This Is Your Empowered Birth

Childbirth Preparation
for Healthy and Positive Birthing

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The information contained in the following slides is not intended to diagnose situations. Although the intention is to provide as much information as possible, it is inevitable that we cannot cover everything in its entirety in relation to labor and birth. Please use this class as a starting point for becoming an informed consumer and an active participant in your birth.

The following information should be used in the context of evidence based decision making, where one weighs the research with their own preferences and the recommendations set forth by their providers.

BLOSSOMING BELLIES
WHOLISTIC BIRTH SERVICES

Additional FREE Resources through Blossoming Bellies

Free Recorded Webinars
https://www.blossomingbelliesbirth.com/webinars-for-parents.html

Social Media
(graphics, educational videos)
@blossomingbelliesbirth
on IG, FB, and TikTok

Blossoming Bellies Families Facebook Group
https://www.facebook.com/groups/1472035192784 96 (be sure to answer the membership questions to be admitted)

Every Laboring Person's Rights

Consideration and respect for every laboring person under all circumstances is the foundation of this statement of rights.

1. Every person has the right to health care before, during, and after pregnancy and childbirth**.**
2. Every person and infant has the right to receive care that is consistent with current scientific evidence about benefits and risks.* Practices that have been found to be safe and beneficial should be used when indicated. Harmful, ineffective, or unnecessary practices should be avoided. Unproven interventions should be used only in the context of research to evaluate their effects.
3. Every person has the right to choose a midwife or a physician as their maternity care provider. Both caregivers skilled in normal childbearing and caregivers skilled in complications are needed to ensure quality care for all.
4. Every person has the right to choose their birth setting from the full range of safe options available in her community, on the basis of complete, objective information about benefits, risks and costs of these options.*
5. Every person has the right to receive all or most of their care from a single caregiver or a small group of caregivers, with whom they can establish a relationship. Every person has the right to leave their caregiver and select another if they becomes dissatisfied with their care.* (Only second sentence is a legal right.)
6. Every person has the right to information about the professional identity and qualifications of those involved with their care, and to know when those involved are trainees.*
7. Every person has the right to communicate with caregivers and receive all care in privacy, which may involve excluding nonessential personnel. They also have the right to have all personal information treated according to standards of confidentiality.*
8. Every person has the right to receive care that identifies and addresses social and behavioral factors that affect their health and that of their baby.** They should receive information to help them take the best care of themselves and their baby and have access to social services and behavioral change programs that could contribute to their health.
9. Every person has the right to full and clear information about benefits, risks, and costs of the procedures, drugs, tests and treatments offered to them, and of all other reasonable options, including no intervention.* They should receive this information about all interventions that are likely to be offered during labor and birth well before the onset of labor.

10. Every person has the right to accept or refuse procedures, drugs, tests and treatments, and to have their choices honored. They have the right to change their mind.*
11. Every person has the right to be informed if their caregivers wish to enroll them or their infant in a research study. They should receive full information about all known and possible benefits and risks of participation, and they have the right to decide whether to participate, free from coercion and without negative consequences.*
12. Every person has the right to unrestricted access to all available records about their pregnancy, their labor, and their infant; to obtain a full copy of these records; and to receive help in understanding them, if necessary.*
13. Every person has the right to receive care that is appropriate to their cultural and religious background, and to receive information in a language in which they can communicate.*
14. Every person has the right to have family members and friends of their choice present during all aspects of their maternity care.**
15. Every person has the right to receive continuous social, emotional, and physical support during labor and birth from a caregiver who has been trained in labor support.**
16. Every person has the right to receive full advance information about risks and benefits of all reasonably available methods for relieving pain during labor and birth, including methods that do not require the use of drugs. They have the right to choose which methods will be used and to change their mind at any time.*
17. Every person has the right to freedom of movement during labor, unencumbered by tubes, wires, or other apparatus. They also have the right to give birth in the position of their choice.*
18. Every person has the right to virtually uninterrupted contact with their newborn from the moment of birth, as long as they and their baby are healthy and do not need care that requires separation.**
19. Every person has the right to receive complete information about the benefits of breastfeeding well in advance of labor, to refuse supplemental bottles and other actions that interfere with breastfeeding, and to have access to skilled lactation support for as long as they choose to breastfeed.**
20. Every person has the right to decide collaboratively with caregivers when they and their baby will leave the birth site for home, based on their condition and circumstances.**
(At this time in the United States, childbearing people are legally entitled to those rights marked with *. The legal system would probably uphold those rights marked with **.)

Evidence-Based Decision Making

has three components.

Research-based Recommendations

Client Values/Belief Systems/Priorities

Care Provider Experience

www.evidencebasedbirth.com

Informed Consent and Informed Refusal

Always begin with:

Am I fine?
Is the baby fine?

This will help you gather information relevant to your decision making process.

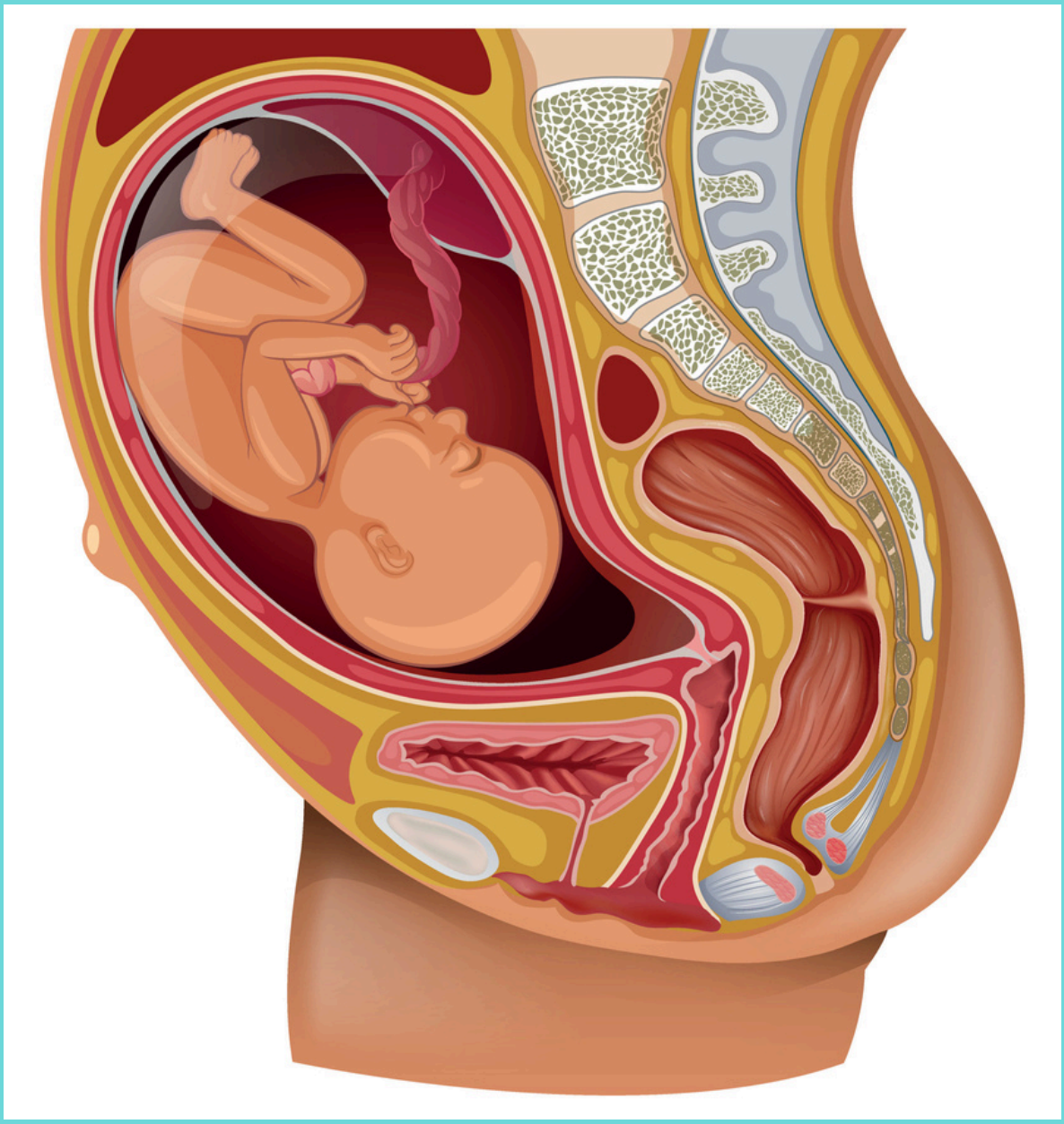
Then Ask:

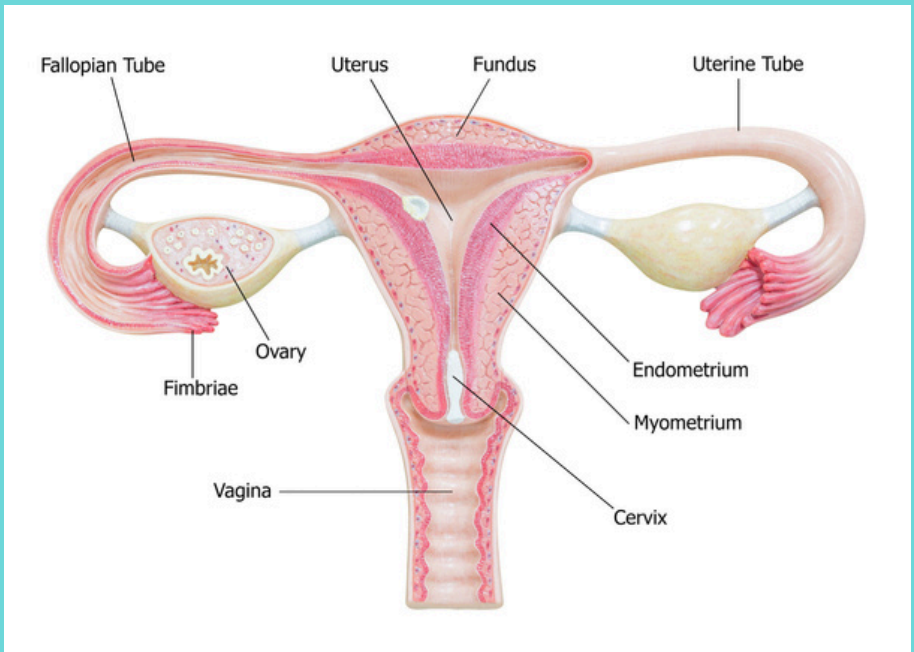
What additional information or benefit will this procedure provide?
What does the procedure entail?
Are there any problems or complications that could arise from this procedure?
What does recent research say about this procedure?
What are the alternatives and their risks and benefits?
What will happen if we wait and do nothing? What are the chances of something happening?

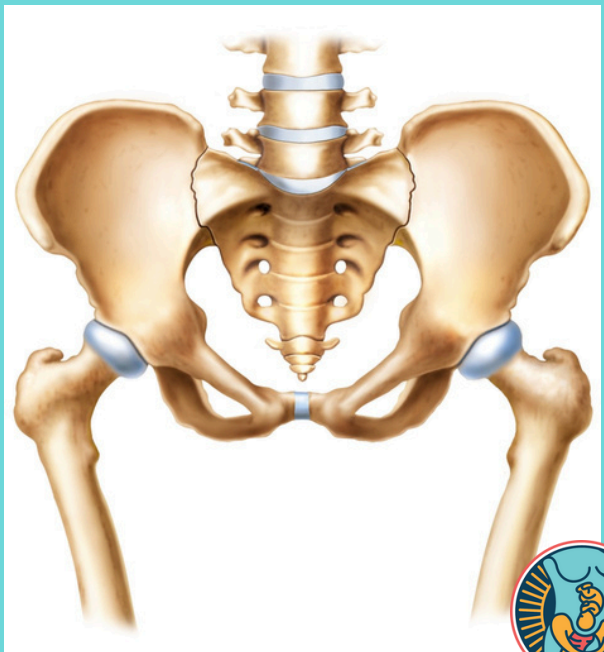
If feeling pressured to make a decision with which you are not comfortable, you have the right to say "I refuse to give my consent for you to do..." or "you do not have my legal consent to do..."
Saying "stop" or "no" may not always be enough.

Great Resources for Research-Based Information:
http://summaries.cochrane.org
http://www.ncbi.nlm.nih.gov/pubmed
http://www.evidencebasedbirth.com

Childbearing Anatomy







Cervical/Pelvic/Internal Exams

Provider inserts two fingers into the vagina to assess:

cervical dilation

how open is the cervix? (0-10cm)

cervical effacement

how thin is the cervix? (0-100%)

fetal station

where is the baby in the pelvis? (-3 to +3 cm)

possibly baby's position

presenting part in relation to parent's body (a series of letters)

Internal exams do not provide info on health of parent or baby, when labor will begin, how long labor will be, or the safety of the labor process.

Labor progress can also be assessed through observing the laboring person although this is not a skill set many clinical providers have.

Affirmations for Encouragement of Inner Strength and Realization of Intuition and Instinct

Laboring Person

I am capable of birthing my baby.
I am creating a totally positive and new birthing experience.
My pelvis is releasing and opening as have those of countless women before me.
I am accepting my labor and believe that it is the right labor for me and for my baby.
I feel the love that others have for me during this pregnancy.
I am treating my partner lovingly during the birth.
I have a beautiful/strong/powerful body. My body is me.
I now see my last birth as a learning experience, from which I am growing and changing.
I embrace the concept of healthy pain.
I am welcoming my contractions.
I have enough love to go around.
There is always enough love for me.
I am strong, confident, assured, assertive, and feminine.
I am helping my baby feel safe so that they can be born.

Partner/Birth Support Person

I am taking care of myself during this pregnancy.
I see my partner as strong and capable woman and this does not threaten me.
I am supporting my partner during labor even when they are in pain.
I am expressing my love to my partner easily and frequently.
I am accepting the labor that is meant for us.
I am accepting feelings of helplessness without feeling the need to take them away.
I am sensitive, tender, open, and trusting.
I am feeling the love that others have for me when I need support.

(Nancy Wainer Cohen and Lois J. Estner; Brittany Sharpe McCollum)

Thoughts to Help Ease the Fear of Labor Pain

Labor surges are bringing your baby closer to you

Labor surges are temporary

Each contraction you move through is one less in front of you

The break in between contractions is longer than the contraction itself for much of labor

Billions and billions of people have done this for thousands of years

Natural labor contractions come in waves

Endorphins are released with each contraction to numb the pain and help relax you

Labor contractions are unlike any sensation you've ever experienced before – their message is that of surrender as opposed to the "fight or flight" pain of physical hurt

Labor and Birth Terms

Care Provider: clinical support including midwives, doctors, and nurses

Vaginal Birth: the birth of a baby through the vagina

Cesarean Birth (often referred to as cesarean section or c-section): the birth of a baby through abdominal surgery

Birth Doula: non-clinical support person during labor and birth, often including prenatal and postpartum visits

Medicated Labor/Birth: labor/vaginal birth in which pharmacological pain relief is used

Unmedicated Labor/Birth: labor/vaginal birth in which non-pharmacological pain relief methods are used

Augmentation: increasing the strength, length, frequency of contractions using a pharmacological method or intervention

Induction: initiating the labor process when labor has not begun yet on its own, often using pharmacological methods but may involve non-pharmacological intervention

Postpartum Doula: non-clinical support person during the postpartum period

TOLAC (toe-lack): trial of labor after a previous cesarean

VBAC (vee-back): vaginal birth after cesarean

Vulva: external childbearing genitalia

Vagina: birth canal

Uterus: womb; muscular organ in which the fetus develops in pregnancy

Pharmacological: concerning the modes, effects, and use of medical drugs

Non-pharmocological: concerning the modes, effects, and use of techniques that do not include medical drugs

Catching the Baby: receiving the baby at birth (often stated as “delivering the baby”

Create an Effective Birth Plan

Birth Plan for Provider

I request the process of informed consent at all times.

I request a nurse who is familiar with a low intervention birth.

- short and to the point
- easy to remember
- flexible
- usable in all circumstances

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Birth Plan for Partner/Friend/Doula

Include preferences for...

induction/augmentation
monitoring
fluids
movement
pain relief
internal exams
pushing
Cesarean birth
third stage of labor
postpartum care
baby interventions

- tool to support advocacy
- guide for support people

Check out our FREE one hour webinar on birth plans as a tool for advocacy at www.blossomingbelliesbirth.com/webinars-for-parents.html

Nutrition During Pregnancy

Helpful Tips

Eat when feeling hungry
Eat foods close to or in their natural state
Avoid processed foods
Eat meat and chicken moderately if not vegetarian
Do not limit or increase your salt intake
Eat organic as often as possible (particularly dairy and meat)
Get your vitamins through food rather than supplements
Protein intake should be 55 to 80 grams
Take in 800 mcg of folic acid per day
Take in 1000 to 2000 mg of calcium
Stay away from refined sugars and fake sweeteners
Drink half your body weight in ounces of water per day (ex: 150 lbs = 75 oz water)
Ensure you are getting calcium, iron, zinc, magnesium in your diet
Make superfoods a diet staple – broccoli, tofu, soybeans, kale, flax, blueberries
Eat more fruits, veggies, and whole grains

Where to Find the Good Stuff

Healthy Fats
olive oil, coconut oil, seeds (pumpkin, sunflower, sesame, flax), nuts (almonds, walnuts), high fat cold water fish (salmon, mackerel, sardines), avocado, grass-fed meats, pastured eggs

Protein
fish, beans, whole grains, tofu, eggs, tempeh, nuts, seeds, veggies

Calcium
dark green leafy veggies (kale, spinach), broccoli, cauliflower, cabbage, okra, bok choy, figs, salmon, sardines, mackerel, tahini, dried fruit, molasses, seaweeds, almonds, red raspberry leaf, kelp, dandelion, nettles, parsley, watercress, papaya, elderberries

Iron
fish, beans, dried apricots, nuts, seeds, seaweed, leafy green veggies (kale, spinach, dandelion, nettles), blackstrap molasses, prunes, raisins, whole grains, beans, tofu, soybeans, oysters, almonds, walnuts

Zinc
high fiber foods (bran), Brazil nuts, parmesan and hard cheeses, seeds, herring, meat

Magnesium
nuts (particularly almonds), soybeans, fish, green vegetables, apples, figs, wheat germ, seeds

Vitamin A
dark green vegetables, yellow vegetables, yellow fruits (broccoli, spinach, turnip greens, carrots, squash, sweet potato, pumpkin, cantaloupe, apricots, liver, milk, butter, cheese, whole eggs
Vitamin D
dark leafy greens (have properties that act like Vit D in the body), shitake/chanterelle mushrooms, oatmeal, oysters, salmon, sardines, sweet potato, tuna, vegetable oil, alfalfa, parsley, cod liver oil, egg yolks, halibut, fatty dairy products, good old sunshine!
Vitamin E
vegetable oils, wheat germ, green leafy vegetables, almonds, hazelnuts, carrots, avocado
Vitamin K
dark green leafy veggies, nettles, alfalfa leaves
B Vitamins
bananas, lentils, chile peppers, tempeh, liver oil, liver, turkey, tuna, nutritional yeast, molasses, potatoes
Vitamin C (aids absorption of iron and calcium)
citrus fruits, kiwi, green cabbage, tomatoes, strawberries, peaches
Folic Acid (a B vitamin)
dark green leafy veggies, beans, legumes, asparagus, whole wheat products, oranges, beans, Brussels sprouts

Herbs for Pregnancy

Red Raspberry Leaf tones the uterus (reducing pain during labor), strengthens the reproductive system, and eases morning sickness (tea)
Alfalfa, nettles, dandelion provide iron and vitamin K to the body (tea or capsules); nettles eases leg cramps and muscle spasms and reduces varicosities; nettles also strengthens the kidneys to prevent bladder infections
Amaranth, Lamb's Quarters, and Violet leaves act as laxatives (cooked or infusion)
Comfrey and nettles (used separately or together) prevent backache due to their calcium, magnesium, vitamins C, D, and E, and B complex (infusion)

****As with all holistic wellness, intent is of the utmost importance. Respect the properties of the herbs you are using and focus on their feel in your body to experience their full effect.****

Brittany Sharpe McCollum, updated 2020; Herbal Information from "Herbal for the Childbearing Year" by Susun Weed

Alternatives to Medical Induction

Alternative Method to Medical Induction (these alternative induction methods should only be used after 40 weeks and/or as alternatives to a planned medical induction)	Possible Side Effects
Sex with Male Ejaculation/Orgasm; Place a pillow under bottom and allow semen to move towards cervix; research is not conclusive as to its effectiveness	increased risk of infection if the water is broken; contraindicated if there is concern over preterm labor
Nipple Stimulation 20 minutes on one side, 20 minutes on the other, take a 20 minute break, repeat	strong contractions (if too strong, stop stimulation); may be best to do under the care of a provider
Oral Sex research is not conclusive as to its effectiveness	none
Castor Oil one tbsp with egg, ice cream, orange juice, one tbsp one hour later if nothing	diarrhea and subsequent dehydration
Sweeping or Stripping the Membranes A finger is placed inside the cervix and "swept" around the inner rim of the cervical os, loosening the bag of waters from the uterine lining; usually done by a careprovider; research shows that it can lessen the "need" for induction and shorten pregnancy by 1-4 days (but does not show that it will cause labor)	often done without consent; accidental rupturing of the bag of waters, cramping, bloody discharge
Acupressure research is limited; may encourage cervical ripening	strong contractions (if too strong, stop stimulation)
Acupuncture research suggests this is likely safe for low risk pregnancies; low-quality evidence suggests this may help ripen cervix	side effects of acupuncture unrelated to pregnancy (fainting, a drop in your blood pressure, drowsiness, discomfort, localized bleeding; manageable in clinic by acupuncturist)

Medical Pain Relief

Reasons for Medical Pain Relief May Include:

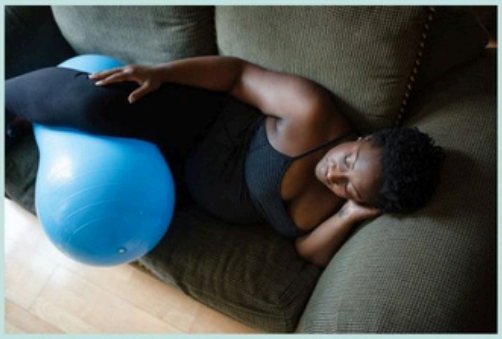
Cesarean Section
High Blood Pressure
Clinical Maternal Exhaustion
Inability to Dilate Due to Tension
Desire to Dull Pain

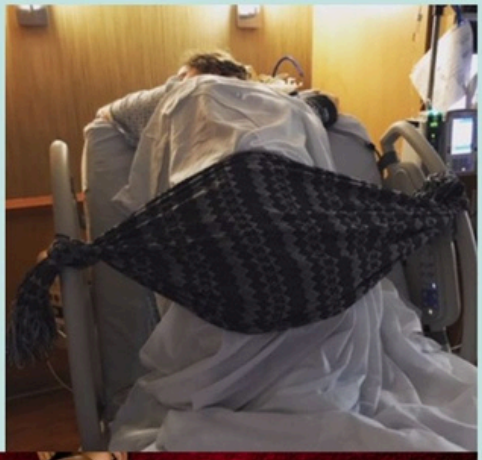
In most hospitals, the expectation is that birthing people will get pain medication. Therefore, laboring without pain medication may require stronger advocacy and support skills in a hospital setting than in a birth center or homebirth setting.

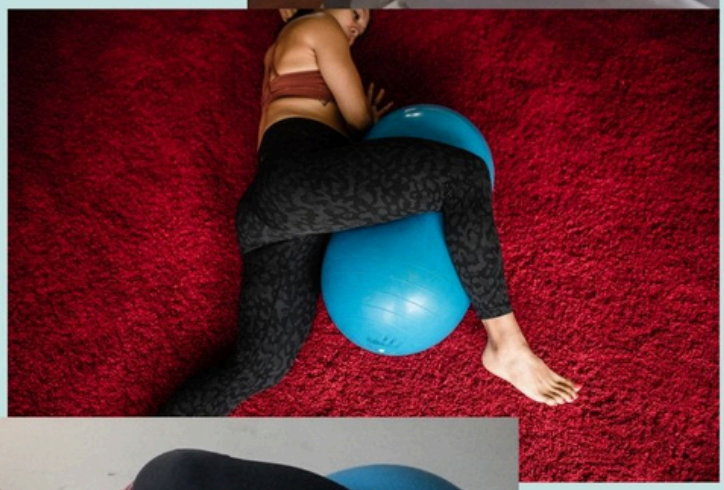
Types of Pain Relief	Mode of Entry	Advantages	Disadavantages
Tranquilizers (Valium), Sedatives, Sleeping Pills	oral	Possibly allows for rest if mild contractions or false labor are preventing sleep	interferes with baby's ability to breathe and suck post-birth, reduces muscle tension
Narcotics (Stadol, Nubain, fentanyl)	injection or IV	Moderate pain relief during beginning and end of contraction	sleepiness, nausea, vomiting, drop in blood pressure, total body itching, decreased reflexes and muscle tone in baby, difficulty breathing/sucking in baby
Nitrous Oxide (not available in all birth places)	inhalation	provides moderate anxiety and pain relief; controlled by the client	limited research on effects on baby, nausea, dizziness, vomiting

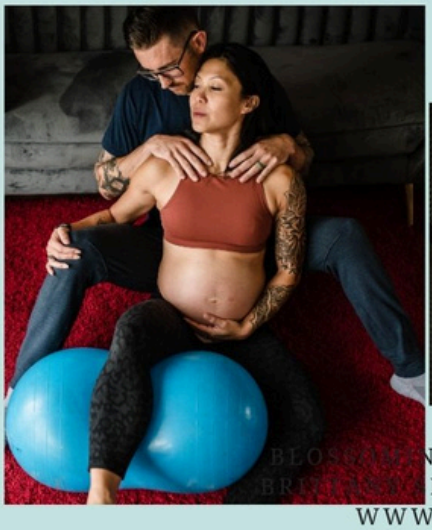
Types of Pain Relief	Mode of Entry	Advantages	Disadavantages
Epidural	continuous drip of narcotic and anesthetic medication into nerves in lower back just outside area membrane that surrounds spinal cord	pain relief, lower blood pressure	restricted mobility, drop in blood pressure, increased risk of fever, total body itching, increased risk of cesarean, weakens pelvic floor muscles, requires further intervention (constant EFM, IV fluids, blood pressure cuff, pulse oximeter, bladder catheter), prolonged labor, occasional incomplete pain relief, increased risk of instrumental delivery, increased risk of tearing, crosses the placenta; can cause fetal heart tone drop, slowed reflexes and breathing in baby; may affect breastfeeding ease
Spinal	single dose of narcotic or anesthetic medication into membrane surrounding spinal cord	excellent pain relief	all risks of epidural, spinal headache, difficulty breastfeeding
Combined Spinal/Epidural (also called CSE, light epidural, walking epidural)	narcotic bolus injected into membrane surrounding spinal cord then continuous drip of anesthetic delivered just outside membrane	quick effective pain relief and better mobility than epidural	all risks of epidural, spinal headache, difficulty breastfeeding directly related to amount of narcotic used
General Anesthesia	inhalation or IV	quick administration	breathing difficulty for baby, nausea, vomiting, aspiration, asleep for birth and groggy after

POSITIONS FOR LABORING WITH PAIN MEDICATION









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Remember to incorporate movement into positions by rocking and rolling the peanut ball!
Use props like the squat bar for upright positioning!

Induction of Labor

Induction methods are used to begin labor when it has not started spontaneously yet. Augmentation is when contractions that are already occurring are made stronger, longer, and more intense.

**** World Health Organization recommends that "No geographical region should have rates of induced labor over ten percent." ****

Induction may be recommended due to:

Hypertension
Diabetes
Kidney Disease
Small-for-Dates Baby
Decrease in Amniotic Fluid
Intrauterine Death With Long Wait for Labor (weeks, not days)
Cancer
Past Due Date
Accommodate Busy Schedules
Reduce Risk of Compromised Baby

***The ARRIVE study is the only study that has shown decreased risk of cesarean birth with routine induction at 39 weeks. There are concerns with this study and its application to all birthing people. See the Evidence Based Birth article for more info at https://evidencebasedbirth.com/arrive/.**

When making a decision about induction with your provider, ask the informed consent/refusal questions and take an evidence based approach.

Check out our FREE webinar on induction, informed decision making, common reasons for induction, and the methods involved at www.blossomingbelliesbirth.com/webinars-for-parents.html

Induction Methods

Amniotomy

Artificial rupturing of membranes surrounding baby (amniotic sac) before or during labor

Possible Side Effects: places time limit on labor, increases risk of infection, umbilical cord prolapse, malpositioning of baby

Cervidil

Synthetic prostaglandin "tampon" administered before or during early labor when water bag is intact; replaced every 12 hours until approx 4 cm dilated

Possible Side Effects: nausea, vomiting, diarrhea, hyperstimulation of uterus

Cytotec

“Off-Label” synthetic prostaglandin tablet administered before or during early or active labor, vaginally when water bag is intact, orally when water bag is not intact

Possible Side Effects: nausea, vomiting, diarrhea, hyperstimulation of uterus, increased risk of infant brain damage, uterine rupture, infant and maternal death

Foley Balloon

balloon portion of bladder catheter is filled with saline solution and administered inside the cervix, between the amniotic sac and the lower uterine portion before or during early labor

Possible Side Effects: strong contractions

Pitocin

Intravenous drip of synthetic oxytocin generally administered at 4+ cm

Possible Side Effects: increased risk of fetal distress, increased risk of low 5 minute Apgar score, decreased natural oxytocin release at 2 days pp, increased risk of cesarean*, greater likelihood of unexpected NICU stays, increased postpartum blood loss

When Is It Real Labor and Not False Labor?

Real labor is a combination of consistent and progressive contractions that create change in the cervix over time.

Some people notice tightening of the uterus from 20 weeks of pregnancy onward. These uterine contractions are often referred to as Braxton-Hicks and are not real labor.

About a third of people experience prodromal labor contractions weeks or days before labor. These feel more like real contractions - an obvious beginning, increase in discomfort, and coming down from the contraction. These are sometimes called false labor because they are not real labor.

Real Labor Contractions Are Consistent and Progressive.

They get stronger, longer, and closer over time.

The First Stage of Labor	Early Phase Dilation up to 6cm Significant effacement Longest part of labor	**Active Phase** **6-8cm dilation** **Ideal window for epidural** **Averages 8-15 hours until birth** **Time to be with your provider!**	Transition Phase 8-10cm Complete thinning of cervix Shortest phase of labor for most parents
Contraction Pattern	5-20 minutes apart Under a minute long Consistent and progressive	**3-4 minutes apart** **Full minute long each** **Happening for a full hour in first time parent**	2-3 minutes apart Up to 2 minutes long
Discomfort Location	Lower belly Possibly lower back	**Entire belly** **Possibly lower back** **Rectal pressure at the peak of contraction**	Entire belly Hips, back, possibly tops of thighs Rectal pressure through whole contraction
Response to Contractions	Chatty, excited, analyzing labor	**Labor haze** **Total body experience** **Immersed in labor**	Talk of transition Primal responses Nausea, flushed cheeks

The Second Stage of Labor	Latent (Resting) Phase Full dilated and effaced May last a few minutes to an hour Encourages baby to descend and rotate for pushing 	Active (Pushing) Phase Spontaneous vs. directed Bearing down with peak of contractions Closed vs. open glottis Two steps forward one step back
Contraction Pattern	3-5 minutes apart 45 seconds long	3-5 minutes apart 45 seconds long
Discomfort Location	Constant rectal pressure	Overwhelming rectal pressure
Response to Contractions	Possible grunting Resting/sleeping in between ctx	Spontaneous pushing

The Third Stage of Labor	Latent Phase 5 to 30 minutes Releasing of the placenta	Active Phase Contractions Gush of blood with full placenta release
Parent	Relief and rest Return from labor haze Skin to skin with baby	Bearing down with ctx Reclined or upright
Baby	Transitions into breathing Skin to skin with parent	Skin to skin with parent

What is Labor?

Below are loose descriptions of what many people feel during the different parts of labor. Labor is divided into stages and phases by textbooks but, in reality, labor is far more of an ebb and flow than a consistent progression from one stage to the next. The process varies from person to person and cannot always fit into neatly defined categories. The different phases and stages of labor can often share characteristics. Each stage is referred to by its textbook definition in addition to a better description of the physical and emotional aspects.

Stage One:

Early Labor Phase

I like to think of early labor as part of the end of pregnancy because contractions are fairly spaced out and short, not usually requiring a lot of external support or touch to feel in control, and early labor can be very lengthy.

Characteristics:

consistent and progressive contractions, at least five minutes apart or farther, under a minute long each
dilation up to 6cm
can be several hours to several days long
pink mucus

How do laboring people often respond to these contractions?

often with excitement, chattiness, analyzing their labor and what they are feeling
although not necessarily comfortable, may be able to lie down during early labor

Suggestions:

watch a movie, cook a meal, go for walks, take a nap, shower or bath

Active Labor Phase

Characteristics:

consistent and progressive contractions, four minutes apart or closer, a full minute long
dilation from 6 to 8cm (*some providers still use the outdated definition of active labor beginning at 4cm)
slight rectal pressure at the peak of contractions when around 6cm
on average, 8 to 15 hours of labor left in first vaginal birth when moving into active labor
bloody mucus
if excessive bleeding or heavy bleeding similar to period, call care provider immediately and head to the hospital

How do laboring people often respond to these contractions?

often by becoming more focused on their bodies and labors
labor becomes all consuming
quiet or vocal with contractions
rhythmic in movement and vocalization
no longer chatty
need to be upright, moving

Suggestions:

hands-on touch measures, massage, verbal encouragement, position suggestions, counterpressure, hydration

Transition Phase

Characteristics:

very long and strong contractions, 2 to 3 minutes apart and up to 2 minutes long, often feeling back to back
dilation from 8 to 10cm
rectal pressure, hip pressure
flushed cheeks
nausea/dry heaving/vomiting
shakiness
usually no longer than one hour in first vaginal birth, can be minutes in subsequent births

How do laboring people often respond to these contractions?

desire to be on all floors, desire to chew on something, take off clothes
loss of confidence
feelings of being overwhelmed
possible grunting at the peak of a contraction

Suggestions:

bath or shower
partners stay present
verbal encouragement
helping laboring person find a positive mantra to repeat (such as “yes” or “open”)

Stage Two:

Resting Phase

Characteristics

occurs between being fully dilated and feeling the uncontrollable urge to push
slow down in intensity and frequency of contractions
contractions space to 3 to 5 minutes apart, often under a minute long
rectal pressure remains but is not all encompassing
anywhere from half hour to 2 hours in first labors, can be just minutes in subsequent births

How do laboring people often respond to these contractions?

relief and rest

Suggestions

allow laboring person to rest

suggest visualization to keep them calm and focused

Pushing Phase

Characteristics:

overwhelming urge to bear down as if passing a bowel movement

constant rectal pressure that intensifies with contractions

often appear sweaty and flushed

averages 1 to 3 hours for first time labors, less for subsequent births

leads to the birth of the baby

How do laboring people often respond to these contractions?

intense pushing several times during a contraction

closed eyes and rest in between contractions

Suggestions:

cold cloths on forehead and neck

hair tie to pull hair out of face

chapstick

if planning to delay cord clamping, inform care provider

Stage Three:

Resting Phase

baby transitions into breathing

parent comes back from "labor land"

feelings may include relief, love, sense of being overwhelmed

baby begins to show signs of wanting to nurse

Pushing Phase

placenta is ready to be birthed within a few minutes up to an hour or more (most care providers expect the placenta to be out within 45 minutes or they will intervene)

gush of fluid

strong but short contractions

How do laboring people often respond to these contractions?

short grunts and small pushes to birth placenta

Suggestions:

love and support for new parent(s) and baby

if planning to keep placenta, inform care provider

What if Labor Happens Faster than Expected?

@blossomingbelliesbirth

For Laboring People

Lengthen your exhale
Focus on your break rather than timing your contractions
Move your body rhythmically
Repeat a positive mantra
Trust your body and your baby

For Support People

Offer hydration
Time contractions for provider
Stay close to laboring person
Place towels under birther
Breathe to stay calm
Reassure birther they are safe

Is Baby Coming Before You're With Your Provider?

Encourage laboring person to be close to a surface like the floor or bed (all fours is great for this)
Help catch the baby (they are slippery!)
Keep parent and baby warm (skin to skin with blankets)
Keep umbilical cord intact (even after placenta births)
Call midwife and/or 911 (for transport to intended birth place)

Blossoming Bellies, Brittany Sharpe McCollum, CCE(BWI), CD(DONA), 2021
https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery?IsMobileSet=false

Managing Early Labor Discomfort

A long prodromal and early labor can be mentally and physically trying for both the laboring person and partner. Here are some reminders for this part of the process.

Don't call everyone you know. Early labor can be lengthy and that's okay.

Rest and nest. Get your energy out and then take a nap.

Eat well and stay hydrated. Focus on foods that are higher in protein and fat.

Distract yourself until you can no longer be distracted. Don't use up all your comfort techniques too soon.

Check in with your doula or independent provider (if applicable). Let them offer guidance and suggestions.

Take a bath or shower to help relax the body and allow for rest.

Stay in the present. Think of this as the end of pregnancy and let go of time constraints and expectations.

Blossoming Bellies Wholistic Birth Services

Comfort Measures for Active Labor through Birth

Physical

Drink water, fruit juice, coconut water, tea, broth
Eat toast with jelly, clear soups with noodles, yogurt, honey
Massage
Use pressure/touch measures
Use warmth on lower back and thighs and cool cloths on forehead and back of neck
Relax your hands
Urinate frequently
Relax your body to release endorphins
Release endorphins to manage discomfort
Use deep and directed breathing exercises
Gentle support of pelvic floor through warm cloth on vulva
Warm water and pressure in bath and shower
Relax your mouth
Use aromatherapy oils on cotton balls around room

Emotional

Give yourself permission to make sounds
Elevate your oxytocin through intimacy
Choose labor support that believes in your ability to birth
Music/comforting sounds
Talk through your fears
Surrender to your body and its ability to birth your baby
Visualize your baby moving through your body
Speak affirmations out loud to yourself and your baby

Comfort Measures for Active Labor through Birth

Informational

Know your rights
Verbalize your preferences to your provider in advance and in the moment
Ensure support people understand their role in advocacy
Ask questions anytime you are faced with decision making
Use direct suggestions or yes/no questions with laboring person
Ask for time to discuss privately

Movement-Based

Follow the Blossoming Bellies 5.4.3 Rule of movement
Move with your support people - slow dance, hip rocking
Sink into your contractions
Rock/roll the peanut ball if using as a prop
Remember to move with an epidural
Free the sacrum
Move your body frequently through every phase of labor including pushing

This is your birth space.
Make it your own and use the space around you to support your birth preferences!

Letting Go of the Thinking Brain in Labor:

Encouraging Oxytocin and Endorphins to Flow

Breathing

- Tension Release Meditation
- Directed Breathing
- Lengthening the Exhale
- Cleansing Breaths at the
- Start and End of Contractions
- Low Moaning Sounds

Environment

- Low Lighting
- Minimal Side Conversation
- Warmth
- Candles
- Privacy
- Quiet

Role of Support People

- Patience
- Confidence in the Process
- Offer Hydration/Nourishment
- Encourage rhythmic movement
- Rhythmic touch strokes
- Massage
- Verbal Encouragement

Perspective

- Break is Longer than Contraction
- Pain Tolerance is Irrelevant
- Stay Present
- Every Contraction is One Step Closer to the Baby
- Affirmations
- Mantras

Blossoming Bellies Wholistic Birth Services, Brittany Sharpe McCollum, CCE(BWI), CD(DONA)

Your Birth is Meant to Move You...
With or Without an Epidural!

Use the Blossoming Bellies 5/4/3 Rule

5 Change Position Every Five Contractions
from early labor through pushing

4 Choose One of Four Basic Positions:
Standing, Seated, All Fours, Reclined/Side-Lying

3 Change It Up with Three Variations:
Femur Rotation, Sacral/Iliac Nutation/Counternutation, Asymmetry

For Comfort, Progress, and Fetal Oxygenation in Labor

Labor Position Suggestions

	Early Labor	Active Labor	Transition	Pushing
Standing	*wide knees *feet turned out/in *pelvic tilts *sideways stair climbing	*vary width of knees *sideways lunge with foot elevated *labor dance *forward lean	*knees neutral *semi-squat *forward lean *sideways lunge with foot elevated *hip rocking	*squat *semi-squat
Seated	*wide knees on ball *backwards straddle on chair *one foot elevated on stool *pelvic tilts *sideways rocking on ball	*vary width of knees on ball *one foot elevated on stool *forward leaning on support person *sideways rocking on ball	*knees neutral *one foot elevated on stool *forward leaning on support person *sideways rocking on ball	*birthing stool *birthing stool with one foot elevated on stool *toilet
All Fours	*leaning on ball *cat/cow *wide knees	*vary width of knees *one foot in lunge position *one knee supported on stool	*knees neutral *one foot in lunge position *one foot in lunge position while leaning on support person	*regular all fours “squatting back”
Side-Lying	*wide knees	*vary width of knees *vary where knees are in relation to hips	*knees neutral *one knee open *vary where knees are in relation to hips	*knees together with peanut ball between ankles *one knee open *one knee up towards chest *one knee up towards chest and closed

Change Position Every Five Contractions To Shift Space in the Pelvis, Maintain Comfort, and Encourage the Descent, Rotation, and Oxygenation of the Baby

Touch Measures for Active Labor and Beyond

Counterpressure Techniques

Double Hip Squeeze: With laboring person slightly forward leaning, on all fours, or seated on ball, place support person's hands on greater trochanter (at the top of the femur, where it meets the pelvis) and apply gentle pressure inward. This works well in early labor to open the top of the pelvis and relieve pressure.

Double Iliac Press: With laboring person forward leaning or on all fours, place partner's hands on tops of the iliac crests and apply gentle pressure inward. This works well from about 6 cm on; it is helpful during transition but may feel a bit intense.

Sacrum Press: Support person applies firm constant pressure on the sacrum during and/or in between contractions.

Hip Rocking: With laboring person in forward leaning or all fours position, support person puts palms on either side of sacrum and applies gentle pressure, rocking hips from one side to the other (slow rhythmical motion).

Supported Pelvic Tilt: With laboring person in forward leaning position or on all fours, support person places hands on either side of the sacrum, just below the posterior superior iliac spines in the space called the greater sciatic notch. Support person applies firm pressure in an upward and inward motion and holds in place; if done correctly, a "cleft" will be noticed between the bum cheeks; laboring person will feel a release in the pubic bones and in the lower back.

Touch Measures for Active Labor and Beyond

Touch Strokes

Energy Release: Sweep hands down back, starting at shoulder blades, moving down waist, and ending at lower back

Back Circles: Following laboring person's breath, make long slow circles over the back while providing gentle support to the belly with the opposite hand

Side to Side Touch: Standing at laboring person's side with flat palms at their middle back, perpendicular to their back, make sweeping motions alternately side to side on back and sides of waist

Hamstring Massage: Make fists with your hands and move them alternately up and down the backs of the thighs

"Shaking the Apples": Lightly hold the backs of the thighs under the bottom or on the bottom and gently "shake"

Massage

Neck and Shoulder
Quadricep (front of thigh) and Hamstring (back of thigh)
Hands and Feet

Low Back Pain:

Sacrum
Sacroiliac Joints

Acupressure Points

Oxytocin Release:

4 Finger Widths Above Ankle Bone on Inside of Leg
Webbed area between Thumb and Forefinger
Area where Neck and Shoulders Come Together

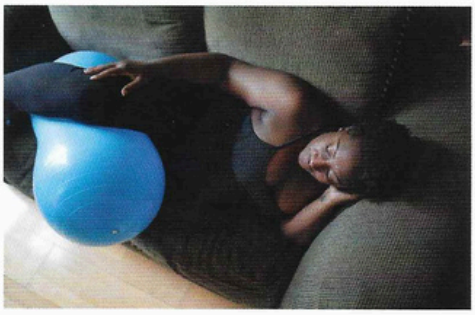
Endorphin Release:

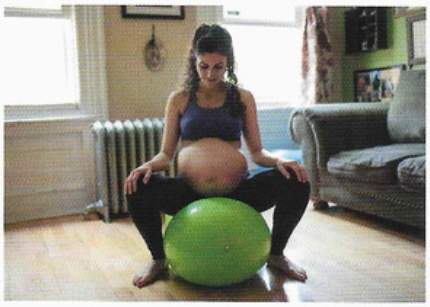
Balls and Heels of Feet
Padded part of Thumb
Lower Lip

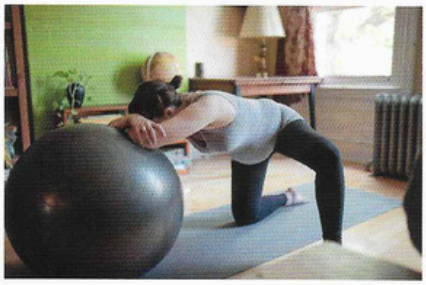
Blossoming Bellies

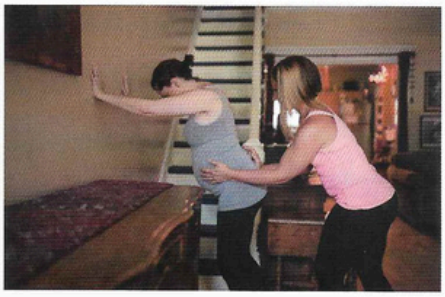
Positions for Labor and Birth

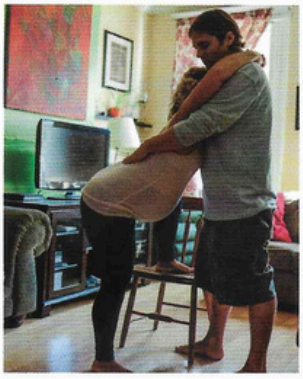
Photos by Tammy Bradshaw Photography

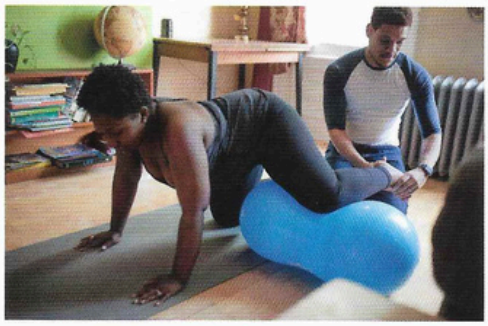


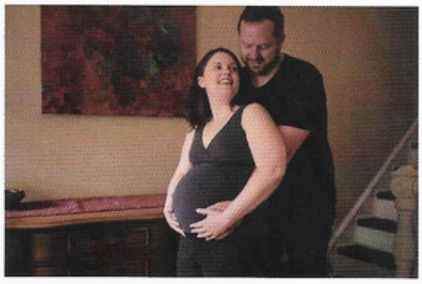


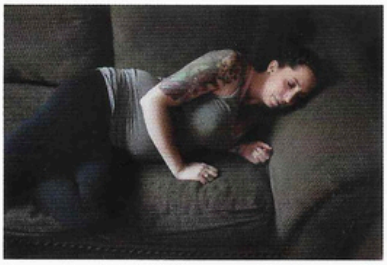


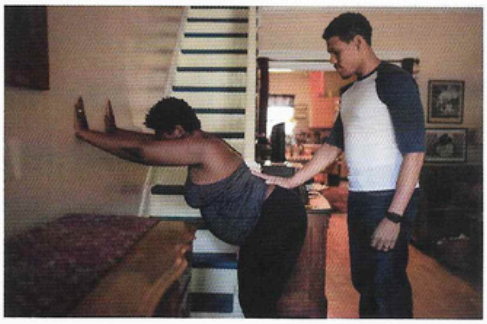


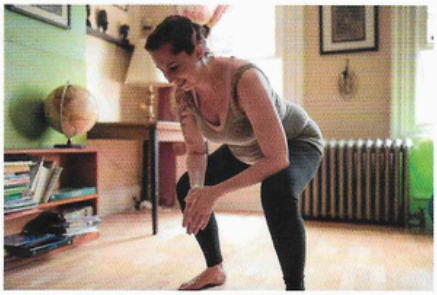


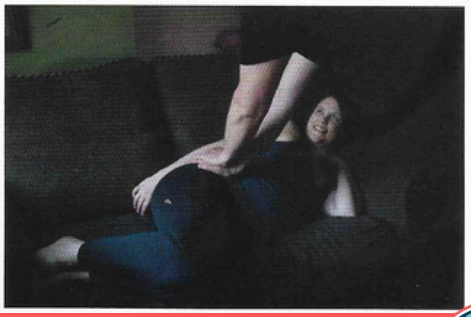












Birth Props and Tools

A rice sock is a simple and cheap tool that you can make at home and use during your pregnancy, labor, and postpartum experience.

You will need:

long sock (knee length or mid calf will work)

four to six cups of uncooked rice (any kind will do)

clean and dry jar (a large mason jar or large spaghetti sauce jar will do)

Optional: 10+ drops of essential oil (*These will not be used on your skin but will be placed inside the sock. Please read safety guide via link below) or dried herbs of choice

PLEASE READ the guide for safe use of essential oils during labor at https://naha.org/assets/uploads/PregnancyGuidelines-Oct11.pdf.

Remember that if you are using essential oils topically or in any other way do so with the guidance of an herbalist.

Directions:

Pour your rice into the jar. Have a support person hold open the sock and place the sock's opening around the mouth of the jar. Pour the rice from the jar into the sock. Shake the sock so that the rice settles. Pour in enough rice to fill the sock about six to eight inches. Drip in your essential oils, if using. Tie a knot in the open end of the sock so that the rice is packed fairly tightly. Roll the sock around to help spread the oils.

The sock can be heated in the microwave on high for one to two minutes. Always check for hot spots and be sure the sock is just slightly warmer than body temperature before using. If you do not have a microwave, you can purchase medical grade hot packs that can be placed inside the sock prior to each use.

_____

A large birth ball is an invaluable tool during the labor process. Unless you are under five feet tall, I'd suggest a 75cm birth ball. You can buy these online (search for exercise balls as they are the same thing and much cheaper than a "birth ball") or at discount stores such or even at some dollar stores. Hospitals and birth centers often have these available for use during labor. However, they tend to be on the smaller side because they are easier to store. Bringing your own can ensure that your ball is clean and the right size for you.

Birth Props and Tools

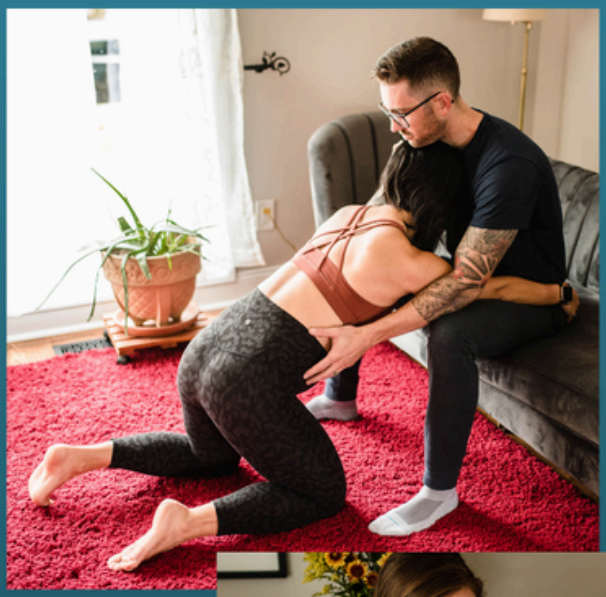
Peanut balls have recently become all the rage in birthing rooms. They are a great tool for supporting the top leg in a sidelying position and can be used for the early phase of labor, resting periods during active labor, and during an induction process and can be a crucial support during medicated births.
Depending on where the leg is being supported, space can be opened higher up in the pelvis or lower in the pelvis. Ideally, the ball should be used to support the leg and create pelvic space that aligns with where the baby requires space for descent and rotation in the pelvis.

The squat bar is a tool available in hospital rooms. It is a padded metal bar that fits into the bottom portion of the hospital bed. It can be used to support the laboring person when squatting on the bed and can be used in both unmedicated and medicated births. Remember - squat to create space in the pelvis where the baby needs it. A deep squat is often good in earlier labor while an elevated squat may be better for pushing.

The birthing stool is available in birth centers and some hospitals. If planning a homebirth, you can inquire with your midwife as to whether they can bring a birthing stool with them.
By supporting the backs of the thighs and allowing the space between the legs and under the vulva to be free of support, the stool uses gravity and lengthening of the pelvic floor muscles to facilitate the pushing phase of labor. Remember to create space for the baby at the outlet which may be better accomplished by using the birth stool backwards. To decrease the likelihood of tearing, allow the sacrum to open by arching the lower back slightly rather than rounding the lower back when pushing.
A squatty potty can be a great alternative to the birthing stool.

Positions for Pushing

Blossoming Bellies Wholistic Birth Services
Brittany Sharpe McCollum, CCE, BWI



More Positions for Pushing

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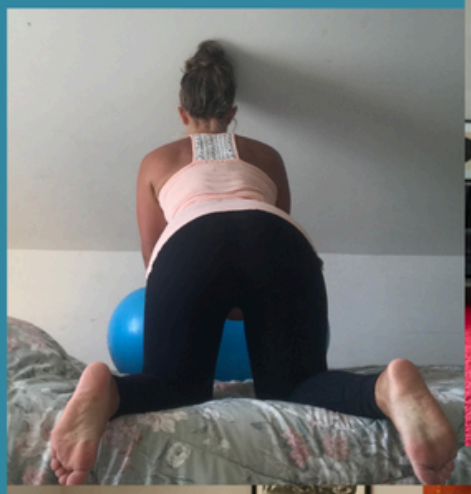

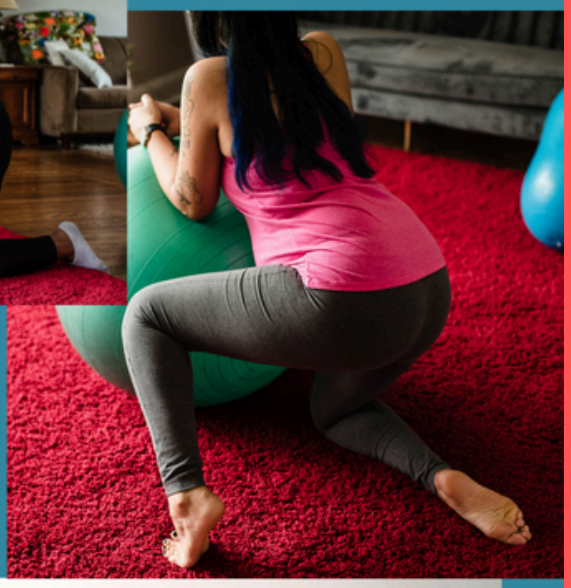

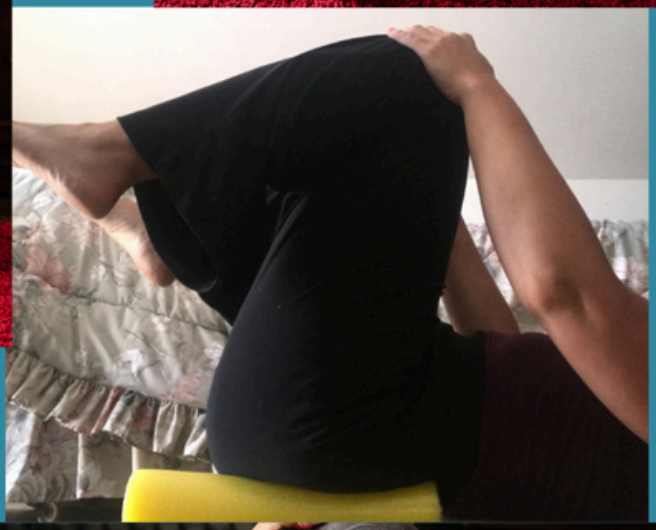

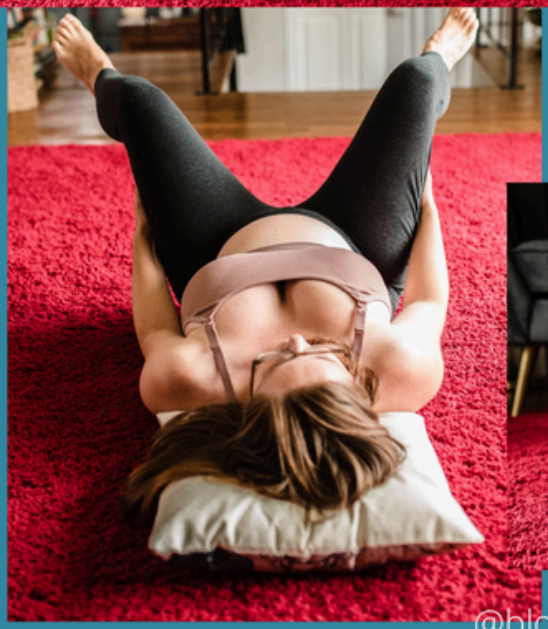

Active Management (AM) of Labor's Third Stage

THIRD STAGE OF LABOR: BIRTH OF THE PLACENTA, REMAINING UMBILICAL CORD, AMNIOTIC SAC

ACTIVE MANAGEMENT: GOAL OF DECREASING RISK OF PP HEMORRHAGE; INCLUDES:
IV OR IM OXYTOCIN (PITOCIN)
EXTERNAL UTERINE "MASSAGE"
TRACTION (PULLING) OF THE UMBILICAL CORD

Research shows:

- uterine atony (tired uterus) is the most common reason for excessive postpartum blood loss
- AM decreases risk of excessive blood loss by about 40%
- may prevent one pp hemorrhage for every 12 births that includes active management of the third stage

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Factors To Take Into Consideration

- oxytocin can be administered preventatively or if excessive bleeding is occurring
- very long or very short labors may tire the uterus more than an "average" labor
- blood loss is not measured but assessed visually by a provider
- traction on the cord can cause the cord to break from placenta
- research shows a decrease in risk of pp hemorrhage with active management
- one's own preferences for intervention paired with their labor circumstances should be taken into consideration when deciding if it is appropriate to intervene
- oxytocin enters the bloodstream and colostrum and is metabolized 10-15 minutes after ending of dosage
- individual preferences may lead to consenting or refusing or taking a "wait and see" approach to this intervention

Brittany Sharpe McCollum, CCE, CD, CLC; Blossoming Bellies Wholistic Birth Services

Understanding Cesarean Birth

Benefits of Cesarean Birth

- Life-saving for parent and/or baby in certain situations (including but not limited to, placenta abruption, cord prolapse, fetal distress, stubbornly transverse fetal position, severe and/or quickly progressing pre-eclampsia, some birth defects, true cephalo-pelvic disproportion)
- May allow for scheduling of baby's birth date

Risks of Cesarean Birth

(Coalition for Improving Maternity Services, 2010, www.motherfriendly.org)

- Parent: accidental surgical cuts to surrounding organs, infection, emergency hysterectomy due to hemorrhaging, complications from anesthesia, pulmonary embolism and stroke (due to clots that can travel to lungs, brain), increased risk for placental issues such as accreta and previa with future pregnancies, status as high risk for VBAC in future pregnancies
- Baby: accidental surgical cuts, being born late pre-term due to scheduled cesarean (and the complications that come with this), respiratory complications from cesarean without prior labor, childhood development of asthma, sensitivity to allergens, or Type 1 diabetes
- Parent/Baby Attachment: increased separation between new parent and baby

It is important to note that the cesarean procedure is very safe as it is the most commonly performed surgery in the U.S. The majority of parental risks of the procedure are those possible with any major surgery.

Understanding Cesarean Birth

The majority of cesarean births that occur during labor are non-emergent although because they are not planned, they are called "emergencies."

Tips for Avoiding Cesarean in a Low Risk Pregnancy

- Stay home until active labor is well established.
- Focus on nutritional quality over quantity. Eat plenty of protein, dark leafy greens, vegetables, and whole grains. Stay well hydrated.
- Avoid ripening agents such as Cervidil and Cytotec.
- Avoid induction.
- Labor actively - change position at least once every five contractions or so, avoid lying on your back for more than a bit at a time, and move those hips around!
- Hire a doula.
- Use only intermittent fetal monitoring unless a medical reason indicates otherwise.
- Understand medical pain relief options and optimal times to use pain medication if planning a medicated birth
- Remember that late pregnancy ultrasound can be off by two weeks in determining gestational age and off by two pounds in either direction in determining weight
- Push in an upright position.
- Make informed decisions and know your rights in the laboring room.
-

Sources:
Evidence Based Birth Podcast 10: ARRIVE study; http://evidencebasedbirth.libsyn.com/ebb-10-arrive-study
Evidence Based Birth: Top Five Myths about Birth - Debunked! - https://evidencebasedbirth.com/topfive/

Understanding Cesarean Birth

The number one reason for primary cesarean births is "failure to progress."

The second reason is "non-reassuring fetal heart tones."

Boyle A, Reddy UM, Landy HJ, Huang CC, Driggers RW, Laughon SK.
Primary cesarean delivery in the United States. Obstet Gynecol. 2013;122(1):33-40.
doi:10.1097/AOG.0b013e3182952242

Birth Place Factors that Decrease Risk of Cesarean

Several studies have looked at factors in birth center and hospital settings that help to decrease the likelihood of a cesarean. Nationally, birth centers have about a 6% risk of cesarean while low risk hospital birth has about a 27% risk of cesarean. The following factors have been shown by research to decrease cesarean rates.

- **Nurses trained in labor support, including use of movement, birth balls, etc.**
- **Patience by care provider in long labors, including long inductions of labor.**
- **Providers allowing for longer pushing time (four hours rather than three hours) in those birthing with an epidural.**
- **Policy to admit only after 4cm dilation in low risk labor**
- **Avoidance of elective induction before 41 weeks (*check out ARRIVE study analysis at source below)**
- **Use of intermittent monitoring in unmedicated birth**

Source:
Evidence Based Birth Podcast 10: ARRIVE study; http://evidencebasedbirth.libsyn.com/ebb-10-arrive-study

Absolute Reasons for a Cesarean

Umbilical Cord Prolapse
Transverse Lie
True Cephalo-Pelvic Disproportion
Placenta Abruption
Complete and possibly Partial Placenta Previa

There are other situations in which a cesarean may be the safest option for parent and baby but that depends on factors surrounding the situation.

Understanding Cesarean Birth

Cesarean Birth Process

- Epidural anesthesia is given - a continuous drip of medication is administered in the lower back in a small area below the spinal cord, right outside the membranes surrounding the spinal cord. (In rare situations in which there is not time to administer an epidural, general anesthesia would be used).
- Spinal anesthesia may be given. This is a one time dosage that is injected into the sac of spinal fluid below the level of the spinal cord. It offers immediate pain relief that lasts one to two hours.
- Pregnant person's breathing, heart rate, and blood pressure are monitored. An oxygen mask may be placed over nose and mouth.
- The birth support person puts on scrubs. One support person is allowed in the OR with pregnant person.
- Pregnant person is taken to the OR while birth support person waits in the labor and delivery room until a nurse comes to get him.
- Pregnant person is prepped for surgery - abdomen is washed with a Betadine solution, the hair above the pubic bone is shaved, a catheter is placed in the bladder to keep it empty during surgery, abdomen is swabbed with antiseptic, and sterile drapes are placed around the abdomen.
- The birth support person is brought to the OR to stand by pregnant person's head. They can stand up and peek over the sterile drapes if they'd like to see the baby born.
- There are several people in the room including a nurse for pregnant person, a nurse for baby, at least one or two nurses assisting the obstetrician, a midwife if she was providing mom's care, an anesthesiologist, and a pediatrician. Students may also be present (you can refuse this). The OR is cold.
-

Understanding Cesarean Birth

Cesarean Birth Process

- A 4 to 6 inch incision is made through the skin and abdomen just above the pubic bone.
- Abdominal muscles are spread and bladder may be pushed aside or taken out and placed on the abdomen.
- An incision is made in the low part of the uterine wall. This is called a low transverse incision or a "bikini-cut." A classical incision, made vertically in the thicker part of the uterus a bit higher up, may be made if the placenta is low lying. Other possible incisions if a low transverse cut is not possible is a "T" or a "J." A large recent study of almost 18,000 people found that the rate of uterine rupture in VBACs with a uterus with a prior low transverse incision is .4% (point 4 percent) vs. the rate of uterine rupture with a prior classical incision being 2% (2 out of every 105). It is very difficult to find a care provider who will support a VBAC with a classical incision.
- Amniotic fluid surrounding the baby is suctioned out and the blood vessels on the edge of the incision are cauterized. You may hear the suctioning and smell the cauterizing.
- Pregnant person may feel nauseous due to the tugging sensation in the abdomen as the baby is born. Pain will not be felt. The nurse will offer a basin to throw up in if she needs to.
- The baby is pulled from the uterus by neck and head first, the cord is cut, and baby is brought over to the warming area for evaluation by a nurse and a pediatrician. Partner can go with baby, talk to baby, and touch baby. Parent(s) voices are all that are familiar to baby at that point - talk away!
- The entire process from the abdominal incision to the birth of the baby is only about 5 to 10 minutes. The stitching up process is longer, about 20 to 45 minutes.

Understanding Cesarean Birth

Cesarean Birth Process

- Pitocin is added to the postpartum person's IV to encourage clamping down of the uterus.
- The placenta is manually removed. You may keep your placenta if you wish.
- The uterus may be removed from the body to repair it. The uterine incision is repaired with either a single layer or double layer suture. Single layer suturing pulls together the cut edges of the uterus and then smaller sutures are used to stop the bleeding and pull together unopposed edges. Double layer suturing pulls together the cut edges and sutures and then a second layer of suturing pulls the uncut tissue together on top of the first layer. It is best to have a conversation with your doc ahead of time regarding single or double layer suturing. Ina May Gaskin is a big proponent of double layer suturing; ICAN (International Cesarean Awareness Network) is a proponent of single layer suturing. Most OBs prefer one or the other; single layer suturing is typically done, particularly with low transverse incisions. As the lower portion of the uterus thins during labor, it is more difficult to pull together uncut tissue (and it takes longer). Research has shown that there are fewer postpartum complications such as inflammation, infection, endometritis, and hemorrhage with single layer suturing. One out of 11 studies found an increased rate of uterine rupture in subsequent births with single layer closure (this is considered inconclusive evidence). Three studies found no increase in placental problems in subsequent pregnancies (previa, accreta) with single layer suturing. Ina May Gaskin, in "Ina May's Guide to Childbirth," discusses the research behind suturing and uses a lot of anecdotal evidence to support double layer suturing, particularly in reference to future VBAC. ICAN's suturing info can be found here http://ican-online.org/vbac/the-suture-debate
- The bladder is then placed back inside if removed and the skin is closed with either more dissolvable sutures or staples (staples need to be removed a few days later).
- Postpartum person is wheeled into recovery where they will be with baby for at least an hour (depending on their and baby's well-being). They will be monitored for up to a few hours before moving to a postpartum room.

Understanding Cesarean Birth

Healing from a Cesarean Birth

The cesarean rate in the United States hovers currently around 32%. The World Health Organization recommends the cesarean rate be about 12%. Healing from a cesarean section requires time, support, patience, and encouragement from postpartum support people and the person recovering.

Do not hesitate to ask for help when needed!

People experience varying levels of discomfort after a cesarean.

No matter how the new parent feels, rest is of the utmost importance.

- **Pain in the abdomen, back, and shoulders is common due to air trapped inside the body during surgery. The gas pains will pass quickly on their own and are a very common part of post-surgery recovery.**
- **Soreness at the incision site can be expected to last for several weeks. Many experience weeping from the scar; an abscess at the incision site and/or opening and draining of the incision site is not normal. A foul odor or yellowish discharge may be a sign of infection. Call your care provider if you have any concerns or experience excessive pain.**
- **To prevent abscess or infection of the incision site, keep the area clean and dry, and allow good air circulation and sunlight to reach the belly for at least 20 minutes per day.**
- **It is preferable to wait to take a bath until one week after the cesarean section.**
- **Rest is incredibly important when healing from major surgery. Motion and flexibility is often impeded. Be extra patient and gentle with yourself as you learn to hold, comfort, and and tend to your baby. Ask a nurse, doula, midwife, or lactation consultant for assistance in finding comfortable nursing positions.**

Source:
"Natural Health After Birth: The Complete Guide to Postpartum Wellness," Aviva Jill Romm

Understanding Cesarean Birth

Gentle Cesarean Birth

Blossoming Bellies Wholistic Birth Services, @blossomingbelliesbirth

- Encourages parent and baby to bond
- Eases transition for the baby and parent
- May reduce stress hormones
- Restores parent and baby as focus
- Reduction of pain
- Decreased likelihood of newborn
- infection and NICU stay
- Stabilizes newborn body temp
- Encourages nursing

Options You Can Request

- Walk into the OR
- Introductions from assisting staff
- ECG leads placed on back rather than chest
- Clear sterile drapes
- Lower lighting, selected music, minimized side conversation
- Research layered suturing and request your preference
- Delayed cord clamping (more than one minute as recommended by WHO)
- Immediate skin to skin contact
- Delay newborn procedures

Reminders for Non-Clinical Support

- Request two support people
- Delay visitors
- Use hand massage to encourage touch during birth
- Drops of peppermint or lavender essential oil onto cotton ball and placed near parent's head
- Talk to the baby, touch the baby if separation must occur
- Ask question of the clinical staff if unsure about routines
- Use positive language and affirmations

Sources: Risks and Benefits of the Skin-to-Skin Cesarean Section: A Retrospective Cohort Study; Immediate or Early Skin- to-Skin Contact After a Cesarean Section: A Review of the Literature; WHO's Delayed umbilical cord clamping for improved maternal and infant health and nutrition outcomes; Lamaze Tips for a Gentle Cesarean or Family-Friendly Cesarean

Newborn Procedures

Erythromycin eye ointment is given within the first hour after birth. It helps prevent eye infection that could lead to blindness, most often caused by gonorrheal and chlamydial infections. It is administered routinely in the U.S. because it easier than separating those who have had good prenatal care from those who haven't (gonorrhea and chlamydia are tested for with routine prenatal bloodwork) and those who've had more than one sex partner during pregnancy, etc. In the UK, it is not done routinely; instead if there is a sign of eye infection (redness, puffiness, puss), antibiotics are then administered. Here's a good article that outlines the research: Evidence on Erythromycin Eye Ointment for Newborns

The vitamin K shot is another intervention typically done within the first hour after birth. Vitamin K is made in the body by bacteria in the baby's intestines and also taken in through the diet. While in the womb, baby's intestines are sterile and they are born with very little vitamin K. They start making their own vitamin K around day 3 and then production peaks at day 8. After that, it begins to level out. Vitamin K acts as a clotting factor in the blood so there is a greater risk of internal bleeding with low levels of vitamin K. For this reason, synthetic vitamin K (20,000 times the FDA's recommended daily dosage) is given to babies via a one-time intramuscular injection in their thigh. Research has shown that this shot of vitamin K decreases the risk for "hemorrhagic disease of the newborn" but does increase the risk for jaundice. Here is a link to the recent article breaking down the research: Evidence on: The Vitamin K Shot in Newborns - Evidence Based Birth® This article is clearly for the vitamin K shot and, with regards to the research, one can't argue with that. However, please remember that you do have the final say as to what goes into your child's body. We do not know of any long-term side effects of the vitamin K injection but that does not mean that they do not exist. That is not research - that is just a reminder that research is not always the be-all/end-all. Evidence-based care takes into consideration family values, research, and provider experience.
An alternative to the Vitamin K shot is oral Vitamin K.

The hepatitis B vaccine is also given the day after birth in a hospital or at the first pediatrician appointment. This is the first in the vaccine series. Hepatitis B is transmitted through bodily fluid touching a mucus membrane; most often this is caused by sex or IV drug use. If you'd like to delay the vaccine, you can get it at the pediatrician's office later in the week or delay for longer. You also have the option to avoid the vaccine altogether. Keep in mind that vaccines do not offer lifetime immunity; their immunity wears off in about 10 years (with some wearing off much sooner) and then a booster would be necessary.

EVIDENCE BASED Birth®

Evidence that Empowers!

Evidence and Ethics on: Circumcision

By Rebecca Dekker, PhD, RN of EvidenceBasedBirth.com

Question: What is circumcision?

Answer: Male circumcision is the surgical removal of the foreskin (also called *prepuce*), which is specialized tissue that covers the head (or *glans*) of the penis.

Question: How common is circumcision?

Answer: About 30-33% of the world's males 15 years or older are circumcised. Of these circumcised males, about 69% are Muslim, 1% are Jewish, and 30% are circumcised for non-religious reasons.[1] The U.S., where 71% of men are circumcised, is unusual in its preference for non-religious circumcision. However, the rate of newborn circumcision is going down. When last reported in 2010, 58% of male newborns were circumcised before hospital discharge, and 42% were not.[2] The Western states have the lowest rate of circumcision, with a low of 31% in 2003.

Question: How does the penis develop?

Answer: Newborn males are normally born with their prepuce fused to their glans by a membrane, making it so that the prepuce cannot be *retracted*, or pulled back from the glans. Babies who are left intact (uncircumcised) should never have their prepuce retracted or pulled back toward their abdomen by force (e.g., during a bath or medical check-up). Forced retraction can cause pain, tearing and bleeding. In normal penis development, the prepuce usually becomes less attached and more retractable over childhood and adolescence.

Question: Is circumcision cleaner?

Answer: Both circumcised and intact males can maintain genital hygiene with regular washing. With an intact penis, there is no need to wash beneath the prepuce until it is easily retractable. The white substance called *smegma* that builds up in folds of genital tissue is normal for males and females (where it can build up between the labia and around the female prepuce, i.e. hood of the clitoris) and can be wiped away with washing. Once males discover (on their own) that the prepuce can be pulled back, they can be taught to clean the glans with water as part of a regular bathing or showering routine.

Question: What is the evidence on circumcision?

Answer: The research on newborn circumcision is extremely limited. Any research involving routine newborn circumcision comes from observational studies, not from randomized, controlled trials. Also, much of the research on circumcision comes from studies on males who were circumcised as adults, sometimes in Sub-Saharan African locations where there is a higher risk for certain infections.

There are serious concerns about how relevant this research is to newborns in other countries. Most of the evidence on newborn circumcision is highly disputed and any recommendations for practice are mostly weak.

Circumcised newborns may experience fewer urinary tract infections (UTIs). A review found that under 1 year of age, 1.38% of intact males had a UTI versus 0.14% of circumcised males.[3] About 111 circumcisions would be needed to prevent a single (treatable) UTI in infancy. Overall, UTIs occur more often in females. About 8% of girls and 2% of intact boys have had a UTI before age 7.

The rate of early complications after newborn circumcision is around 2%.[4] The most common complications are bleeding, swelling, and cosmetic concerns following the procedure that may lead to reoperation. Circumcision is also a very painful procedure that requires pain treatment.

Question: What is the ethical debate around routine male infant circumcision?

Answer: The debate centers on whether the practice respects or violates the principle of *autonomy*, or bodily integrity, of the male infant. For more info on the ethical debate, see page 2 of this handout.

> **"There is no compelling evidence to justify routine male infant circumcision on medical grounds."**

1. WHO and Joint UN Programme on HIV/AIDS (2007). Male circumcision: global trends and determinants of prevalence, safety and acceptability.
2. Owings, M., Uddin, S. and Williams, S. (2013). Trends in circumcision for male newborns in U.S. hospitals: 1979-2010.
3. Singh-Grewal, D., Macdessi, J. and Craig, J. (2005). Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observ ationalstudies. Arch Dis Child, 90(8), 853-858.
4. Weiss, H.A., Larke, N., Halperin, D., et al. (2010). Complications of circumcision in male neonates, infants and children: a systematic review. BMC Urol, 10, 2.

EVIDENCE BASED Birth®

Evidence that Empowers!

Evidence and Ethics on: Circumcision

By Rebecca Dekker, PhD, RN of EvidenceBasedBirth.com

Ethical Debate:

In addition to the medical evidence on circumcision, we also examined the research on 'Circumcision' and 'Ethics' published within the last 10 years.

We found 21 articles that discussed routine male infant circumcision, and we grouped them according to whether the author's viewpoint suggested they found the practice to be unethical or ethically justified. Of these, 13 papers portrayed routine male infant circumcision as unethical, 5 papers made the case that it is ethically justified, and 3 papers discussed both viewpoints.

We summarize the main points from these papers below to show their diverse views on circumcision and ethics:

View That Routine Male Infant Circumcision Is Not Ethical	View That Routine Male Infant Circumcision Is Ethical

• It is irreversible surgery on healthy minors who cannot give consent
• It causes pain and trauma during the surgery and suffering as the wound heals
• There are both immediate post-surgical risks, as well as unknown risks beyond the immediate post-surgical period, which together may outweigh the benefits
• It deprives the male of tissue that protects the glans and urinary opening
• It reduces the sensitivity of the penis by removing sensitive tissue
• There are less invasive and more effective preventions and treatments for many conditions it addresses (for example, condoms for HIV prevention and oral antibiotics to treat UTIs)
• New proposals to remove tissue from healthy infants would never get approval
• There is a *double standard* — a rule that is unfairly applied to one group but not another
  o Society would likely consider it unethical to remove healthy tissue from female infants' genitals even if there was evidence of health benefits
  o Every type of female genital cutting is recognized internationally as a violation, even when it does not remove any tissue (i.e. a ritual "prick")
  o We should "protect all non-consenting persons, regardless of sex or gender, from medically unnecessary genital cutting"
	• This view argues that it leads to significant medical and public health benefits over a lifetime
	• Its (known) benefits outweigh its (known) harms
	• Injection of local anesthetic to the base of the penis is safe and effective at reducing pain
	• Autonomy is respected by allowing parents to decide in the best interests of their child
	• Parents should be allowed to decide in the best interests of their child
	• We live in a diverse society that must be tolerant of families who elect the procedure for cosmetic preference or family tradition/belonging
	• Delaying the option until the age of consent misses some of the benefits of circumcision in early life (e.g., reduction in UTIs) and results in a higher rate of complications than when done in infancy
	• The risk of immediate complications is low (about 2% for newborns in prospective studies and 2-4% for adult males in African RCTs)

Supporting a Healthy Postpartum

The postpartum period is an exciting and challenging time in your life. It is normal to feel hormonal ups and downs during this transition. Traditional midwifery includes the 3 months following the birth of a child as part of the "childbearing year." It is normal and healthy to experience emotional shifts as your body, your mind, and your spirit adapt to new changes in lifestyle and love (both for your baby, your partner, and the world). Allow yourself time to be pampered in the postpartum just as you should be during pregnancy. Surround yourself with supportive friends and family and spend the day in bed with your baby whenever you can. Your body, your baby, and your sanity will thank you!

80% of birth parents in the United States experience baby blues. Baby blues show up in bouts of sudden tearfulness, mood swings, fatigue, anxiety, irritability, insomnia, and exhaustion. The best way to beat the blues is to relax, drink a cup of tea, go for a walk, get a massage from your partner, take some deep breaths, and relax. Baby blues will go away on its own and does not require treatment.

Postpartum depression is more serious. It affects up to 20% of new moms in the United States and can occur 4 weeks up to one year after the birth of a baby. Symptoms interfere with daily life; changes in weight and appetite, extreme fatigue, depressive episodes, rage, forgetfulness, feelings of incompetence, panic, sadness, poor concentration, social withdrawal, crying spells, guilt, confusion, and lack of interest or concern for the baby are all symptoms. Postpartum depression can affect partners as well; it is important for both parents to be supported in the postpartum period. Often the depressed parent is not in a state of paying attention to her/his need for help at this point. It is up to the partner to be conscious of the changes taking place and to help the partner seek treatment. Treatment can include counseling, vitamin therapy, medicine, homeopathy, and herbs.

DO NOT BE ASHAMED TO ASK FOR HELP!

Supporting a Healthy Postpartum

RESOURCES FOR EMOTIONAL POSTPARTUM SUPPORT

Postpartum Support International 1-800-944-4PPD
The Center for Postpartum Depression Dr. Barbara Lewin Germantown, PA
(some insurances accepted) 215-247-2114
The Pierce Women's Mood Center Dr. Barbara Lewin Germantown, PA
(flexible fees) 215-248-6107 Catherine White, LCSW Germantown, PA
(sliding fee scale) 215-307-7915
Parent to Child Kathryn Snyder, ATR-BC, LPC South Philadelphia, PA 215-450-5271
Perri Shaw Borish, MSS, LSW Center City, Philadelphia, PA 215-840-3554
Post Partum Support Services Andrea Elovson
Mt. Airy, PA 215-242-4548
The Postpartum Stress Center Karen Kleiman, MSW Rosemont, PA 610-525-7527
Counseling Practice of Donna Monk Donna Monk, RN, MS, LMFT Warminster, PA 215-343-3415
Tracey L. Dugan, SCSW Cherry Hill, NJ 856-797-6744
Dads Adventure www.dadsadventure.com
Postpartum Men www.postpartummen.com

Supporting a Healthy Postpartum

Coping with Postpartum Changes

Encourage support person to be home and available as much as possible

Advise support people about importance of nurturing parents and baby

Ask for help from the baby's older siblings

Limit outside responsibilities and engagements

Schedule time for the both partners if applicable

Set visiting hours and phone hours for friends and family

Take the help people offer

Have friends/family help with chores when visiting

Prepare meals in advance and freeze

Have drinks and snacks available

Create a nursing nook with pillows, books, phone, snacks, and drinks within reach

Have the numbers of local lactation resources available if applicable

Supporting a Healthy Postpartum

Coping with Postpartum Changes

Let your partner know when you need help or support

Breathe

Walk

Wear your baby and move your body

Limit or eliminate time with people who are not supportive or positive

Get out with your baby

Seek out other new families

Attend lactation and new parent support meetings

Supporting a Healthy Postpartum

Physical Postpartum Changes

While the uterus returns to its pre-pregnancy size, a vaginal discharge of mostly blood and uterine lining is shed. This is called lochia. It begins red then turns brown, white, or yellow. It may take up to 8 weeks for the lining to shed. increases in activity will increase the bleeding and is a sign to slow down.

Continue with kegels and pelvic tilts the day after you give birth. These will help strengthen and lengthen the pelvic floor muscles that have been affected by pregnancy. (It is normal to feel like you have little control over your bladder in the first few days after birth.) Keep the perineum clean and wipe from front to back always. Healing can take 4 weeks or longer.

After birth, the uterus is hard and round under the belly button. Within 6 weeks, it returns to its pre-pregnancy size. Uterine contractions during the first postpartum weeks can be uncomfortable or painful (more so with subsequent births) and you may have to breathe through them as you did in labor. They are felt more strongly while nursing as oxytocin helps your uterus return to its pre-pregnancy size. Drink plenty of water and keep emptying your bladder.

Cope with hemorrhoids using witch hazel pads, black tea bags, and continuing kegels. Eat plenty of fiber and drink lots of water.

Supporting a Healthy Postpartum

Physical Postpartum Changes

Within 24 to 48 hours after birth, most people will have their first post-birth bowel movement. Postpartum people should not take over-the-counter laxatives or stimulating herbal laxatives while nursing.

Increased sweating and urination are normal parts of eliminating the extra body fluid that accumulated during pregnancy. This can last several months. Many traditional cultures avoid all cold foods and ice in the postpartum period to encourage fluid elimination. Ginger or cinnamon tea can help encourage fluid elimination.

Vaginal dryness is nature's way of helping you to take care of your baby by making it uncomfortable to have sex. Use lubricant when making love.

Sex can resume when your bleeding stops and both partners feel ready. Be gentle to your body and give yourself time. Loss of interest in sex is normal at this time due to all the changes taking place and decreased estrogen. Explore other ways to be intimate and sexual.

Do not lift anything heavier than your baby while you are bleeding! Pelvic tilts, kegels, and walks with your baby are enough exercise.

Listen to your body.

Check out our FREE one hour webinar on physical postpartum recovery at www.blossomingbelliesbirth.com/webinars-for-parents.html

BIrth Plan Template

This template is intended to be used as a way of discussing preferences and priorities in advance of the birth process.

Through seeing an in-depth list of common procedures, expecting parents can do research and figure out what they prefer and what they do not prefer.

This is intended to be used as a tool for informed decision making, communication with providers, and the evidence based decision making process.

Laboring people have the right to consent, refuse, or delay any procedure. The wording of this form is meant to show that right and is not intended to encourage or promote one decision over another.

This Is Your Birth.

THIS IS YOUR BIRTH.

Blossoming Bellies Wholistic Birth Services
Brittany Sharpe McCollum, CCE(BWI), CD(DONA), CLC, Pernatal Pelvic Biomechanics Educator
www.blossomingbelliesbirth.com
@blossomingbelliesbirth

My In-Depth Birth Plan

@blossomingbelliesbirth

My birth support team includes:

My Top Priorities In My Birth Are...

Additional Things Very Important to Me Are...

Checklist for Your In-Depth Birth Plan: Labor

@blossomingbelliesbirth

Clinical Support

My preferred provider for labor support is:

- ☐ midwife
- ☐ obstetrician
- ☐ other: _____

☐ I want the informed consent process at all times. Please share with me all benefits, risks, recent research, alternatives, and information about the option of doing nothing.

In regards to medical/nursing students, I am comfortable:

- ☐ having them clinically involved
- ☐ having them present but NOT clinically involved
- ☐ not having them present

Movement

☐ I want to be encouraged to change position every five contractions.

☐ I plan to move all throughout labor, with or without an epidural, including during the second stage.

Monitoring

My preference for monitoring is:

- ☐ intermittent with the Doppler
- ☐ intermittent with the electronic fetal monitor
- ☐ continuous with wireless monitor
- ☐ continuous with the electronic fetal monitor

Checklist for Your In-Depth Birth Plan: Labor

@blossomingbelliesbirth

Induction/Augmentation

- [ ] If I consent to induction, I expect a conversation about available methods including the Foley or Cook's balloon, Cervidil, Cytotec, and Pitocin.
- [ ] I do not want Pitocin administered automatically.
- [ ] I do not want my water broken artificially unless I give explicit consent..
- [ ] I do not want Cytotec administered for augmentation.

Hydration/Nourishment

- [ ] I will hydrate by mouth.
- [ ] I do not want IV fluids unless I choose to have an epidural.
- [ ] I will eat as desired throughout my labor..

Pain Relief

- [ ] I do not want narcotic pain relief.
- [ ] I do not want nitrous oxide.
- [ ] I do not want an epidural.
- [ ] I will request pain relief if I desire.

- [ ] I would like the following for pain relief: _____

Checklist for Your In-Depth Birth Plan: Labor

@blossomingbelliesbirth

Additional Preferences

- [ ] I would like to use the shower and/or tub for support.
- [ ] I would like to use props for support such as the birth ball, peanut ball, squat bar, birthing stool, CUB, and birthing chair.
- [ ] I would like pictures of my labor and birth.
- [ ] I have created a music playlist for labor.
- [ ] I would like low lighting in the room.
- [ ] I would like the room to be warm.
- [ ] I have specific clothing I would like to wear. This includes:

  _____

  _____

  _____.
- [ ] I would like the room to be warm.

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Checklist for Your In-Depth Birth Plan: Vaginal Birth

@blossomingbelliesbirth

Movement/Positions

- [ ] I will continue to move every five contractions with or without an epidural.
- [ ] I would like to be supported in birthing upright - semi-squat, kneeling
- [ ] I would like to try side-lying and modifications to reclined positions such as placing a rolled towel under my back or under one side of my bottom.
- [ ] I will use positions that free my sacrum.
- [ ] I will use internal thigh rotation to create maximum space at the outlet of my pelvis throughout pushing.

Pushing/Crowning

- [ ] I will push when my baby is at the pelvic outlet (+2 station) or bearing down is involuntary even if this is not immediately upon full dilation.
- [ ] I will exhale as I bear down to protect my pelvic floor.
- [ ] I will push without a timeline as long as I am fine and my baby is fine.
- [ ] I do not give consent for my provider to use perineal massage.
- [ ] I do not want perineal support at the point of crowning.
- [ ] I would like a mirror to see my baby crowning.
- [ ] I do not give consent for an episiotomy.
- [ ] I do not want vacuum or forceps unless I give explicit consent. .
- [ ] I do not give consent to the baby being suctioned routinely..
- [ ] I would like my support person or doula to take pictures of the birth.

Checklist for Your In-Depth Birth Plan: Cesarean Birth

@blossomingbelliesbirth

Provider Expectations

- [ ] I would like each step of the process to be clearly explained to me prior to the start of the cesarean.
- [ ] Please minimize side conversation.
- [ ] I do not want students present.
- [ ] I do not want the baby's sex to be called out.

Support

- [ ] I would like my primary support person and my doula to be present.

Environment

- [ ] I would like low lighting.
- [ ] I would like warm temperature in the OR.
- [ ] I have music that I would like played.
- [ ] I would like a clear drape or the drape to be removed when the baby is born.

Type of Suture

- [ ] I would prefer double layer suturing if possible.

Additional Preferences

- [ ] I would like to walk into the OR if I do not have pain medication prior.
- [ ] I do not want my hands tied down.
- [ ] I request delayed cord clamping.
- [ ] I request skin to skin with my baby in the OR.
- [ ] I want photos taken at the time of birth and in the postpartum.

Checklist for Your In-Depth Birth Plan: Postpartum

@blossomingbelliesbirth

Immediate Postpartum After Vaginal Birth

- [ ] I request skin to skin contact until I state otherwise.
- [ ] I request delayed cord clamping until the cord is white; I will decide when it is time to cut the cord.
- [ ] If there is any need for the baby to leave my room, I or my partner will accompany them at all times.
- [ ] If there is any need for the baby to leave my room, I or my partner will accompany them at all times.
- [ ] I do not consent to fundal massage unless there is a concern about my bleeding.
- [ ] I do not consent to IM or IV Pitocin unless there is a concern about my bleeding.
- [ ] If there is a need for suturing, please fully discuss with me each step of the process including pain medication options.
- [ ] I will be keeping my placenta.

Immediate Postpartum After Cesarean Birth

- [ ] I would like to nurse my baby as soon as possible.
- [ ] If I am unable to nurse my baby, I request a pump be brought to me within the first hour after birth so that I can begin stimulation by two hours postpartum.
- [ ] If general anesthesia was administered, I would like my support person or doula to help initiate nursing.
- [ ] I will be keeping my placenta.

Checklist for Your In-Depth Birth Plan: Newborn Procedures

@blossomingbelliesbirth

some procedures are standard therefore you will have to decline them if preferring they not be done

The First Few Hours After Birth

- [ ] I do not give consent for the Vitamin K shot.
- [ ] I will be administering oral Vitamin K.
- [ ] I do not give consent to erythromycin eye ointment.
- [ ] I do not give consent to the PKU test.
- [ ] I do not want a pacifier used or a bottle given.
- [ ] I do not want formula or sugar water given. I will pump and provide colostrum if necessary.
- [ ] All newborn procedures must be completed in my room.

The First Few Days After Birth

- [ ] All newborn procedures must be completed in my room.
- [ ] I do not give consent to the hearing test.
- [ ] If my baby develops jaundice, I would like all my options discussed in depth.
- [ ] I will not be circumcising my newborn.
- [ ] I would like to see the lactation consultant as soon as possible.
- [ ] I will not be giving our baby a sponge bath.
- [ ] I would like my nurse to show me how to bathe my baby.

Send all birth records to our pediatrician at:

_____

_____

_____

Checklist for Your In-Depth Birth Plan: In the Case of Extenuating Circumstances

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- [ ] I want every opportunity possible to see and hold my baby.
- [ ] If I am unable to hold my baby, my support person will.
- [ ] If I am unable to make decisions, I give permission for _____ to make decisions on my behalf.
- [ ] I give consent for a blood transfusion.
- [ ] I do not give consent for a blood transfusion.
- [ ] If my baby goes to the NICU, I will be pumping to build supply and feed my baby.
- [ ] If my baby goes to the NICU, I would like access to donor milk.

Additional Information:

_____

_____

_____

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