Good Birth Practices

1. Hospitals encourage laboring at home until active labor

In recent years, the definition of active labor has changed to reflect current research that active labor begins around six cm. That is not to say that hard work requiring significant coping doesn't happen prior to six cm, but everyone understands that for healthy low-risk pregnant people, interventions are more likely to be avoided if they are admitted once they reach active labor. You need to be prepared for possibly doing a lot of laboring outside the hospital. Early labor can last 24 hours or more and that is very normal. Be ready to do a lot of laboring at home. Use your relaxation/distraction skills. Watch a movie, go for a walk, take a bath, listen to music, clean the house, etc. Go to the hospital when contractions are 4 min apart for two hours lasting 1 min and ½ each.

2. Active and expectant management of PROM are both equally good choices

For about ten percent of pregnant people, the membranes release prior to contractions or labor. This is called PROM which stands for premature rupture of membranes. Current best practice shows that the outcomes for both the pregnant parent and the newborn are the same (APGAR scores, cesarean rates, infection, etc) if families wait for 24 plus hours for labor (expectant management) or choose to get labor started with an induction shortly after the water breaks (active management). Waiting is an option and most people will go into labor within 24-48 hours. ACOG is now encouraging families to receive information and have the choice of waiting or getting things going medically. The risk of infection starts 24 hour after something has been in the vagina (vaginal exam, sex, etc) not 24 hours after membranes have ruptured. You can also monitor yourself for signs of infection. Take your temperature every hour and watch to see if it rises.

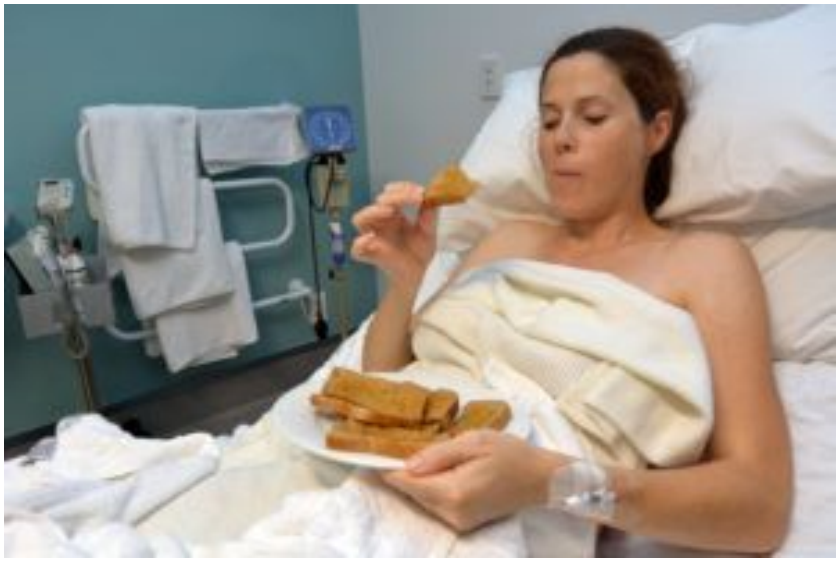
3. Intermittent fetal heart rate monitoring is appropriate for low-risk labors

Evidence has shown for years that continuous fetal monitoring for low-risk labors does not improve outcomes yet many people are not given the option of intermittent auscultation during their labors. ACOG finally recognizes that intermittent monitoring is appropriate for many people and should be offered. Discuss this option in advance of labor with your doctor or midwife. Continuous fetal monitoring for a low-risk labor can actually increase unnecessary interventions. With continuous monitoring, mom is asked to remain near or in the bed so the baby can be monitored and then she remains tethered to the monitoring responders and wires. This limits her movements and can possibly lead to needing an epidural or slowing labor down.

4. Artificial rupture of membranes in labor is not necessary

ACOG now recognizes what research has demonstrated for years, that artificially breaking the water has little benefit to the labor and in fact may increase the risk of infection, cause a malpositioned baby and in a very small number of births, create an emergency from a prolapsed cord or placental abruption. Membranes will release at the appropriate time and it is perfectly normal to labor with intact membranes and it is not necessary to have your doctor or midwife break them. Current research and the new committee opinion supports this.

5. Eat, drink and labor on!



In this recent committee opinion, ACOG has stated that drinking during labor is preferable to IV hydration. Be prepared with lots of healthy beverages (coconut water, sports drinks, EmergenC, broths, juice) to consume during your labor. Bring along your favorite sports water bottle to make drinking even easier. ACOG even alludes to the benefits of eating in labor, acknowledging that the risk of eating solid food in labor is almost non-existent and that in fact, eating can keep a person strong and energized. For low-risk labors that are not medicated, there is no reason to be receiving IV fluids. Evidence Based birth recently evaluated the research and found that food is restricted in labor due to anesthesiologists worrying that women could aspirate (vomits stomach contents into lungs) in an emergency c-section. According to the research only 1 death occurred in 1.4 million births. That means your risk is very low of that happening to you. Being tired and worn down from not eating in labor actually increases your chance of need a c-section. Most hospitals will not give you food or drink in labor, so plan on bringing lots of snacks or sending your support team to get you food.

6. **Labor down and push spontaneously with the urge to push**

Most people do not benefit from being told to hold their breath and push to a count of ten during second stage. In fact, research shows that people will spontaneously push to a count of six when left alone to do it on their own. Letting breath out during the push through vocalizations or noises can be helpful, and pushing with the urge to push for as long as feels good helps the baby to stay oxygenated during this stage of labor. Additionally, being ten cm does not automatically mean that a person must start pushing. The uterus is a strong, amazing muscle and can do lots of work to move the baby down and into the birth canal without much pushing effort on the part of the laboring person. As the baby moves into the vagina, the urge to push will usually start to become more intense. That is a great time to start pushing! This is especially beneficial for people who have chosen to have an epidural. It can be normal to delay pushing until the baby moves down a bit lower and there is more of an urge to push. ACOG is

recommending that people be permitted to push as they feel appropriate and that laboring down, especially with an epidural, offers many benefits.

7. Reducing labor and birth interventions is a good thing

Many choices exist in labor to help you as you labor. As soon as you choose for your care provider to **intervene** in the birthing process to assist in the delivery of your baby there are consequences good and bad. You will have to decide what is best for your situation. Here are some examples. Choosing an I.V., heplock, or continual baby monitoring limits your movements and may cause you to feel uncomfortable which adds to your stress instead of calming you in labor. You just lost your freedom of movement in labor. Walking the halls and some labor positions are hard to get into with an I.V. Here's another example. Choosing an epidural leads to needing an I.V., catheter, blood pressure cuff, pulse ox, and baby monitoring. All of these wires and the inability to move your legs majorly limits your positions and labor progress. Plus, choosing an epidural can lead to "epidural fever" and needing pitocin to speed up labor. You just increased your risk of needing a c-section. Researchers are now looking into if the relaxed uterine muscles due to an epidural cause the baby to get into a bad position therefore needing a c-section. If you want the best birth possible with the most options, ask your care provider for other options before deciding. Use B.R.A.N.D. : Ask about the Benefits, Risks, Alternatives, Now/Not Now/Never, and Decision. What are the Benefits of what you suggested? What are the Risks of what you suggested? What are the Alternatives? Could we get results trying something else? What happens if we do it Now/Not Now/ Never? Can you give us a few minutes alone to decide? If they are talking to you, there is time for you to ask questions before deciding (even if you only take 2 minutes).

Following these suggestions can help you to have the best birth possible and possibly avoid a c-section. Once you have a c-section, your options are severely limited for your next birth. It can be hard to find a care provider to support you for a VBAC (Vaginal Birth After Cesarean).