter coat for any chance of avoiding awkward, dirty looks from the other passengers.

When my beautiful daughter, Kaia, was born on March 2, 2007, I was in love. Everything that happened until that moment had been worth it. I devoured her with all my senses. She was perfect.

I was allowed to take two weeks off with her but, after that, needed to go back to school to keep my funding which allowed me to attend and meet my basic living expenses. We would bus together, go to class together, and it became her and I against the world.

Being a single mom, raising her on my own, and going to school was a challenge! As a teen parent, the bigger challenge was feeling the need to prove to society that I was good enough. Parenting is hard enough without feeling judged for your every move.

To make matters worse, I actually had no idea what I was doing. No one told me I needed to bring diapers to the hospital or that everywhere on my body was going to leak or that poop explosions are a thing to arm yourself for. I know now that as new parents most of us, no matter our age, really have no idea what we are doing. I wish someone had told me that.

I loved going to school with Kaia. At school I was normal. I was actually one of the oldest moms attending: my peers as young as 14. The girls at the school were so inspiring, generous with their knowledge from their own experiences, and we all
learned to navigate early parenting from each other and the supports offered at the school.

At Braemar, I felt like a good mom. To my shock, some of the moms would ask me questions! I could breastfeed in class, and I was getting really good grades. My Biology 30 student teacher pulled me aside after class one day. She said, “Jill, what are you doing after you graduate?” I told her I wanted to become a massage therapist and start my own business. She said, “Jill, you are really smart. You know that, right? You know you are capable of anything that you want to do. Make sure you never settle. You got this!”

I was different. I was not going to be one of those negative, “Teen mom” stats. I graduated that June with Kaia in my arms, with my peers and their babies by my side. We did it; but why was I different?

For me, having Kaia motivated me. Maybe I was a bit of a stubborn Taurus and wanted to prove everyone wrong about me too, but I had enough resilience to find or create new pathways towards a good life. I believe it was my positive relationships that I developed throughout my life, my little cheerleaders along the way, that helped shape my ability to be resilient, but also all those little ‘blips’ in my life, that helped to make me believe that I was truly on the right path. The Charlottes, the Mrs. Wingham’s, and the others who looked at me and saw something good.

As a society, we have the opportunity to be a positive ‘blip’ in people’s lives. The way we treat people, the empowerment and confidence that we instill in teen parents, and the guidance we can support them with has the ability to trickle down from generation to generation, and it can help other young parents tip the scale in a positive direction.

Our experiences, good and bad, shape who we are. How we experience the world around us forms the building blocks of our brain development, therefore what we experience early in life forms our foundation for the rest of our lives.6

By knowing that, as we grow and develop, the structure of our brain is actually built as a result of our experiences, we then can see that our ability to cope with stresses and how we make decisions is determined by this structural development. When we look at our own stories, or the stories of other people, we can begin to have a greater understanding and empathy for the reasons behind certain emotions, behaviors, and actions.

“Adversity during development may become hard-wired into brain and body functioning across the life course.”

Between 1995 and 1997, the Centers for Disease Control and Prevention conducted a study,7 called the “ACE study” or “Adverse Childhood Experiences Study”, to investigate the correlation between childhood trauma and health and well-being later in life. Adverse Childhood Experiences, or ‘ACEs’, are any negative, stressful, or traumatizing experience that happens in someone’s life before they are 18. ACEs are common: about two-thirds of the population have at least one; over a quarter of the population has three or more; over 5% of the population has six or more. When children are exposed to ACEs, the result is an accumulation of toxic stress that causes the development of patterns of physiological disruptions in the body that have been shown can lead to a lifetime of compromised health. We become a product of our upbringing.8

The ACEs have been recognized as:

- Physical or emotional neglect
- Parental separation or divorce
- Household mental illness
- Physical abuse
- Sexual abuse
- Emotional abuse
- Exposure to domestic violence
- Household substance abuse
- Incarcerated household member

According to the ongoing findings of the ACE study, there is a direct correlation between Adverse Childhood Experiences and teen pregnancy. Their research has also shown, that males who experience ACEs are also more likely to have a paternal role in impregnating teen women.

Knowing that there is this direct correlation between a person’s ACE score and their ‘risk’ for teenage pregnancy will help us to be aware that there is a likelihood that the young parents population within our community have experienced trauma in their life, and by being trauma informed we can be
more empathetic to them and sensitive to the support they may need.

What would happen if we looked at all people through trauma-informed eyes? Rather than placing judgement and wondering, “What is wrong with you?” we would recognize that we all have a story. Instead we can look at, “What has happened to you?” as a way to help support and understand one another.

When I learned this research, I had such mixed emotions about my own life, as I fall into the category of the 5% of the population with six or more ACEs. In fact, I have seven out of ten. Part of me was mad. Mad that I had been exposed to these things, and I was sad that the ones I loved, who were supposed to protect me, had not. At the same time, I had to forgive. I had to remember that those who hurt me and the things that happened around me, those things were also a product of someone’s experiences and upbringing. My life, and the way it unfolded is okay; however, I am stopping, or doing my absolute best to stop, the cycle of trauma for my own kids.

Fortunately, new research in neuroscience has brought forward the ability we have to create new brain pathways and build new habits and resilience. We can learn the skills that we need to be resilient and thrive despite adversity.6,9

Some risk factors for our teen parent population are:

❉ Likely to drop out of school
❉ To be living in poverty
❉ Have feeling of isolation
❉ Have Postpartum Depression
❉ Experience personal or projected neglect/abuse
❉ Potential substance addictions
❉ Toxic stress from ACEs

However, there are specific supports that help teen parents have the best possible outcome and help support resiliency for their future: a high school diploma or further education, financial supports, and housing. These are the crucial supports for teen parents, so that they can meet their basic human needs, now and in the future.

For optimal success, teen parents also need:

❉ Boundaries
❉ Parenting, and child developmental tools and education
❉ Sense of community and belonging
❉ Peer support
❉ Positive encouragement

❉ Positive role models
❉ Improved self confidence

As a community, it is our job to help those around us thrive by bringing them up, rather than breaking them down further. By recognizing the supports that instill resiliency and build success in our teen population, we can work on an individual and communal level to nurture these elements for young parents.

The stigma that exists for teen parents is not always presented because people do not want to be kind and empathetic, but because we have these deeply rooted unconscious attitudes, reactions, stereotypes, and categories that affect behavior and understanding.10 If you have a brain, bias is nearly impossible to eradicate on its own, even if you are aware of it.

It is important to put protections in place to help us diminish some of this implicit bias that exists. We can do this by: encouraging empathy, and listening to the opinions and experiences of other people can break us out of our own assumptive patterns of thinking; become more engaged and aware of the teen parent demographic; critically reflect and analyze your own assumptions, practice non-judgement.

Looking at the negative statistics for teen parents, we have to wonder whether they are the result of the stigma and stereotypes that shame and devalue our teen parents from being successful, and how protecting against bias, and breaking down these stereotypes can support and bring these teen parents up to achieve success.

As humans, we gain a sense of belonging from the groups that we belong to; however, for real confidence and resiliency to form from those groups we need to feel validated. For many teen parents, especially those who have grown up with childhood trauma or been exposed to criticism and stereotypes in their parenthood journey or as adolescents, not having the opportunity to develop their sense of who they are in the world, confidence can be lacking.

Recently, in an interview I did with some teen parents in my community, I asked a young mom, “Tell me about the supports that have propelled you in a positive direction so that you could be a good mom?” She looked at me blank-faced. I tried to ask my question again, forming my sentence differently, thinking she did not understand the question. Again, she looked at me not sure what to say. I realized then, that I was asking the wrong question...
I changed my question to, “Do you think you are a good mom?” She did not know. Her answer, as tears formed in her eyes was, “Kinda.”

This amazing mom was so strong, despite never having felt what being cared for was. She had no idea that she was breaking the cycle. Her love for her son, the way she nurtured him, the way she spoke of him, was incredible. She was a good mom. She needed to hear that from me. She will need to continue hearing that from people to combat her feelings of doubt, to build up confidence that has never had the opportunity to form.

It is society’s job to help bring up these teen parents in a world where they can find the strength and motivation to persevere, rather than fall victim to their circumstance. These parents need to feel loved, they need to feel validated, and they need to know that they have the strength within themselves to thrive despite adversity.

We can be there, we can be someone that helps give them the words of encouragement to keep pushing through each day. Depending on the circumstance, we may be only a small moment in someone’s life, but with real authentic encouragement and by role modelling positivity, caring, and nurturing, we can give them another weight on the resiliency scale to keep tipping them in the right direction.

When I made that wish down by the Salmo River 12 years ago for my daughter to be happy, healthy, and free, I could not have imagined the incredible, funny, bubbly young woman she has become. She is a straight A student, with aspirations to become a writer, and to work with kids. The two of us have an unbreakable bond. I am so grateful that she came into my life to teach me who I am and show me what love really means.

My hope is that through sharing my story and this information, I can help break down stereotypes, build understanding and empathy, and call the community to action to truly bring up teen parents. My dream has already come true for her and me, and I believe that together we can help more teen parents realize their capacity to be success stories too.

Editor’s Notes:

6. Near@Home Toolkit, Near@Home. url: www.nearathome.org
12. The following resources helped inform this article, although were not directly quoted, and can provide a good source of further reading on the topic:

Jillian Rieckmann is the owner of “Shakti Health” massage therapy company and “Pure Love Infant Massage” in Edmonton. She is a mother of two spirited girls (12 and 5). And consistently biting off more than she can chew- continuing her education at the U of A, taking part in adventures, rock climbing, cycling, and travelling the world. And now amateur writing. *
My first period

My first period came to me as a huge surprise. I knew it was normal for women to bleed, but I was completely shocked when it lasted for more than a day! True story. Five days into my first period, it hit me: I was going to bleed for almost a week every single month for the rest of my life. I was devastated. Obviously, no one told me about menopause, either.

Maybe they covered it in Sex Education Class and I forgot or maybe they did not, but either way, I began my menstrual cycle without a clue of what was going on or what to expect. Even as an adult, with many moons under my belt, I did not fully understand my cycles. This all changed when I was 23 years old, all thanks to my fertility awareness practice. Which makes me wonder – what would it have been like if I had discovered fertility awareness when I was much younger? What would it be like for a young teen who charts her cycles?

What is fertility awareness?

What exactly is fertility awareness? It is the daily practice of observing and charting your signs of fertility and infertility to gain awareness of the events that happen in your female reproductive cycle.

First, you chart your menstruation. You record the number of days and the amount you bleed. Then you chart your cervical mucus by observing your toilet paper before and after you use the bathroom. You can also chart your basal body temperature and cervical position. You take your temperature around the same time each morning to record your accurate basal body temperature. You feel your cervix each evening for its physical characteristics of open or closed, soft or hard, and high or low. At the end of the night, you record your observations on a chart. These might include physical and emotional symptoms like breast tenderness, back pain, or mood changes. Each chart represents one complete, beautiful cycle.
Who practices fertility awareness?

Having this awareness of your fertility and cycle has awesome applications. I was first introduced to fertility awareness as a natural means of birth control. Through charting, you can prevent pregnancy highly effectively without the synthetic hormones and side effects! You can practice fertility awareness to do the exact opposite – to achieve pregnancy. Also, the female reproductive cycle is your fifth vital sign; you can gain insight and monitor your reproductive and overall health.

Now, I know you are thinking, “This all sounds great for women who are concerned with avoiding or achieving pregnancy, but what exactly would be the point of teaching fertility awareness to young teens who may not even be sexually active?”

Well, every single person I have spoken with who practices fertility awareness has told me, “I wish I would have learned this when I was younger.”

Why? How would teens benefit from practicing fertility awareness? What would a teen who charts her cycle be like?

Meet the teen who charts her cycles

1) She feels comfortable, not cursed

Why is it that most of us spend our remarkable reproductive life with a tampon hidden up our sleeve? A teen who charts her cycle knows that menstruation is not dirty or gross. She knows that it is a normal, healthy part of being a woman in her reproductive years.

She knows it is normal to bleed every cycle for a few days (definitely more than one, but not more than a week) and that it is a special time for rest and relaxation. She will also become familiar with what is normal for her body, and whether this falls into the normal range of healthy menstruation – including flow, length, colour, spotting, and other factors. She also knows that she should experience very little pain or discomfort due to her cycle.

She does not experience menstruation as a curse or inconvenience like many of her peers. Instead, being equipped with all of this information, she is comfortable with this event happening in her body – even takes advantage of this time to put herself and her self-care first!

2) She knows when to expect her period

Being comfortable with her period might also have something to do with the fact that she is always prepared for it. After charting a few cycles, she will know exactly when to expect it. One of the parameters of her cycle she will be able to identify is the length of her luteal phase. The luteal phase is the second half of the cycle. It begins after ovulation and ends on the last day before her next period. A healthy luteal phase remains fairly constant, so after a few cycles, she knows how many days are in her normal variation of a luteal phase and she is able to count the days until her next period. This means her backpack is stocked with her favourite menstrual products and no more period surprises.

3) She knows that stuff in her toilet paper is normal

A teen who charts her cycle knows that menstruation is not the main event: ovulation is. With ovulation comes cervical mucus! That sticky, tacky, or stretchy, and cloudy, clear, or yellow stuff she sometimes sees on her toilet paper. Unlike
many people, she does not mistake her cervical mucus for an infection. She knows it is a normal part of being fertile.

She is also aware of other vaginal discharge, too. She is not embarrassed when her underwear has that yellow, crumbly stuff or worried when her toilet paper looks shiny. She knows that is just vaginal cell slough and an important part of owning a self-cleaning vagina!

4) She knows that other changes are normal too

Fertility awareness charting equips the teen who charts her cycles with an understanding of hormonal shifts that happen throughout the cycle and how these influence her moods and behaviours, including her sleep cycle, appetite, and energy levels.

Charting has helped her recognize the five distinctive hormonal phases. First, menstruation, the Resting Phase, where she takes it easy and feels connected to a deep part of herself. This is followed by pre-ovulation, the Extroverted Phase, where she feels at her ‘best’: upbeat, energetic, and full of new ideas. Then comes ovulation or the Creative Phase. She’s aware of the power of this phase to get things done because she has enormous energy, confidence, and feels like she can take on the world! Post-ovulation is the Evaluation and Reflection Phase. Now she’s taking a breath and taking time to relax. Feeling calm and reflective, her energy turns inwards. Finally, pre-menstruation, the Heightened Sensitivity Phase, is the time when she has the opportunity to tune into what she’s grateful for, what she wants more of, and what is no longer working for her.

Self-awareness of each phase makes all the difference in her ability to handle them and live in flow with them.

5) She will know when things are not okay

When the teen who charts her cycles knows what is normal for her, she is quicker to spot things that are not. This means the teen who charts will be able to spot warning signs of conditions like polycystic ovarian syndrome, endometriosis, or fibroids. She will also be able to pick up on other important knowledge about her body and her health, including nutritional deficits, food sensitivities, or even thyroid...
dysfunction, just to name a few. Then she can work with her health care providers to alleviate these issues preventatively and holistically, so that the problem is not simply masked but treated. Her charts become a tool to help her make the best decisions for her health and well-being.8

6) She has developed a positive relationship with her body

It is only natural that as she continues to chart her cycle, she becomes mindful of her body and learns more about herself and what she needs. She has a daily routine that respects and honours her body and the changes it goes through during her cycle. She has the opportunity to develop self-care practices and coping strategies for different phases and times of life. Charting has helped her develop self-compassion and body literacy. She sees her cyclical nature as something to be proud of and flow with as she appreciates her reproductive body. Yes, this is possible!

Just imagine

Even as an adult, I have reaped these benefits from my current fertility awareness practice. I know when to expect my period and I celebrate it when it comes. Observing my cervical mucus has become second nature to me and has helped foster a deeper appreciation for my fertile phase. I feel in flow with my hormonal changes instead of a victim of them. My charts have helped me recognize and support a suboptimal functioning thyroid, iron deficiency, and depression. Over the cycles, I have developed my own period rituals, self-care practices, and a deep love for my cervix.

Just imagine if I would have started charting with my first period, instead of well into my adulthood. Imagine the wealth of information I would have acquired about myself and the ways I could have supported my health and well-being through my teenage years.

Like many of the women I know who practice fertility awareness, I wish I had started earlier. Fertility awareness is a life skill that should be practiced well before it has to be used to achieve or avoid pregnancy and has so many benefits for teens, too. In fact, what a gift it is to celebrate a teen’s coming of age with their very first fertility awareness chart. I encourage you to talk to your daughters and the young women in your life about fertility awareness and how it might be helpful for them.

Where to turn now

Starting can be as simple as paying attention to menstruation, observing toilet paper, and picking up on the subtle physical and emotional changes that happen every single day.

Reading the book, Cycle Savvy, by Toni Weschler and working with a Fertility Awareness Educator, are great resources for learning. You can find a directory of Fertility Awareness Educators on the Justisse website, and on the Association of Fertility Awareness Professionals website.9

Additionally, the Association of Safe Alternatives in Childbirth (ASAC) offers a free workshop on Cycle Charting for Fertility Awareness as part of their Birth and Baby Talk Series. Look out for their fall series to find the next date.

Editor’s Notes:


3. The first four vital signs are body temperature, pulse (heart) rate, breathing (respiration) rate, and blood pressure. Lisa Hendrickson-Jack, The Fifth Vital Sign: Master Your Cycles and Optimize Your Fertility. (Fertility Friday Publishing Inc., 2019).


Chloe Skerlak is a seasoned ovulator, proud owner of a menstrual cup, a charter for eight years, and professionally teaching charting for two years. She hosts Mother/Daughter Period Positivity workshops and loves to post pictures of her cervical mucus on Instagram. For more information follow @chloeskerlak or email chloeskerlak@gmail.com #
STIS, HIV AND YOUTH IN ALBERTA

By Lauren Calleja, BA, Birth Doula, CLE

For many years, I worked in the field of human immunodeficiency virus (HIV) and sexually transmitted infections (STI) education, primarily working with youth. I am now a birth doula and a certified lactation educator (CLE) with a passion for women’s health equity, and I have begun supporting pregnant women living with HIV through education and mentoring other doulas. I believe in harm reduction and education as prevention, starting with empowering youth to make safe and healthy sexual decisions.

STIs are on the rise in Alberta with an increase of 159.8% from 2010 to 2015. The rates of gonorrhea, syphilis and chlamydia continue to rise, particularly amongst young people ages 15 - 24. In my experience, I believe there are many reasons for the steady and often increased rate of STIs amongst youth:

- With the rise of hookup sites, the lack of communication between sexual partners, and lack of STI testing. Between 1998 and 2015, chlamydia — the most commonly reported STI in Canada — has risen from 39,372 to 125,499 annual cases among all ages and genders, and gonorrhea infections increased from 5,076 to 19,845 in the same time period. Infectious syphilis rates rose dramatically from 501 to 4,551 cases. In addition, I believe that a lack of education is a contributing factor as many youth look to social media or google to gather their information, which can be problematic as oftentimes the information received is incomplete or incorrect. Youth who are basing their sexual health choices on misinformation from peers and the internet are putting themselves at risk as they do not have the facts.

- STIs in marginalized populations
  - LGBTQ+ youth are particularly at risk of contracting STIs as, many times, there are social determinants of health — such as discrimination and economic status — that prevent them from accessing services such as STI testing or accessing medications to treat common STIs. They are also at increased risk of sexual violence, which increases their overall risk of STIs. “Research has shown that the rate of violent victimization among individuals who self-identify as lesbian, gay or bisexual continues to be significantly higher than among their heterosexual counterparts. [...] In 2014, overall, there were more than 100,000 incidents of violent victimization involving a bisexual victim and more than 49,000 incidents involving a lesbian or gay victim, corresponding to rates of 267 and 142 incidents per 1,000 population, respectively.”
  - Indigenous peoples are also at increased risk of contracting STIs and HIV. Indigenous people made up 4.9% of the
Canadian population in 2016, however, they are over-represented in the HIV epidemic, representing about 11% of all new HIV infections.5 “In Canada, Indigenous populations are very diverse, with communities that reflect variations in historical backgrounds, language and cultural traditions. These communities are disproportionately affected by many social, economic and cultural factors [...] that increase their vulnerability to HIV infection.”

Untreated STIs
If left untreated, STIs can negatively impact fertility as “[…] most cases of tubal factor infertility are attributable to untreated sexually transmitted diseases that ascend along the reproductive tract and are capable of causing tubal inflammation, damage, and scarring. Evidence has consistently demonstrated the effects of Chlamydia trachomatis and Neisseria gonorrhoeae as pathogenic bacteria involved in reproductive tract morbidities including tubal factor infertility and pelvic inflammatory disease.”6

If left untreated, sexually transmitted infections can make a person more susceptible to contracting HIV, or can make the HIV positive person more likely to transmit HIV to their sexual partner. The reason for this is due to the immune system’s ability to fight off infection. CATIE explains the increased risk of co-infection and transmission well as, “[STIs] are caused by bacteria, viruses and parasites, also known as germs. When germs enter the body, they are recognized by the immune system which, as part of the body’s response to infection, starts a process known as inflammation. This leads to the symptoms associated with many STIs, such as redness, swelling and pain. The inflammatory process ‘activates’ our immune cells to fight germs and recruits more immune cells to the site of the infection, helping the body clear the germs.”7 Subsequently, research suggests that inflammation plays an important role as it increases the amount of ‘activated’ immune cells in the area infected with the STI. “Although the inflammatory response is meant to help fight the sexually transmitted infection, HIV likes to infect some of these recruited immune cells, also known as CD4 cells. Also, HIV finds it easier to infect, and replicate in, CD4 cells that are ‘activated’. Therefore, if someone has an STI in the mouth, genitals, or rectum, and that area is exposed to HIV, the higher concentration of ‘activated’ CD4 cells facilitates HIV infection, replication, and spread throughout the body.”7

All types of STIs cause inflammation and therefore may increase the risk of becoming infected with HIV in this way. Also, some types of STIs increase the risk of HIV infection through ulcers, which create ‘holes’ or ways for HIV to enter the body through the mouth, genitals or rectum.”7

HIV and youth
According to CATIE,8 in Canada, some of the statistics surrounding HIV in youth can be quite surprising. The number of new HIV diagnoses amongst youth has increased by 10% from 2013 to 2017. Just under one-quarter (23%) of all new HIV diagnoses in 2017 were in youth (aged 15 to 29). The majority of new HIV diagnoses in Canada were amongst men, accounting for 78% of youth HIV diagnoses. Among all HIV diagnoses in males in 2017, 24% were male youth and of all HIV diagnoses in females in 2017, 20% were female youth. The prevalence rate among street youth, youth who inject drugs, and young MSM (men who have sex with men) is much higher than the overall youth population in Canada.

Despite hearing little about HIV nowadays in mainstream media, HIV is very much alive in our communities. We have come a long way since the AIDS epidemic of the 80’s and 90’s but educating our youth and discussing prevention and safe sexual behaviors is key to prevention. There are many
misconceptions regarding who contracts HIV, as many believe it is only gay men or injection drug users. However, the bottom line is: if you are having unprotected vaginal or anal sex, you are at risk for contracting HIV.

Is there a cure for HIV?

Unfortunately, there is no cure for HIV but HIV is treatable and manageable. The medications given to manage HIV are a life-long commitment and are necessary to keep those living with HIV healthy. Antiretrovirals are very effective at treating HIV and allowing HIV positive individuals to remain undetectable, meaning that, “when a person living with HIV is on effective treatment, it will reduce the level of HIV to undetectable levels which protects their health and makes them incapable of transmitting HIV to their sexual partners. This is what we call, “Undetectable = Untransmittable: U=U. As a prevention strategy, we call it Treatment as Prevention.”

Can you be HIV positive and still have a baby?

Yes! We have made great strides in medication that not only enables HIV positive women to have children but to also, in many cases, have a vaginal birth.

How do I talk to youth about STIs and HIV?

Healthy sexual relationships, consent, and advocating for oneself to use barrier methods are learned through support systems and adequate sexual education. The world of sex can be very overwhelming for young people and having someone who is informed and understanding to speak with about sexual health is essential to preventing STIs amongst youth, whether that be a parent, family member, older sibling, friend, teacher, or support worker. The best thing to do is to start an open dialogue that is not fear based but rather based on the understanding that over 66% of youth aged 15-24 have had sexual intercourse. The reality is that youth are having sex and that they are also at highest risk of STIs. Our job as parents is to speak to them openly, and without judgement, and to find them the information and resources they need to make choices for themselves. Teachers also play a large role in educating youth about sexual health, and I encourage parents to speak to teachers about their sexual health curriculum, so they can offer additional support and guidance outside of the classroom.

Resources

Testing in Edmonton:

Testing is not offered as standard procedure by most physicians at check-ups, but if you are having any sexual relationship regular testing is essential. You can ask your family doctor for STI and HIV screening, however, there are many places in Edmonton to access free and confidential testing services:

For a 24/7 Free and Confidential STI Info Line Dial 811

STI clinic
#3820 11111 Jasper Ave, Walk in Clinic from Mondays-Fridays

Women’s Health Options
Offers STI testing, Pap exams, birth control, abortion services, and ultrasound. 12409 109A Ave, Phone: (780)484-1124 www.womanshealthoptions.com
The Birth Control Centre
Offers contraceptive and sexual health related testing (i.e. Pap testing, STIs testing and pregnancy testing) for all ages.
#405 (North Tower), 10030 107St, Phone: (780)735-0010

Resources for youth:
HIV Edmonton: HIV Edmonton is a harm reduction agency, working to provide the best education and prevention methods to a wide variety of audiences. www.hivedmonton.com/resources

Compass Centre for Sexual Wellness:
www.compasscentre.ca/home/

Youthspace.ca: Youthspace.ca is an online support network for youth (up to 30 years old). They offer emotional support and crisis intervention via Chat, Text, Email Counselling, and a Forum. The site is a non-judgmental space where you can voice your thoughts and get free, confidential support from a compassionate volunteer.

Website: www.youthspace.ca

Kids Help Phone: Anonymous, confidential and non-judgmental phone and web counselling available 24/7. For ages 20 and under. They also have a free smart phone app called “Always There.”

Phone: 1-800-668-6868 (Toll Free)
Website: www.kidshelpphone.ca

Bully Free Alberta: If you are a victim of bullying or abuse, call trained staff at any time of day, or chat online from noon-to-8 p.m. Online chats and calls to the helpline are anonymous.

Phone: 1-888-456-2323 (Toll Free)
Email: bullyfree.alberta@gov.ab.ca
Website: www.bullyfreealberta.ca

Resources for parents:
Alberta Health Services: The Teaching Sexual Health initiative was developed to support teachers, educators and parents in teaching sexual health to children and youth. This online resource includes both a teacher and parent portal.

www.albertahealthservices.ca/info/Page14354.aspx

Resources for LGBTQ+ youth:
Alberta Gay Straight Alliance Network: Alberta GSA is the Alberta chapter of the GSA network of student-run groups that provides a safe place for any and all students to meet and learn about all different orientations, to support each other while working together to end homophobia, and to raise awareness and promote equality for all human beings.

Websites: www.albertagsanetwork.ca and www.facebook.com/groups/AlbertaGSANetwork

Resources for Indigenous youth:
Native Youth Sexual Health Centre: The Native Youth Sexual Health Network (NYSHN) is an organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice throughout the United States and Canada.

www.nativeyouthsexualhealth.com/index.html

HIV Edmonton: www.hivedmonton.com/resources

Editor’s Notes:
2. The acronym LGBTQ+ has been used to represent the acronym LGBTTQQIA meaning Lesbian Gay Bisexual Transgendered Two-Spirited Queer Questioning Intersexed Asexual.

Lauren Calleja is a mother of one son and her her husband, Carlos, are expecting their second son in June of this year. She has a BA in Political Science and English from the University of Alberta, is a birth doula and a Certified Lactation Educator with Beautiful Blessings Birth Services and is a fierce advocate for health equity for all. %
WHAT I HAVE LEARNED FROM MY CHILDREN ABOUT TEACHING SEXUAL AND REPRODUCTIVE HEALTH

By Michelle Neraasen

I can only speak from my experience as a parent walking this path with my children.

Why consider having age appropriate, open conversations about reproduction, sexual health, and sexuality with your children from early in their life? It creates good foundations. If you think of constructing a building, right after the plan, the first step is to build a good foundation. In this case, good foundations include such topics as positive body image, open communication, confidence, understanding consent, healthy relationships, protection, how to say no as well as knowing when to seek help. Some questions you can ask yourself include:

❉ What body image and values do you want your children to have?
❉ What kind of relationships do you want your children to value and engage in?
How much do you want your children to know, when in their lives do you want them to know it by, and from whom do you wish them to obtain this knowledge?

Not teaching our children about sexual health is not an option. If we do not teach our children about sexual and reproductive health then they risk a higher rate of sexually transmitted infections (STIs), a higher rate of teen and unwanted pregnancies, a higher rate of abuse as well as an unhealthy or skewed ideology of sexual and reproductive health. There is a wide variety of places and people where our children can obtain knowledge of sexual health, reproductive health and sexuality throughout their life, not all of which are under our control. On a daily basis society is exposed to sexuality through advertising and the media we consume. Other sources of information include the internet, books, schools, peers, friends, family, and parents or legal guardians. Open discussion with our children becomes important so we can find out what they have been exposed to, what their options are, and how to guide them if necessary.

So let us look at how the education system teaches sexual and reproductive health to our children. Under the NDP government, the curriculum in Alberta was progressively being looked at, updated, and in some areas changed. With the UCP government now being in power there is uncertainty in how and if this process will continue, or what it will look like. Current curriculum goals can be found on the Learn Alberta website. It is also valuable to know the current Ministry of Education Human Sexuality Education Policy: which states that, prior to your child being taught anything that deals explicitly with religion or sexuality, you as the parent or legal guardian need to be informed, and you may choose not to have this content taught to your child. Doing your research and advocating can play a large role in your child's education.

Currently, as of writing this article, when looking at the curriculum and learning outcomes it is helpful to know that in the early grades, below grade five, the children are taught about wellness in general. This includes personal safety, healthy friendships, healthy relationships, identifying emotions, expressing emotions and managing emotions. Children from grades four will cover maturation and changes that occur in puberty, while sexual and reproductive health will be taught in grades four to nine under the heading of Health and Life Skills.

From my experience with children in junior high, there may be outside agencies that come into the school...
to teach certain aspects of sexual and reproductive health in addition to or instead of a program that the school teachers will teach. If you want to know what exactly will be taught to your child with regards to sexual and reproductive health, I recommend speaking directly with the school that your child attends. If you want to know the content being presented to your child, ask the school if it is possible to speak to the presenter(s). At the high school level, grades ten–twelve students are required to take Career and Life Management (CALM) in order to graduate. It is in this course that sexual and reproductive health is taught and discussed.⁴

Now that I have spoken a bit about what can be found in the school curriculum I would like to quickly speak to why there should be age appropriate conversations early in your child’s life with regard to sexuality. The statistics out there with regards to sexual abuse are, quite frankly, shocking. Research conducted by the Centers for Disease Control (CDC) in the United States of America estimates that approximately one in six boys and one in four girls are sexually abused before the age of 18 with only 10% of perpetrators being strangers to the child.⁷ You may also be shocked that 23% of child sexual abuse is child-on-child abuse, and in some of these instances the perpetrator may not even be aware that the behaviour is wrong.⁷ Two websites that give some good information to help protect our children are Parents.com⁸ and Childmind.org.⁷

When speaking to your child about what is wrong you should consider teaching them about appropriate and inappropriate touching and secret keeping. If your child knows what is wrong and has a safe trusting adult to report it to then they can better protect themselves.

When speaking to your child about sexual and reproductive health consent is an important topic. A resource about consent that is clear and simple can be found at Today.com.⁹ Consent goes hand in hand with knowing how to, and when to, say no to something and having that decision respected regardless of the desire, temptation, or pleasure someone else may feel. All parties involved should be able to reach and express their own decision without coercion. We need to remember to teach our children how to accept no as an answer. Consent is applicable in a person’s daily interactions with others, children included: from offering a person something to eat or drink, to trying to convince somebody to do something for us. As an example let us talk about consent in regards to hugs. A person may want to give a hug, but the person they want to hug is not...
comfortable with someone else in their space. Just because one person wants to hug, and means to do so out of affection and kindness, it does not outweigh the other person’s body autonomy and right to be comfortable, even if that means not being touched. While giving a hug either person in the embrace may become uncomfortable, be it that the hug is too tight or lasts too long, the person should be able to voice their discomfort and have the hug end.

On the surface consent seems like a pretty straightforward concept, yet in practice it is never that simple. Something important to consider, especially as your children get older, is what the law says about consent. A part of the law regarding consent that needs to be understood by children, teens and young adults that directly effects them would be the legal age of consent: someone under 16-years-old cannot consent to someone who is five years or older than them, anyone under 14-years-old cannot consent to someone two or more years older. Other important points to remember are: no consent is given if anyone other than the person in question agrees (not a friend or family member), if the person in question is incapable of consenting (asleep, unconscious, intoxicated, or high), if the person receiving the advances has verbally expressed they do not consent or if they withdraw their consent in the middle of the act, and no consent is acknowledged if the person performing the (sexual) act has used a position of power to gain consent.

You can ensure you prevent committing a sexual assault by: making sure your partner consents; talking about what your partner is comfortable doing and expressing your own expectations; listen and do not make assumptions; be careful around alcohol and drugs as they can change your ability to interpret or respond to the situation, and they can alter your memory; make sure your partner is of legal age without simply assuming; and if someone is passed out or asleep they cannot give consent.

I would like to share with you some interesting facts I learned over the last year. I was School Council Chair at a junior high school when the program to teach sexual health by an outside agency was scrutinized due to its financial links with certain religious groups. I sat through the presentation by this group and did not find any religious view, abstinence-only content, or gender bias evident during the presentation. As Chair, in order to make a fair presentation to the school district board, I had to put my own opinions aside and look at the values as well as
the drawbacks of this program. Two of my children within the district attended this program. They both liked the small group size presentation given by a person knowledgeable in the field but whom they felt would not judge them for the questions that were asked. Unfortunately, outside agencies that have the human resources to provide multiple small presentations may receive some funding from groups that can be seen as controversial; in this sense, not only does the content need to be approved, but the funding source may have to be approved as well.

Teachers can be tasked, and some do an excellent job, with the responsibility to teach sexual and reproductive health. However, questions to consider include would students feel empowered to ask all they are curious about when they may fear (whether it is founded or not) that the teacher would judge them? The student may worry they will feel a sense of embarrassment or shame every time they see that teacher. The school districts need to provide approved, safe, and accurate resources for sexual and reproductive health to the teachers who will be teaching the subject. This helps eliminate the need for teachers to be searching the web looking for information about sexual practices and sexual health that may or may not be accurate. It also mitigates the questioning of a teacher’s motives, or any disciplinary action that may follow, for seeking sexual content online. The school districts also need to set out strict guidelines for teachers to abide by while teaching sexual and reproductive health, including things such as keeping personal opinions out of the curriculum. Unfortunately, I know of parental complaints where teachers voiced a biased opinion or belief and discredited a student’s lifestyle choice.

As parents and legal guardians, there are times when we need resources to help us teach our children. Two great sites that I mentioned earlier are Parents.com and Childmind.org. I also like the Alberta Health Services resource since it aligns with the Alberta curriculum. This resource has a teacher portal as well as the parent portal. It provides parents with sexual health information for children and youth aged zero-to-eighteen years by age, by topic, or by teaching. In addition there are tips to increase communication between parents and children and links to reliable community agencies. This resource can be found at Alberta Health Services’ website.11

In the end, teaching our children about sexual and reproductive health – be it by ourselves, through schools, or a combination – comes down to creating good foundations, open communication, knowing what is taught in school, and educating oneself through reliable resources.

Editor’s notes:


6. Learning outcomes for grades four-to-nine may be found at www.learnalberta.ca/content/mychildlearning/.


11. Michelle Neraasen is mother to five lovely children, currently in grades four-to-twelve, experiencing sexual health education from three provinces and four school districts. Michelle is active in the school council for her older children. She enjoys various volunteer work and, when not being a mother, she is a full spectrum doula.
Birth control methods help to prevent pregnancy. If you do not use birth control, you have an 85% chance of getting pregnant if you have unprotected sex for one year.

There are many methods of birth control. Some methods prevent a pregnancy by stopping the ovaries from releasing an egg during ovulation. Other methods of birth control act as a barrier to prevent sperm from reaching and getting inside the egg. Using dual protection for any sexual activity gives the best protection against unintended pregnancy and sexually transmitted infections (STIs). Dual protection means using a condom to decrease the chances of getting an STI and using another method of birth control to prevent pregnancy. It is safe for most people to take birth control and use it as long as they want to.
It is best to choose a method of birth control that fits your lifestyle. This will give you the best protection because you will be more likely to use it correctly and consistently. Talk to your health care provider about your medical history, lifestyle, and the method of birth control that you think is right for you.

Visit Sexual and Reproductive Health\(^1\) to get more information about how and where to get birth control, pregnancy options, safer sex practices, and counselling. You can also contact your health care provider to learn about resources and support in your area.

**Methods of birth control**

There are many methods of birth control to prevent a pregnancy.

**Hormonal birth control**

Hormonal birth control have hormones that prevent a pregnancy by stopping the ovaries from releasing an egg.

- Birth Control Pill
- Progestin Only Pill (POP)
- Birth Control Patch
- Vaginal Contraceptive Ring
- Birth Control Injection
- Intrauterine System (IUS, IUD, or IUS)
- Extended and Continuous Use Birth Control

**Non-hormonal birth control**

Non-hormonal birth control methods create a barrier between sperm and the egg, change the chemistry of the reproductive tract or do both.

- Condom
- Intrauterine Device (IUD)
- Vaginal Condom
- The Sponge
- Diaphragm
- Vaginal Spermicides
- Tubal Ligation
- Vasectomy

**Natural methods**

Natural methods of birth control do not use medicine or devices to prevent pregnancy. Instead they prevent a pregnancy by using certain behaviors and/or making observations about the body and menstrual cycle. Natural birth control methods include:

- Fertility Awareness-Based methods (FAB)
- Abstinence
- Lactation Amenorrhea
- Withdrawal
- Emergency contraception

You can use emergency contraception to help prevent pregnancy after having unprotected sex or if you are not sure you are protected from pregnancy (for example if you have missed taking hormonal birth control pills or the condom breaks). Methods of emergency contraception include:

- Copper IUD
- Emergency Contraception Pill

**Editor’s Notes:**

1. This article is a brief overview of birth control options in Alberta. It was taken from Alberta Health Services’ website on Sexual and Reproductive Health under the section “Birth Control”. The article was printed with permission, as it was originally published. This material is for information purposes only. It should not be used in place of medical advice, instruction, or treatment. If you have questions, talk with your doctor or appropriate healthcare provider.
2019
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Friday, September 20

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Keynote Speaker:
Dr. Michael Klein,
Author of Dissident
Doctor: Catching Babies
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#AAMCONF2019
I do not remember getting much useful information about the menstrual cycle from my sex education classes in school. I remember a friendly nurse saying that you could mark the date of your period on a calendar to know when the next one was coming. I also remember learning about vaginal discharge, but only in enough detail to say that it existed and was normal. I found this concept embarrassing and hoped that I would not experience it much.

As it turns out, I was a nerdy kid in high school, and so I went to the public library and started reading books about sex and birth control to try to fill in some of the gaps for myself.

In my late teens, I was fortunate to come across some resources explaining how you could chart your cycle as a means of birth control. I was fascinated by this concept and taught myself how to do it from library books. It was so empowering to find out that the fertile time of my cycle was actually quite short, and that I could clearly and easily identify it for myself.

Twenty years later, I have a career as a professional fertility awareness educator, and I am continually saddened by how little most adult women and menstruators know about their bodies. I regularly hear stories from women who had thought they only had one hole that both the pee and the baby come out of. Many have no understanding of their hormonal cycles, and have no idea how to tell whether or when they are ovulating.

There is a huge gap in what and how we are taught about the menstrual cycle. Even comprehensive, progressive sex education programs do not always manage to escape the stigma and taboos around periods. The result is a population of teenage girls, adult women, and other menstruators who lack body literacy.

The term body literacy was coined by Calgary-based sexual health educator Laura Wershler in 2005 at the Society for Menstrual Cycle Research conference. As she wrote at the time, “The concept of body literacy occurred to me after I read a novel illustrating the disempowering impact of illiteracy. The inability to read diminishes self-esteem and opportunities to participate in the exchange of ideas. The connection to the lives of girls and women is obvious — the education of girls is a key strategy in all international development work. It struck me that most educated women in developed countries live with another kind of illiteracy — (we) are not taught to ‘read’ or understand (our) own bodies. On the contrary, (we) are taught to distrust (our) bodies and accept various artificial means to ‘manage’ them.”

Many sex education (Sex Ed) programs have a very narrow focus on preventing teen pregnancy (assuming that the curriculum even addresses contraception at all, since some areas still teach an abstinence-only approach to teen sexuality).

When the menstrual cycle is talked about, the focus is on periods and how to manage them with various products or contraceptive methods. Cycle charting is not taught or discussed, except perhaps with a mention of the outdated calendar rhythm method.

Also, I keep hearing from clients that many so-called facts they learned in Sex Ed are just plain wrong. For instance, the myths that you can get pregnant at any time in the cycle, that you
can ovulate more than once per cycle, that ovulation always occurs on day 14, or that periods and ovulation only matter when you are trying to have a baby.

To address these knowledge deficits, here are some of the things that I would want to see added to Sex Ed programming:

1. **Comprehensive education about the menstrual and ovarian cycles**

   Sex Ed curriculums need to impart an accurate understanding of the different phases of the menstruation cycle, the existence and role of cervical mucus, the length of the fertile window, and the importance of ovulation and how to recognize it.

   Teens need to learn about the key reproductive hormones of the cycle: estrogen and progesterone. They should know that both hormones are at their lowest level during menstruation and in the days following menstruation; that estrogen rises and peaks just before ovulation, and that progesterone is mainly produced after ovulation and is dominant for the latter portion of the cycle.

   They should be aware that a healthy balance between estrogen and progesterone is necessary for our whole body health, including for our moods, heart health, digestion, and bone density, regardless of when or whether you want to have children. Without regular ovulation, our bodies do not produce these beneficial hormones in optimal quantities, particularly progesterone.

   Sex Ed should also include discussion about cervical mucus: what it is, when it occurs, and what it looks like. (See Chloe Skerlak's article in this issue for more information.) Ideally students would learn about the different types of cervical mucus, and its role in extending the fertile window by allowing for sperm survival within the cervix for up to three-to-five days. A good curriculum would also distinguish healthy cervical mucus from infectious or unhealthy vaginal discharges.

   This could be done fairly simply by discussing the concepts of red flow and white flow. Our menstrual blood is the red flow and our cervical mucus can be thought of as the white flow that typically appears for four-to-six days around ovulation.

   Now, if you are thinking that this is too complicated for teens to learn, well, my high school felt I needed to learn calculus at age 16, and I assure you that basic cycle biology is much easier to master.

2. **Acknowledgement of the positive aspects of the menstrual cycle**

   I do not think there are nearly enough positive messages out there about why our cycles are important and how they can actually be a source of strength and power and self-knowledge.

   Many teens grow up thinking of their periods as a ‘curse’: as something yucky, gross, and inconvenient at best; and as a source of misery, pain, and shame at worst. Periods are often presented as inconvenient and unnecessary, and ovulation can be dismissed as irrelevant unless you are actually planning a pregnancy.

   This mentality has arisen from millennia of menstrual taboos, misogyny, and ignorance about women’s creative power. It’s based in cultural myth, not in fact.

   Body literacy-based education treats the menstrual cycle as a positive thing. There are actually lots of benefits to understanding your cycle, such as knowing when your periods are coming, or when to expect mood swings, increased libido, or fluctuations in your energy.

   I like to think of fertility metaphorically in terms of creative energy that we can use for any purpose. To me, ovulation is not just about the possibility of pregnancy - it is about feeling fully in touch with your vitality, and about having the power to bring something new and wonderful into the world, whether that is a work project, a new look to your home, or a piece of art.

   Similarly, the premenstrual time gets a bad rap as a negative time, but I think of it as a time of heightened sensitivity. A lot of people find that they have increased intuition, more vivid dreams, or easier access to their creativity during the premenstrual time. It is also a great time to make decisions - the stereotypical short-temperedness of premenstrual syndrome (PMS) has the benefit of helping you identify the situations in your life you no longer want to tolerate.

3. **The menstrual cycle as a vital sign of health**

   There is a movement towards recognizing the menstrual cycle as a vital sign of health, including for teens and adolescents. In 2015, the American College of Obstetricians and Gynecologists released a committee opinion stating that, “Clinicians should educate girls and their caretakers (e.g., parents or guardians) about what to expect of a first menstrual
period and the range for normal cycle length of subsequent menses. Identification of abnormal menstrual patterns in adolescence may improve early identification of potential health concerns for adulthood."2

This only makes sense, since the health of the menstrual cycle is a reflection of our overall health. Period problems do not happen in a vacuum – often they are connected to our nutritional status, stress levels, endocrine function, toxic load, and ancestral histories.

To quote Laura Wershler again, body literacy, “helps us understand how our sexual, reproductive, and general health and well-being are connected to our menstrual cycles. Body literacy supports, if not compels, our fully informed participation in health-care decision making.”1

4. Acknowledgement of psychosocial issues and gender diversity

When it comes to Sex Ed, I would like to see integrated classrooms, so that cisgender teen boys can have positive and accurate information about the menstrual cycle to counter some of the sexist stereotyping and toxic messages received from mainstream culture. An integrated classroom is also the ideal place to address some of the relational questions affecting sexuality, such as pleasure, consent, communication, and healthy boundaries in relationships.

There are some innovative programs that are working to transcend clinical language and provide menstrual cycle education that recognizes the experience of the whole person. A group of educators in Australia are developing a program for 13–16 year olds to counter the fact that,

“teaching of the ovulatory-menstrual (OM) cycle is predominantly couched in biology. A whole-person framework that integrates spiritual, intellectual, social and emotional dimensions with the physical changes of the OM cycle is needed to facilitate adolescent OM health literacy.”3

Finally, this education needs to be provided in a way that acknowledges gender diversity. Yes, menstrual cycle education is essential information for cisgender girls. However, we also need to recognize that menstruators include trans boys and non-binary teens, or that trans girls might want to connect with their body cycles in their own way, perhaps by acknowledging the phases of the moon.

I think our culture would change dramatically if we learned about the amazing wonder and beauty of the menstrual cycle, instead of only focusing on the negatives in a clinical way. It is time for a body literacy revolution.

Editor’s Notes:


Rose Yewchuk, cycle-charter since 1998, says, “Better ovulate than never!” She offers private sessions and classes online and in Edmonton, and trains practitioners as a faculty member of Justisse College. You can catch Rose and her colleague, Chloe Skerlak, delivering ASAC’s two yearly free cycle charting workshops as part of the Birth and Baby Talk Series. 🍎
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Write to your MLA

Below is a template of a letter you can send to your MLA. You can find the letter online at birthissues.org/mla-letter/. Find your MLA’s address here: http://www.assembly.ab.ca/net/index.aspx?p=mla_home

Today’s date

The Honourable MLA;
Office Address

I am writing in regards to midwifery care in Alberta and midwives’ current funding structure.

Alberta healthcare is not offering many families the right to midwifery care, nor is it maximizing saving potential within maternity care: forcing families to birth in ways that stretch both the infrastructure and finances of the health care system. Alberta needs to educate families on midwifery care, increase access to midwives by revising the funding model as well as continuing to grow access in underserved rural populations, and increase the funds midwives receive for a course of care for the first time since public funding a decade ago.

The current funding model does not streamline financing to directly supplement the growing demand for midwifery services. As a consequence, many mothers are unable to find midwifery support, placed on waitlists, and must find alternate means of giving birth. Changing the funding model would remove the problem of the ‘cap’ on how many women can access midwifery care each year; this would ensure our newly trained graduates are staying within Alberta, that they are working to their full capacity, and receiving a livable wage. Maternity care provided by midwives must be more widely recognized as an essential service and should be joined under Alberta Health. The funding model must adapt to ensure maternity dollars follow mothers and babies, not caregivers.

Alberta Midwives currently deliver 5.5% of the babies in our province; this is well below the national average of 10.8% of midwifery assisted births, or the leading provinces of BC and Ontario at 22.4% and 18% respectively. Midwives reduce the patient care load of busy obstetricians who are in great demand for high-risk births and mothers with health concerns. Midwifery also offers the option of home and birth centre births for low-risk women, which frees up space in crowded hospital maternity wards and saves money and resources in the provincial health care budget.

In times of economic constraint, changing the funding model for midwifery makes sound financial sense. According to the most recent data midwives already save the province over $3 million each year. In 2020 when our current midwives are able to work at full capacity they have the potential to save the province an additional $3 million. If education in midwifery and homebirth is increased throughout the province, and we align our midwifery attended births with the leading provinces (~20%), we could save an additional $8.6 million. Yet midwives have not received an increase in cost of living, or the price of a course of care for each pregnant woman attended, in a decade since becoming publicly funded.

Birth is a life-changing event that alters the lives of families and society as a whole. Midwifery improves outcomes in low-risk pregnancy, it empowers families, and sets these families up for success; midwifery is cost effective, and relieves an over-worked healthcare system.

Please ensure increased access to midwifery, upgrading the midwifery funding model, and raising the cost of a midwife’s course of care are priorities in Alberta.

Thank you for your consideration.

Yours Truly,
Arthrogryposis multiplex congenita (AMC) refers to the development of multiple joint contractures affecting two or more areas of the body prior to birth. A contracture occurs when a joint becomes permanently fixed in a bent or straightened position, which can impact the function and range of motion of the joint and may lead to muscle atrophy. AMC is not a specific diagnosis, but rather a physical symptom that can be associated with many different medical conditions. It is suspected that AMC is related to decreased fetal movement during development which can have a variety of different causes, including environmental factors (i.e. maternal illness, limited space), single gene changes (autosomal dominant, autosomal recessive, X-linked), chromosomal abnormalities and various syndromes. Treatment varies based on the signs and symptoms found in each person, but may include physical therapy, removable splints, exercise, and/or surgery.

Breaking the bag of water can happen spontaneously at any time after 37 weeks. In the majority of cases, membranes rupture spontaneously during pushing. In the rare case that your membranes rupture before labour starts know that labour can take between 1 to 30 hours to start. Most caregivers will want you to go into labour within 24 hours, but it is up to you to make an informed choice. If your water is brown, green, thick like pea soup, or has blood clots—go immediately to the hospital as this may indicate that your baby is compromised. Some caregivers like to know if your membranes break because there is a slight chance that the umbilical cord gets trapped while the water flows out, which could affect the proper oxygenation of your baby. These caregivers will want to listen to fetal heart rate, assess fetal movement, check the colour of the fluid, and do a vaginal exam. Note that vaginal exams push bacteria up the vaginal canal closer to baby, which can cause infections. Membranes can also be broken artificially by your caregiver during a vaginal exam to hasten your labour or pushing. They have no nerve endings so the rupture does not hurt. However, some women find that the pressure before it breaks can be intense.

Breech birth is when a baby is presenting its bottom (frank breech) or feet first (footling), rather than the head. Today the Society of Obstetricians and Gynaecologists of Canada (SOGC) encourages women to give birth vaginally, rather than having a caesarean section—even if your baby is breech when you go into labour. It is considered a high-risk birth thus GPs and midwives have to transfer or consult with an obstetrician. For the mom, breech births may be longer, with back-to-back contractions that are more painful in the lower back. For baby, there is an increased risk for being stuck at the time of pushing and the breathing then be compromised. Breech births are often accompanied with meconium staining, which means that baby poops. It is quite common because the bum is being continuously squeezed like toothpaste. A vaginal breech birth will often be a medical event and highly managed—there may be many people watching! It may occur in the operating room. Some obstetricians will advocate for you to have an epidural just in case you need a caesarean. Be sure to get informed, communicate without fear with your caregiver, and only accept what feels right so that you can give birth without feeling overwhelmed.

Epidural analgesia is an injection of a cocktail of drugs, including narcotics, into the epidural space of the spine. It blocks the highway of information to the brain, allowing a woman to not feel pain. Depending on the strength of the cocktail and her body’s reaction to it, she may feel nothing or will still feel a certain amount of pressure but without pain. It can allow a woman to relax (being high-strung can create physical tension in the body which may prevent her baby from descending into her pelvis), and sometimes to have a vaginal birth rather than a caesarean section. She will have a catheter placed, an IV, saline and synthetic oxytocin administered, blood pressure cuff, continuous monitoring, and will be bed bound. The epidural is known to slow down the body’s production of the natural form of oxytocin. Without oxytocin there are no uterine contractions, so no labour! This is why a synthetic form of it is administered to the labouring mom intravenously. The epidural is associated with a number of risks including contractions slowing down, malpositioning of baby, tectonic contractions (lasting more than 90 seconds), placental abruption, poor fetal heart tones, and instrument delivery. These risks depend on when the epidural was placed (at 4 cm or 8 cm; the earlier it is placed the higher the associated risk), for how long it has been in the body, and how strong the dose is. An epidural has also been associated with an increased risk of interventions—one intervention leading to another to compensate for the negative effects of the previous intervention. Non-gravity friendly positions associated with being bed-bound can cause the baby to stay high. Analgesic effect of the pelvic floor prevents the baby from rotating, and the lack of sensations from the mother prevents her from pushing effectively. The epidural also affects the baby as the drug passes to baby via the blood stream. Since narcotics are respiratory suppressants and babies have immature lungs, epidurals increase the risk of having poor fetal heart tones, low APGAR scores, and babies that will need resuscitation after birth.

Induction procedures are always begun and progressed at the hospital, and may take several days before you are in active labour: although you may go home in-between applications of Cervidil or another progesterone suppository designed to dilate the cervix. Women have reported that the contraction pattern is strong. Some women cope well but most will end up asking for an epidural. Some babies find this contraction pattern too strong too and may have trouble coping over the long term, which can lead to a caesarean. If your caregiver recommends an induction but your baby is not in distress, remember that the SOGC recommends a wait-and-see approach or to consider it ten days after the due date.

A LEEP procedure will be performed in the same position as a Pap test – lying on your back with your feet up in stirrups.
The doctor will place a speculum (the same instrument used during a Pap test) into the vagina to keep it open. Local freezing will be used to numb your cervix and you may be given pain medicine by mouth or IV. The removed cells are then analyzed by a pathologist in a lab. Most women are able to return to normal activity within one-to-three days, and resume sexual activity within three-to-four weeks. A woman will then be asked to return to regular Pap exams every four-to-six months until the results have been normal a few times. If disease persists, there is a chance the woman will be asked to repeat the LEEP procedure. Common side effects include uterine cramping, brown discharge within the first week, and spotting or discharge within the next three weeks. Less common but more serious side effects, that should be followed up with your physician, include: heavy bleeding from the vagina, pain that does not go away with pain medication, or signs of infection (such as increasing pain, fever, or discharge that is yellowish in colour and smells bad). Rarely women can experience a narrowing or scarring of the cervix which can make menstruation painful afterwards, can cause fertility issues, in subsequent births it can lead to preterm birth, or trouble with dilation during labour.

Non-stress test (NST) is named “non-stress” because no stress is placed on the baby during the test. It is not a stress test, which would be giving a woman oxytocin to trigger some contractions in order to see how baby reacts. NST involves attaching one belt to the mother’s abdomen to measure fetal heart rate and another belt to measure contractions. Movement, heart rate, and ‘reactivity’ of heart rate to movement are measured for 20-30 minutes. If the baby does not move, it does not necessarily indicate that there is a problem; the baby could just be asleep. It may be performed if you sense that the baby is not moving as frequently as usual, if your placenta is not functioning adequately, or you are past your due date.

Pitocin is administered with an IV. It is given when a woman has an epidural, during an induction, or an augment. There may be different reasons for it: perhaps your labour is long and you are tired, your contractions have slowed down, your contractions are far apart, your contractions are not long enough, we need to start labour, to rotate a baby in a more optimal position, or to prevent your labour from stopping altogether. Sometimes if your bag of water has broken some caregivers like to speed labour with this form of synthetic oxytocin to minimize the risks of infection. When present, it reduces the ability of the body to produce the natural form of the hormone, which in turn means that a woman will have to keep the IV for several hours postpartum or until her uterus is firm and low. It may impede with breastfeeding and increase the feeling of being sick and dependent. In any case, when you are administered this form of medication, your labour is now managed and mobility reduced.
Lactation Consultants @ Home

This section is reserved for lactation consultants who do home visits in Alberta. They do not ask their clients to come to them, at their office or clinic.

We know that there may be many Lactation Consultants in hospital and clinical settings; however most mothers find it difficult to leave home when they have a newborn. They will delay accessing help because of it, which has an impact on her breastfeeding success.

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Email: helping_hand@shaw.ca
Website: www.helpinghandprenatal.weebly.com

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Time: Private customized prenatal classes in your home on your schedule
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Phone: 780-721-5430
Email: birthspace@yahoo.ca
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Mitzi Gerber CLD, LE(CAPPA), CBE
Niko Palmer (CD) DONA, CBE, PES
Stefanie McKinnon CD(DONA), CBE, PES
Heather Hill (CD) DONA, CBE
Location: Edmonton, Lucina Center
Phone: 780-450-0983 or 780-266-3773
Email: mitger@telus.net
Website: doulacare.vpweb.ca

Energy of Birthing: Ava Curtola R.N.
Location: Spruce Grove and Edmonton
Time: Weekend, 4 hours/class—8 hours
Phone: 780-504-1424
Website: www.theEnergyofBirthing.com

Hypnobabies Childbirth Education:
Full Circle Birth Collective
Nicole Sailes, Certified Hypnobabies Instructor
Serving Edmonton, Beaumont and area
Time: Sundays at 1 pm and weeknights at 6 pm
Phone: 780-929-0103
Email: Nicole@fullcirclebirthcollective.com
Website: www.fullcirclebirthcollective.com

Hypnobabies Childbirth Education:
Ricky Issler CD(DONA), HCHI
Location: Edmonton and Beaumont
Time: Weekly for 6 weeks, 3 hour/class (see website for class schedule)
Phone: 780-929-4669
Email: comfortinghands@telus.net
Website: www.comfortinghandsdoula.com

Midwifery Care Partners:
Barbara Scriver, RM
Location: Edmonton South
Time: Weekly, Mondays, 2 hours/class—6 hours
Phone: 780-490-5383
Email: info@midwiferycp.ca
Website: www.midwiferycp.ca

Ohm Birth Angel: Childbirth classes
Moonlight in the night: Abortion healing circle
Gwladys Jousselme, Phd, Childbirth educator
Location: Bonnie Doon
Time: on week-ends, weekly for 9 weeks, 3 hour/class
Email: contact.gwladys@gmail.com
Website: www.the-womb-of-love.com

Terra – Centre for Pregnant & Parenting Teens
Location: Edmonton Centre
Times: Weekly, 2 hours
Phone: 780-428-3772
Email: terra@terraassociation.com
Website: terracentre.ca

Women Before Us Doula Services:
Taryn McLafferty BSc, CLC, LCCE
Location: Edmonton, Sherwood Park, Vegreville
Time: series and 1 day workshops
Phone: 780-717-3717
Email: doulataryn@gmail.com
Website: www.doulataryn.com

YEG Prenatal
Location: Edmonton area
Time: 2 x 2 hr private in-home classes, at your convenience
Phone: 780-709-7562
Email: yegprenatal@gmail.com
Website: www.yegprenatal.com
ASAC BIRTH & BABY TALKS

These FREE sessions are hosted every Wednesday from 7 - 9 p.m. at ASAC, every Spring and Fall. The talks are geared towards new and expecting parents, those trying to conceive, intended parents, or those who have recently adopted. ASAC is inclusive and all families are welcome!

Please join us on Facebook for information on our Fall Birth & Baby Talks soon.
Follow the ASAC Business page on Facebook to RSVP to the events.

Please visit our Facebook Page at https://www.facebook.com/groups/EdmontonASAC/events/ for presenter information and dates, as we will be confirming the Fall series shortly.
If you have any questions, please email Lauren at presentations@asac.ab.ca

PHOTO BY: DAWN PHOTOGRAPHY SERVICES
What is a midwife?

Registered midwives are health professionals who provide primary care to you and your baby during pregnancy, labour, birth and the postpartum period.

**Prenatal care**

Midwives provide complete care during pregnancy, including regular visits, diagnostic tests, routine bloodwork, and emotional support. You can call a midwife as soon as you know you are pregnant to request care; you do not need a referral from a doctor.

**Care during birth**

Midwives are there for you during your birth, no matter when, where, or how long it takes. If necessary, midwives access emergency services and collaborate with other health professionals during birth.

**Postnatal care**

Midwives visit you and your newborn in your own home in the first week after birth. They continue to provide care to you and your newborn for at least six weeks after birth.

**Primary care**

Midwives in Canada are autonomous, primary health care providers. They provide comprehensive care to individuals and their newborns during pregnancy, labour, and at least six weeks postpartum.

**Partnership**

Midwives work in partnership with you and your loved ones when you are pregnant. They provide support in a non-authoritarian way that respects your needs and experiences.

**Informed choice**

Midwives believe that every person has the right to be the primary decision maker about their own care. Midwives encourage you to fully participate in the planning of your own care, and care for your newborn. They allow enough time during your visits for meaningful discussion and for your questions to be answered.

**Evidence-based care**

Midwifery practice is informed by research, evidence-based guidelines, clinical experience and the unique values and needs of those in their care.

**Choice of birth place**

Midwives provide care to people in their birth setting of choice. You can plan to give birth at home, in a hospital, at a birth centre, or in a health clinic, depending on what facilities are available in your area.

Follow us

facebook.com/AlbertaAssociationOfMidwives
@alberta-midwives
@albertamidwives

WhatIsAMidwife.ca

Credit: Canadian Association of Midwives
Community Resource Listing

Alberta Health Advocate
Albertans do not need to know which Advocate they need before calling or writing. This is a place to come to for advice on how to solve problems and staff will direct you to the correct Advocate or resources.
Address: 12th Floor, Centre West Building 10035-108 St, Edmonton, AB, T5J 3E1
780-422-1812 | Toll-Free: 310-0000
healthadvocates@gov.ca | www.albertahealthadvocates.ca

Compass Centre for Sexual Wellness
780-423-3737 | info@compasscentre.ca
http://www.compasscentre.ca/home

Doula Association of Edmonton
Are you pregnant? Have you just given birth? Would you like extra professional support during your pregnancy, birth or even after? Talk with a doula from the Doula Association of Alberta.
780-945-8080 | contactus@edmontondoula.org
www.edmontondoula.org

Edmonton VBAC Support Association/ICAN of Edmonton
Cesarean and VBAC parent meetings. Cesarean prevention class. Our Facebook page is where everything happens.
#201, 8135 - 102 Street, Edmonton, Alberta |
edmontonVBAC@gmail.com

Friends of Freebirth
Planning to freebirth? Experienced freebirth? Support the freebirth option? Our growing community of families shares wisdom and resources.
friendsoffreebirth@yahoo.ca

Friends of Medicare
Do you care about your healthcare system? FOM is a non-partisan provincial coalition raising public awareness on concerns related to Medicare in Alberta and Canada, lobbying governments to maintain a health care system that adheres to the spirit and the letter of the Canada Health Act, and opposing investor-owned, for-profit, two tiered or private health care.
780-423-4581 | info@friendsofmedicare.org | www.friendsofmedicare.org

International Cesarean Awareness Network (ICAN) Canada
Location: Online
Time: Ongoing web seminars—unlimited!
Phone: 1-800-686-ICAN (4226)
Email: info@ican-online.org
Website: www.ican-online.org/webinars

Nurture Her
Women’s physiotherapy blog and informational videos. We know you take great care of your kids, but are you taking great care of yourself? Imagine how satisfying it would feel if you could run, jump and play easily with your kids. How much more fun could you have?
www.nurtureher.ca

Parent Care:
Support group run out of Edmonton.
http://www.parent-care.ca

Terra Centre for Teen Parents
Free Prenatal Class aimed towards young parents, on Wednesday and Thursday every six weeks.
Phone: 780-428-3772
ASAC CONTACTS

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Becoming a Member of ASAC

for just $25 a year (or $100 for a 5-year membership), you can support the organization that supports safe childbirth and parenting alternatives! Become a member @ www.asac.ab.ca

Be part of a unique organization!

ASAC educates women about pregnancy, birth and parenting.

❉ Publishes Birth Issues magazine
❉ Makes available its extensive library
❉ Information on midwifery care, doulas, VBAC, and natural childbirth options
❉ Presents free lecture series
❉ Organizes guest speaker special events
❉ Public outreach at Mom Pop & Tot Fair, Women’s Shows, and baby fairs

ASAC creates community and support for new families

❉ Weekly playgroup
❉ Monthly meetings
❉ Birth movie screenings
❉ Support other local groups such as doula associations, VBAC associations, Alberta Association of Midwives, and a large network of Alberta and Canadian natural childbirth consumers

ASAC is working to increase the number of midwives in Northern Alberta

❉ Lobby for midwifery education
❉ Political action through rallies and letter writing campaigns
❉ Social networking

❉ Membership to boards
❉ Policy work

ASAC improves birthing conditions for local women

❉ Donating birth stools to Lois Hole Hospital
❉ Campaigning to change waterbirth bans at hospitals
❉ Encouraging cooperation between doctors, midwives and nurses

For more information | ASAC meetings 7219 – 106 Street, side door
ASAC mailing address Box 1197, Main P.O.
Edmonton, Alberta T5J 2M4 | Website
www.asac.ab.ca | E-mail info@asac.ab.ca

Become a Member of ASAC

Join the conversation about options in birth and parenting

 Fist ASAC (Association for Safe Alternatives in Childbirth) Foot @BirthIssues

www.birthissues.org | SUMMER 2019 | birthissues 65
Alberta currently has 127 registered midwives. Midwives are primary caregivers that offer continuity of care through pregnancy, birth, and to six weeks postpartum. They currently attend about 6% of out of hospital births in Alberta.
Registered midwives are health care professionals who provide primary care to you and your baby during pregnancy, labour, birth and the postpartum period.

Follow us
facebook.com/AlbertaAssociationOfMidwives
@alberta-midwives
@albertamidwives
Tracy Bradley Doula offers:
Hypnobabies & childbirth education
Birth pool & equipment rental       Classes Start: April 17
Full birth preparation & care       March 9
Postpartum doula care               April 13
Preparation for Birth $99 class
pregnancy health, birth options
& comfort measures, newborn,
characteristics & care, early breastfeeding.

Grow Centre 10516 - 82 Avenue
780.952.3699 or www.steadyhanddoula.com

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Just $349!

Learn how to use hypnosis for your pregnancy, birth & postpartum time.
Teaches comfort, relaxation, childbirth options, comfort measures, newborn characteristics & more.
Includes more than 18 hours of instruction, & 17 or more relaxing scripts and affirmations.

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780.952.3699 or www.steadyhanddoula.com

Culturally sensitive maternity support for Indigenous Families in pregnancy, birth, breastfeeding & parenting.
Taking clients for birth, breastfeeding, postpartum & midwifery care.

www.indigenousbirthalberta.org
indigenousbirthalberta@gmail.com
780.919.6870

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