THE Labor + Birth TOOLKIT

THEEDUCATEDBIRTH.COM

ABOUT THIS TOOLKIT

The Educated Birth creates and curates inclusive reproductive health education and storytelling content. We create infographics and illustrations reproductive health workers can use as teaching tools, and parents can learn from.

Written by Cheyenne Varner. Edited by Janice Formichella. Peer-reviewed by professionals in the reproductive health space.

None of the information in this toolkit is or should be interpreted as medical advice. Always talk to your care provider about any questions or concerns you may have!

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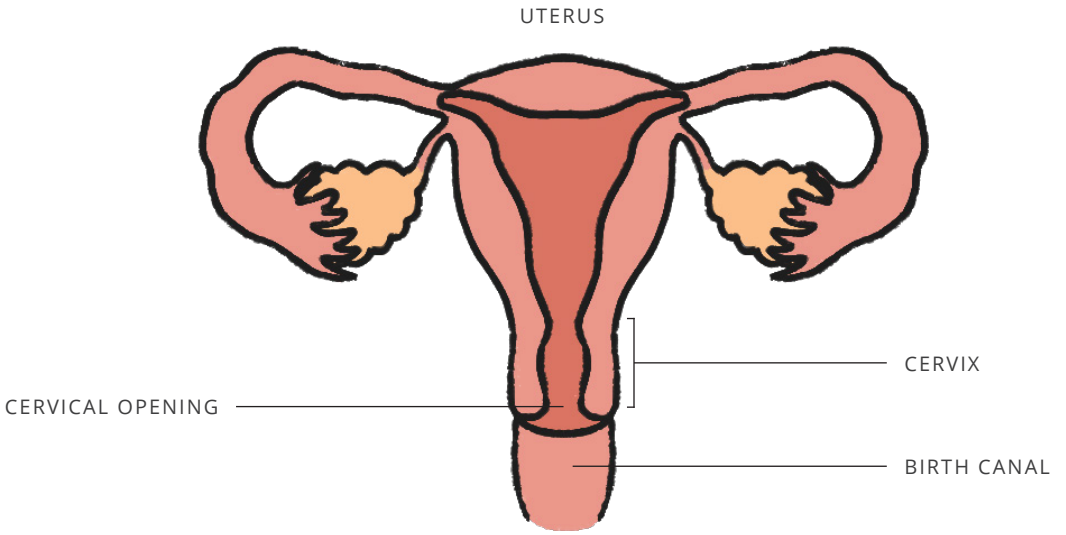
TIPS FOR USING THIS TOOLKIT

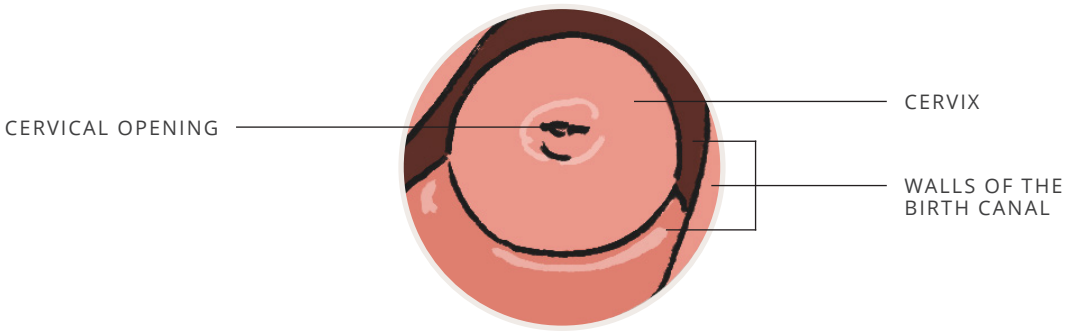
This toolkit can be used in digital and print formats. Provide the digital toolkit via email to clients who book with you. Print activity pages as needed to pass out in classes, place into client packets, or offer during individual prenatal sessions.

See our website www.theeducatedbirth.store for poster-sized prints of anatomy pages to put up on office, patient room, and/or classroom walls.

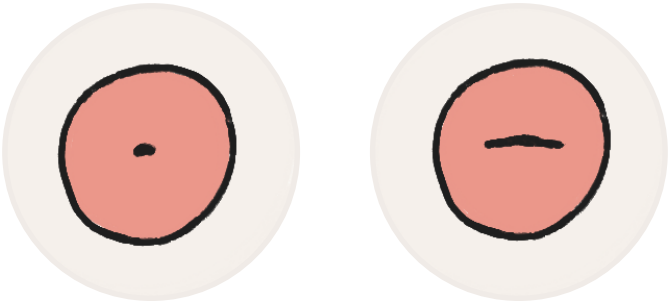
The Cervix

ANATOMY SHEET





View of the cervix from inside the birth canal



The cervical opening before pregnancy

The cervical opening after pregnancy

The Pelvis + Fetal Station

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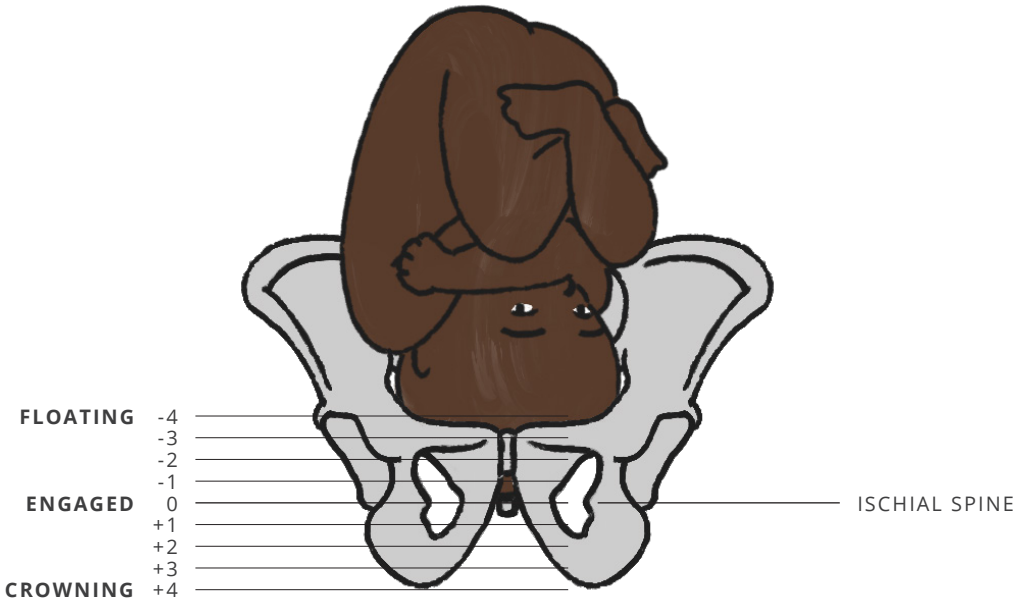
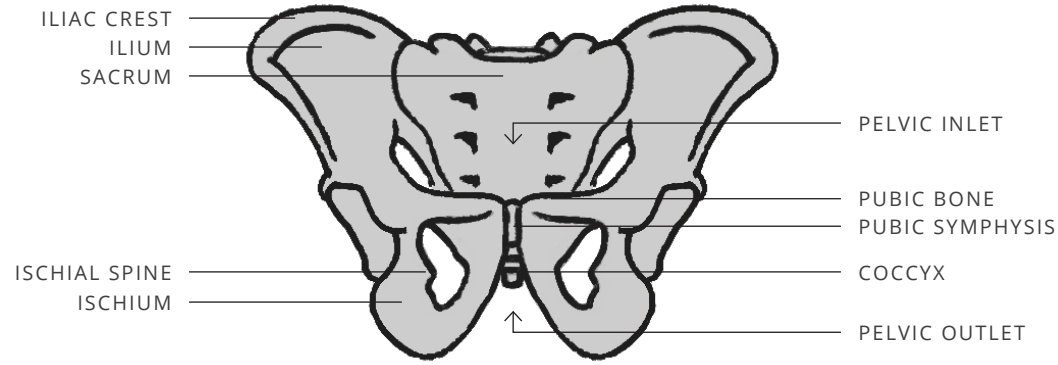
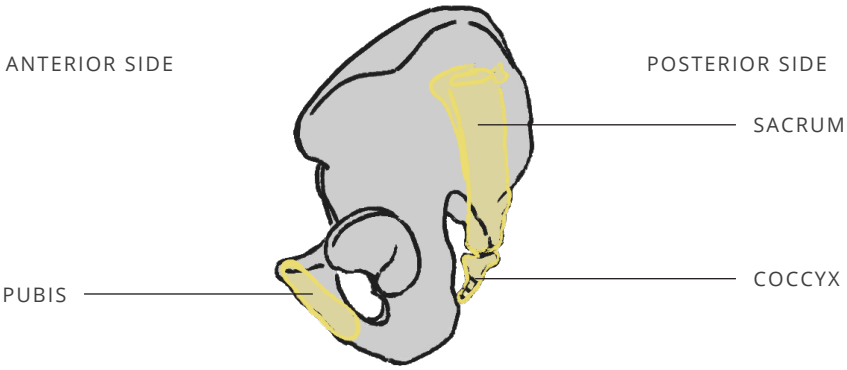
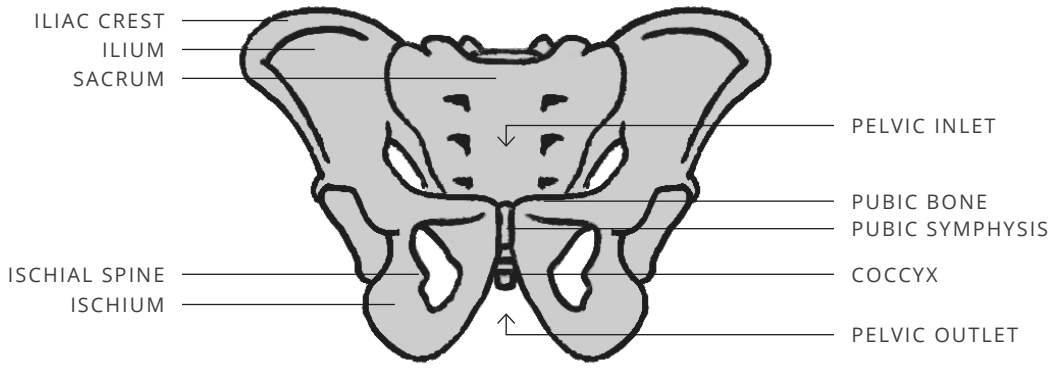


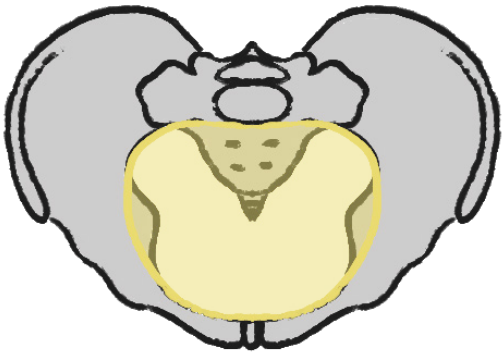




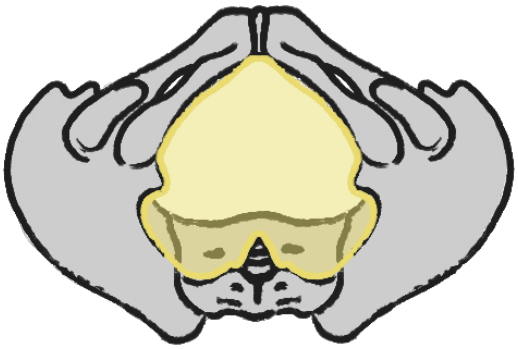
The Pelvic Inlet + Outlet

ANATOMY SHEET





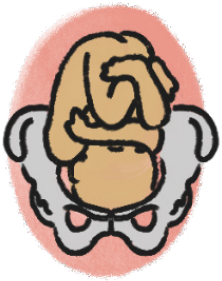
View of the pelvic inlet from the top of the pelvis



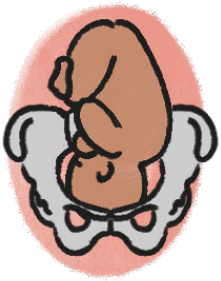
View of the pelvic outlet from the bottom of the pelvis

Fetal Positions

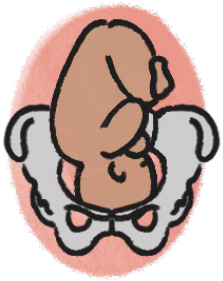
ANATOMY SHEET



Right Occiput Posterior (ROP)

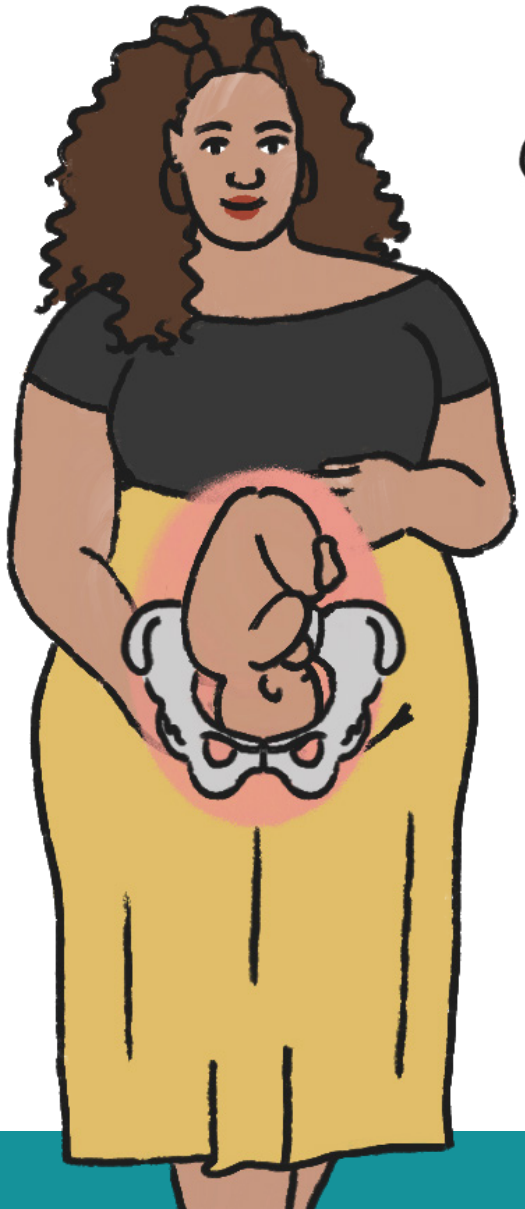


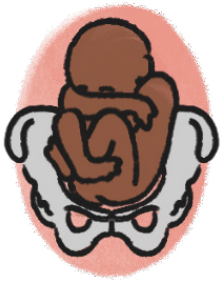
Left Occiput Anterior (LOA)



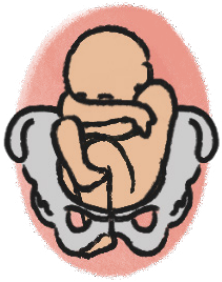
Right Occiput Anterior (ROA)

Left Occiput Posterior (LOP)



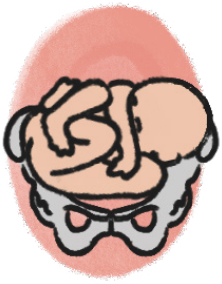


Complete Breech



Footling Breech

Frank Breech

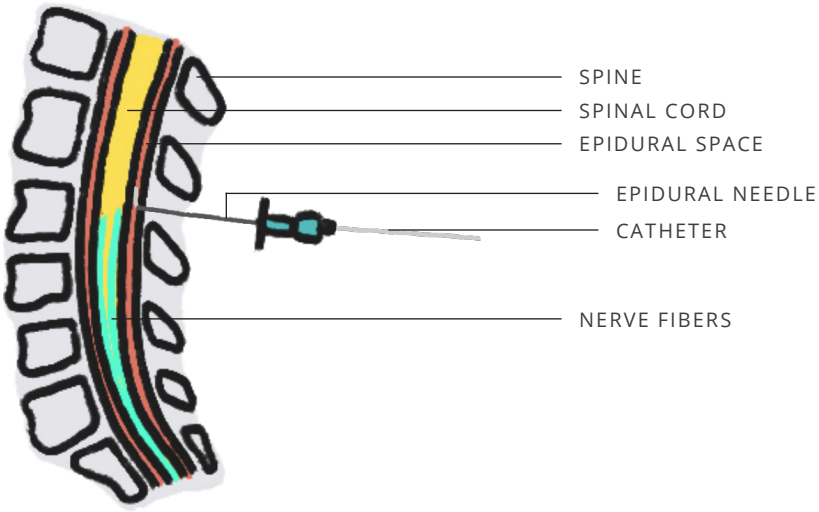


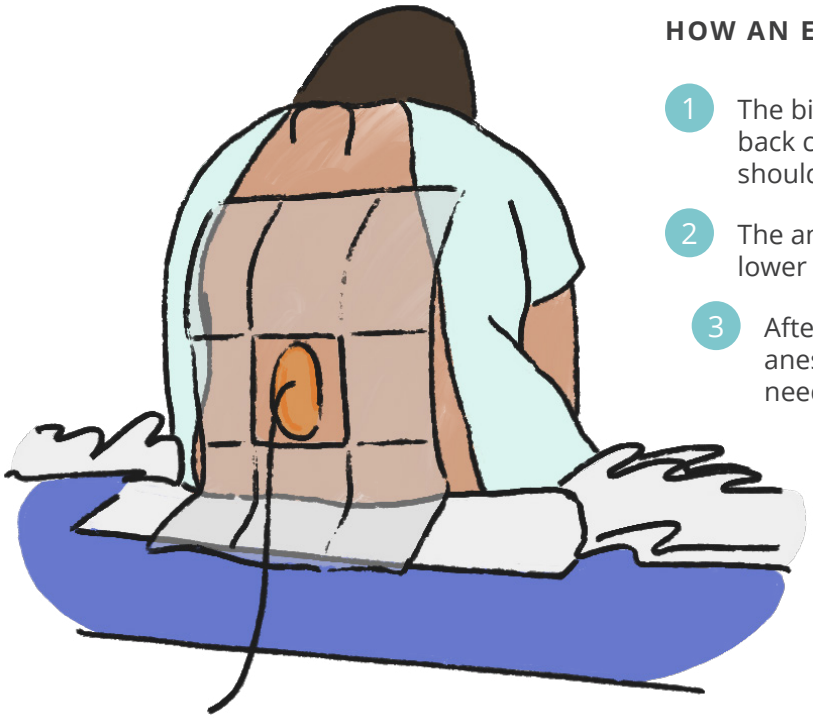
Transverse

Oblique

Epidural Placement

ANATOMY SHEET



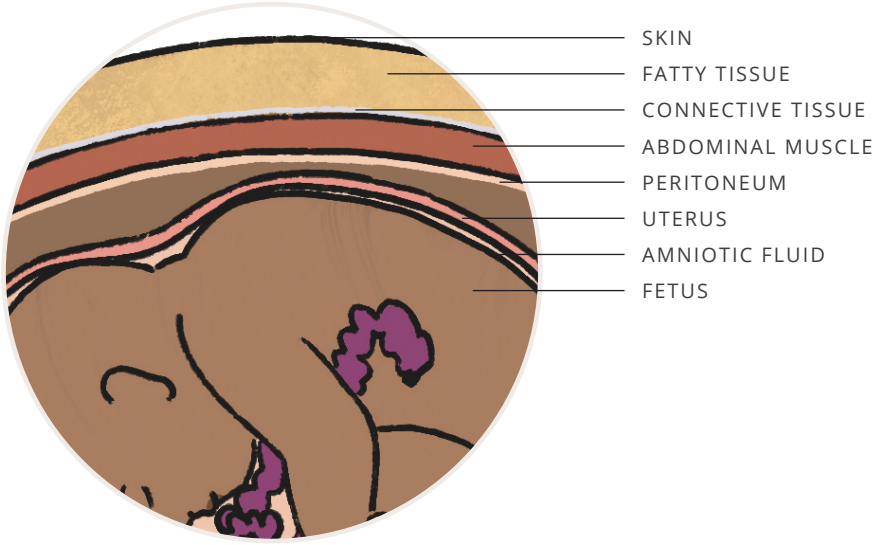


HOW AN EPIDURAL IS PLACED

1. The birthing person sits with their back curved, lower back pushed out, shoulders down, and chin down.
2. The anesthesiologist cleans their lower back and numbs their skin.
3. After the skin is numb, the anesthesiologist places the epidural needle into their back.
4. The anesthesiologist threads the epidural catheter through the needle.
5. After the catheter is in place, the needle is taken out and the catheter is taped to the lower back.

Cesarean Birth

ANATOMY SHEET



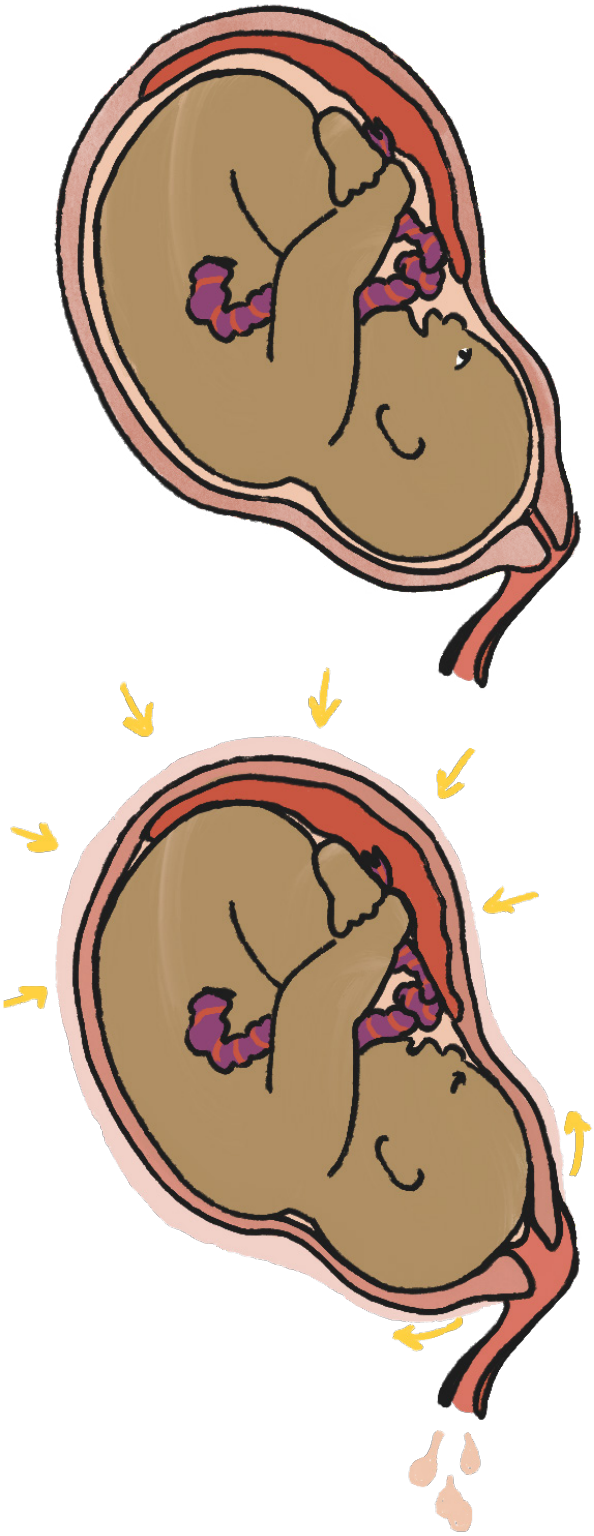
STEPS OF A CESAREAN SECTION*

1. The birthing person is given an IV, a spinal block or epidural anesthetic, and their bladder is drained with a catheter. They're positioned lying flat on a table with their legs secured — hair around the surgical site is shaved, the skin is cleaned, and sterile material is draped all around the belly.
2. The first incision in the skin can be made vertically (from the belly button to the pubic hairline) or horizontally (from side to side).
3. Additional incisions go through fatty tissue and connective tissue.
4. Abdominal muscles are separated (not cut), and lastly incisions are made in the peritoneum and the uterus.
5. Pressure and pulling are often felt as the amniotic sac is opened and the baby is born through this abdominal passage.

**a non-emergency cesarean section*

Contractions

BRIEFLY EXPLAINED



1 Hard work from one of your strongest muscles. By the third trimester the uterus is about the size of a watermelon, extending from the bottom of the rib cage down to the pubic area. It's known as one of the strongest muscles in the body, alongside the heart.

2 They're driven by the hormone Oxytocin. Hormones are a substance that's produced in our glands and sent through the bloodstream to various tissues, telling them what to do. Oxytocin is released through the Pituitary gland in the brain. It tells the muscles of the uterus to contract, and also leads to the release of other hormones like prostaglandins, which create more contractions, and endorphins, which are calming and pain-relieving.

3 You might call them "Waves" or "Surges" instead. If the word "contractions" feels scary, replace it with another that feels more positive. Fear produces the hormone adrenaline, which can slow or stop labor altogether.

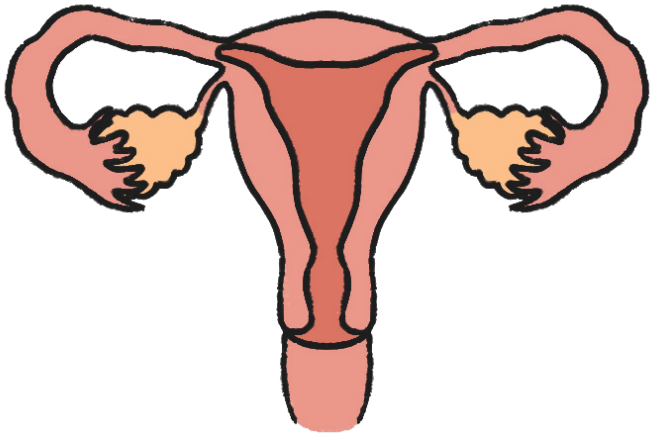
4 Naturally, they follow a wave-like pattern. Contractions produced by your body's flow of Oxytocin swell in and swell out over 30 to 90 seconds — starting, building, peaking, calming, and allowing for rest in-between. The more you breathe through and tune into each one, the more hormonal benefit you receive.

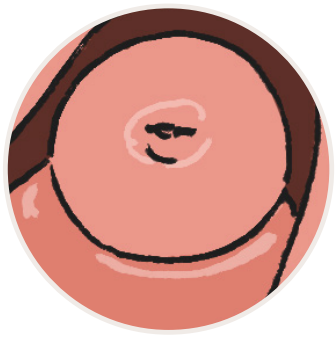
5 Contractions do a lot! Early contractions prepare your cervix to soften, thin and dilate, get your ligaments and muscles and pelvis ready, and can re-position your baby. Later, contractions push your baby down your pelvis, through the birth canal, and into the world with you.

Sources + Recommended Resources: American College of Obstetricians and Gynecologists; Verywell Family; Cleveland Clinic

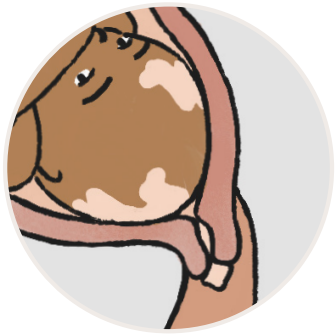
The Cervix

BRIEFLY EXPLAINED





View of the cervix from inside the birth canal



The mucus plug sealing the cervix

What is the cervix? The cervix is the lower part of the uterus. About two inches long, it looks like a raised, dimpled circle poking into the birth canal.

What does the cervix do? The cervix is the opening to the uterus.

During menstruation it allows blood to pass through. During intercourse and intrauterine insemination it allows sperm to pass through (it even secretes a special mucus that makes it easier for sperm to enter around ovulation). During pregnancy, the cervix secretes a thick mucus that prevents access to the uterus.

Before labor begins, the cervix starts to change. Information about the position of the cervix, how firm/soft it is, how much it has thinned out (or effaced), how much it has dilated, and where the fetus is in the pelvis can help inform what options are used to encourage and/or support the start of labor.

During labor, as contractions push the baby down, the cervix will dilate to about 10cm and the baby will move down through the pelvis into the birth canal.

What is the mucus plug? The mucus plug is a thick collection of mucus the cervix creates to seal the uterus off and protect the baby from bacteria and infection. As the cervix begins to dilate, it can fall out in a large glob or in pieces. It can look clear/off-white, or be tinged slightly with blood. The mucus plug isn't always noticeable. Some people never know they've lost it.

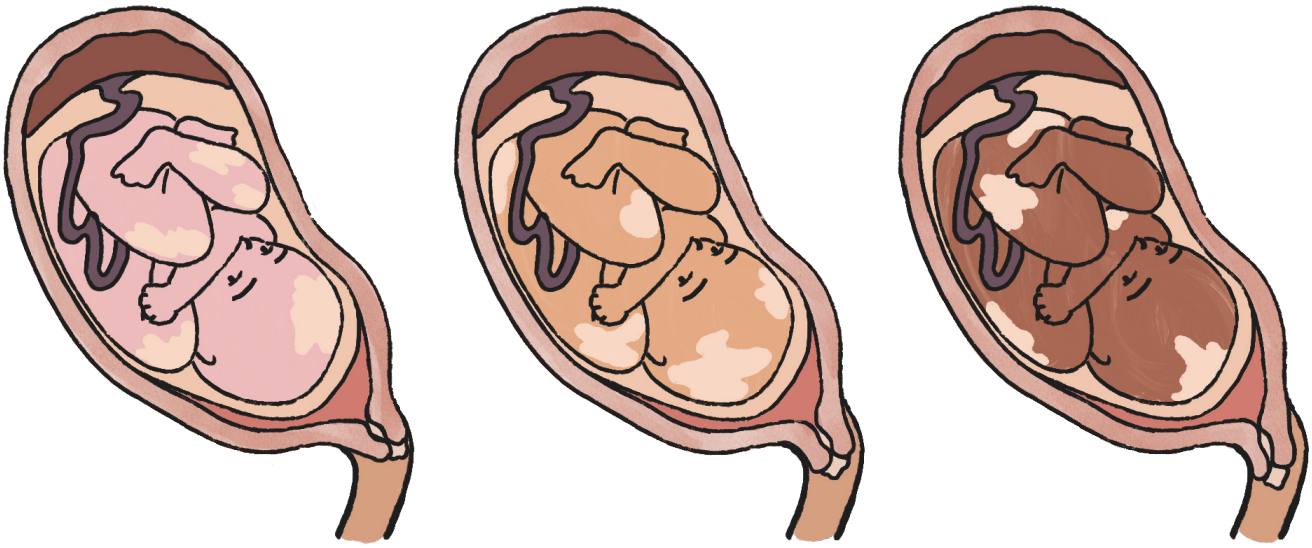
What is a cervical cerclage? In uncommon cases where the cervix softens, shortens, or opens too early in pregnancy, a cerclage — a stitch that keeps the cervix closed — may be offered. Later in pregnancy, the stitches are removed for labor and birth.

Sources + Recommended Resources: American College of Obstetricians and Gynecologists; Verywell Family; Cleveland Clinic

How the Cervix Changes

BRIEFLY EXPLAINED

POSITION + SOFTNESS



POSTERIOR CERVIX | MIDLINE CERVIX | ANTERIOR CERVIX

How do I know if my cervix is changing? In the final weeks of pregnancy, your provider may offer to do a cervical exam. You can also feel your cervix yourself!

How, when, and why does the cervix move? Around week 37 or 38 of pregnancy, **the cervix usually shifts forward** — from a posterior to an anterior position. This happens outside of pregnancy, too — the cervix moves to a higher (posterior) position during ovulation, and a lower (anterior) position during menstruation.

When does the cervix soften? Before labor begins **the cervix also starts to soften**. It goes from feeling firm, like a knuckle or the tip of your nose to soft, feeling more like your lips.

What helps the cervix soften? Hormones like prostaglandins and pressure from a lowering fetus's head help soften the cervix. Medical interventions like applying prostaglandins via medication, membrane sweeps, or a foley bulb can help the cervix soften. Non-medical interventions include sex and nipple stimulation. These are all known as methods of **cervical ripening**.

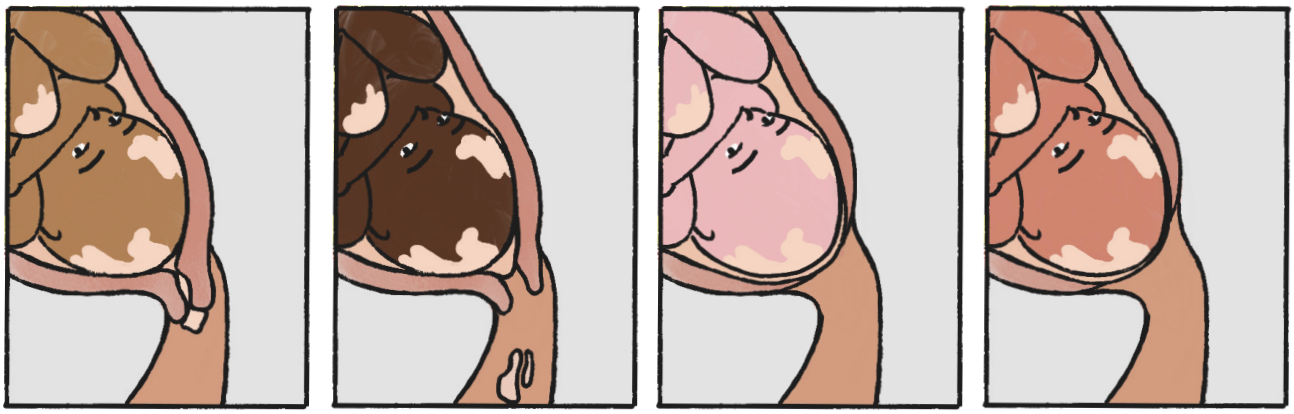
WILL A CERVICAL EXAM TELL ME WHEN LABOR WILL BEGIN?

A cervical change in late pregnancy is not a solid sign that labor is near or starting by itself! It simply provides information that may help you decide with your birth team what options to use (or not use) to encourage and/or support the start of labor.

How the Cervix Changes

BRIEFLY EXPLAINED

EFFACEMENT AND DILATION



0% EFFACED,
0 CM DILATED

60% EFFACED,
2 CM DILATED

100% EFFACED,
5 CM DILATED

100% EFFACED,
10 CM DILATED

What are effacement and dilation?

Effacement is the stretching and thinning of the **cervix**. **Dilation** is the opening of the **cervix** from 0 to 10 centimeters. Both happen as a result of uterine contractions and pressure from the fetus's head lowering.

Do they always happen in the same order?

For first-time birthing people, **effacement** usually happens first, followed by **dilation**. For people who've given birth before, they usually happen at the same time. The cervix can be 2 cm opened, for example, and 70% thinned out. Once the cervix is fully effaced and fully dilated, the fetus can lower more through the pelvis.

While it's easy to become attached to these numbers, it's important to know that the pace of labor is different for most birthing people and even different births for the same people.

What do these measurements mean for labor?

While you may use this information to guide what you decide to do next (rest, get active, try a new position, get in the water, etc.), these numbers do not tell us how much longer a labor will be.

What is a mucus plug and what does it have to do with the cervix?

One sign that the **cervix** has started to **efface** is the loss of the **mucus plug**. During pregnancy, mucus forms on the cervix to protect it from infection. As the cervix thins out, this mucus loosens and drops from the birth canal. When the mucus is tinged with blood, this is called **bloody show**.

Sources + Recommended Resources: Healthline: Parenthood; What to Expect; The American College of Obstetricians and Gynecologists; March of Dimes; University of Michigan Medicine; Spinning Babies; Evidence Based Birth; Verywell Family

WHAT IS THE BISHOP SCORE + WHAT SHOULD I KNOW ABOUT IT?

The Bishop Score is a measure from 0 to 13 based on the cervix's dilation, thinness (effacement), softness, position, and how high/low the baby is in the pelvis. It may be used to assess how "ripe" or ready the cervix is for labor — a lower score meaning it isn't ready, a higher score meaning it is. The Bishop Score has some important limitations, including that it doesn't consider whether someone has given birth before.

Dilation + Cervical Exams

BRIEFLY EXPLAINED

1 They do not predict the start or length of labor. A cervix can be dilated 1-2 centimeters and still be preparing for labor for hours, days, even weeks. Generally speaking, dilation (which means opening/widening) is aided by long, strong contractions, bonding calmly with a partner/loved one(s), and movement and positions that put pressure on the cervix. It can be stalled by restriction of movement, fear, and mental/emotional distress.

2 Evidence disputes the benefit of weekly cervical exams at the end of pregnancy. When studied, some researchers found no harm or benefit from the practice, while others found parents with weekly cervical exams were three times more likely to have premature water breaking.

3 Cervical exams and membrane sweeping. Cervical exams tend to be most comfortable when they're not rushed and the birthing person can breathe and focus on relaxing the pelvic floor while the exam happens. A cervical exam may lead to early water breaking if it includes membrane sweeping. Membrane sweeping is when a care provider uses their finger to separate the bottom of the uterus from the amniotic sac. Membrane sweeping is often meant to decrease the need of induction, but it can also be painful, cause bleeding, irregular contractions, early water breaking, and induction. Be clear with your care provider if you're not interested in a membrane sweep with your cervical exam; it should only be performed with informed consent.

4 You can ask why. Ask your care provider why they suggest a cervical exam if you're unsure. If you're planning an induction or if you've been actively laboring in a changed position for a few hours, for example, knowing how dilated the cervix is may help determine next steps.

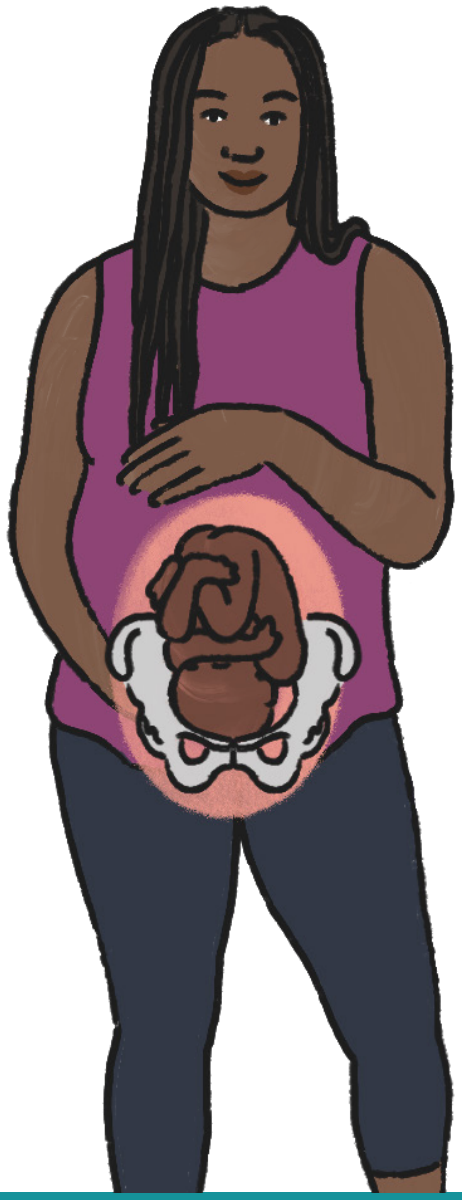
5 You can say no. You don't need a specific reason to decline. "No, I don't want it," is more than enough.

Sources + Recommended Resources: Evidence Based Birth; Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

Position of the Baby

BRIEFLY EXPLAINED

1 "Station" is where the baby's head is in the pelvis. Travel from the top of the pelvis to the bottom is measured on a scale of -5 to 0 to +5. When a baby is at station 0, they're in the middle. When a baby is at station +5, they're beginning to crown. Descent into the pelvis can start before labor begins, though not always. Most descent happens during the pushing stage of labor.



2 "Presentation" is which part of the baby's body will be birthed first. If the crown of the baby's head will be delivered first, that's called vertex or cephalic. If butt first, that's frank breech; foot/feet first, that's footling; butt and feet, that's complete breech; there's also shoulder, face, or brow. If baby is lying sideways over the pelvis, that's called transverse.

3 "Position" is the direction of the baby's head. Doctors and midwives have shorthands for these positions: LOA, OP, LOP, ROT, RSA, etc. LOA (Left Occiput Anterior). Posterior position, when baby faces your belly, is more likely to cause back labor.

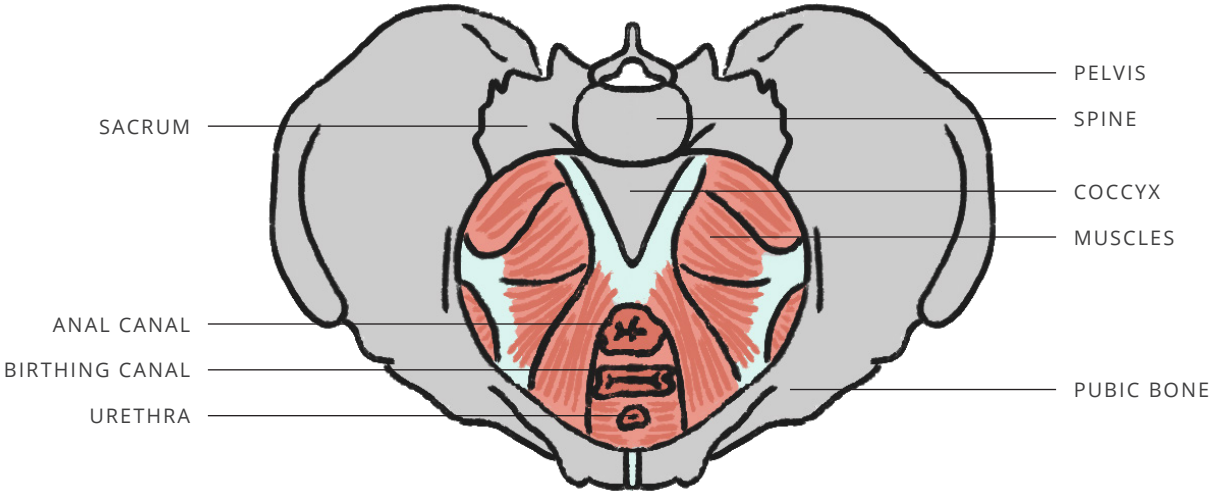
4 Babies' positions can sometimes be turned before or during labor. Babies are born in many positions everyday! When a baby's position does pose a challenge, there are techniques that can be used to encourage movement before and during labor. Results may include eased discomfort, shorter labors, and even the prevention of c-sections.

5 Vaginal delivery is possible with most positions. Many providers are trained for and/or have more experience with head-down positioning during birth. But again, babies can be born in many positions! So discuss your care provider's experience with them — review scenarios and create a plan in advance that best fits your needs and preferences.

Sources + Recommended Resources: Spinning Babies; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

The Pelvic Floor

BRIEFLY EXPLAINED



1 Your pelvic floor muscles work hard throughout pregnancy. The muscles of the pelvic floor are draped across the bottom of your pelvic bones and around your vagina, anus, and urethra, supporting abdominal organs like your bladder, rectum, and uterus. Both hormones and the weight of the uterus during pregnancy stretch and loosen these muscles, which can lead to damage that therapy can help prevent or resolve.

2 Abdominal muscle separation (aka "Diastasis Recti") is a common pelvic health issue. Abdominal muscles stretch and separate during pregnancy. When the gap remains after birth into postpartum, lost core strength can cause dysfunction in the pelvic floor and lower back. Gentle, safe exercises instructed by a professional to target the right muscles have proven to shrink gaps.

3 Episiotomies cause more damage than tearing. An episiotomy is when the perineum is cut during childbirth. Evidence overwhelmingly rejects this method to prevent tearing; it can in fact create greater tears.

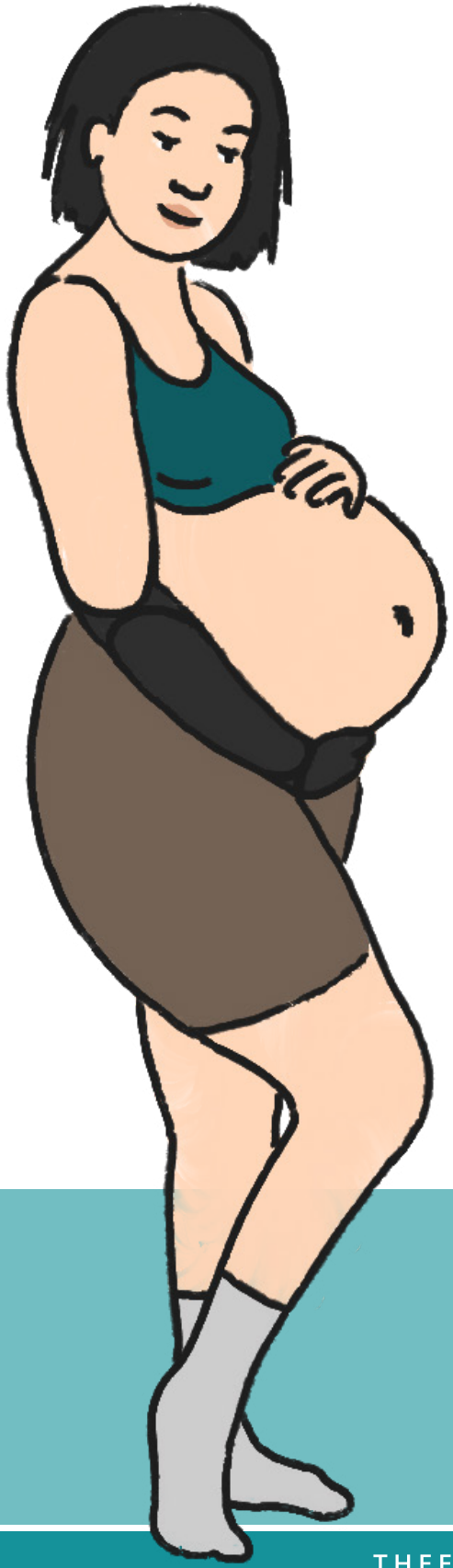
4 Incontinence is another common pelvic health issue. During pregnancy, a growing uterus presses the bladder, causing less urinary control. When this continues or worsens after birth, pelvic therapy is the best treatment.

5 All parents can benefit from seeing a pelvic therapist. Pregnancy and birth come with great change to and stress on the pelvic floor. Seeing a pelvic health therapist through and after pregnancy helps identify present/potential problems and maximize your body's healing.

Sources + Recommended Resources: Childbirth Connection; Cochrane; Parents.com; University of Colorado (Urogynecology); NY Times Parenting

Possible Signs of Labor

BRIEFLY EXPLAINED



How do I know that labor is coming soon? Remember, everyone and every labor is different — so the start of labor for you may or may not involve these signs.

Here are some of the common signs that labor is around the corner:

- ☑ **Loose stool or diarrhea**. This can be a side effect of the release of hormones called prostaglandins, and the body's way of flushing the bowels so the uterus can contract effectively.
- ☑ **Losing the mucus plug.** As the cervix begins to dilate, the mucus that's sealed it off during pregnancy can fall out. When tinged with blood it's known as "bloody show," and is a stronger sign that the cervix is changing.
- ☑ **The baby "dropping."** As labor nears, baby may lower down into the pelvis.
- ☑ **Backache.** Some back pain late in pregnancy is common, but a noticeable increase in discomfort periodically can be a sign of labor getting closer.
- ☑ **"Practice" contractions.** These are irregular tightening sensations at the top of the abdomen that can go away with movement, lying down, or a drink.
- ☑ **Progressing contractions.** Cramping in the lower pelvis that becomes more intense and frequent over time, regardless of movement, lying down, or a drink.

WHEN SHOULD I CALL MY CARE PROVIDER?

It's always worth being cautious and contacting your care provider if/when you feel uncertain or anxious. If you are experiencing pain, less movement from baby, any severe symptoms, and/or any signs of labor alongside contractions, call your care provider to discuss.

Sources + Recommended Resources: Childbirth Connection; Cochrane; Parents.com; University of Colorado (Urogynecology); NY Times Parenting

Types of Contractions

BRIEFLY EXPLAINED

PRACTICE CONTRACTIONS

The uterus tightening

Often felt in the top and/or front of the abdomen

Go away with movement, lying down, or having something to drink

Do not feel intense, and do not become longer, stronger, and more frequent over time

Happen randomly with no pattern

Often do not happen alongside other signs of labor

PROGRESSING LABOR CONTRACTIONS

The uterus tightening

Often felt in the lower pelvic area and/or in the lower back

Stay throughout movement, lying down, or having something to drink

Are intense, and/or become longer, stronger, and more frequent over time

Develop a pattern in length and frequency

Often happen alongside other signs of labor (loose stool, mucus/bloody show, leaking fluid, backache, etc.)

PRODROMAL LABOR CONTRACTIONS

The uterus tightening

Often felt in the lower pelvic area and/or in the lower back

May go or stay throughout movement, lying down, or having something to drink

May feel intense, but do not become longer, stronger, and more frequent over time

May develop a pattern for a few hours, but will not progress further

May or may not happen alongside other signs of labor

SHOULD I CALL MY CARE PROVIDER?

It's always worth being cautious and contacting your care provider if/when you feel uncertain or anxious. If you are experiencing pain, less movement from baby, any severe symptoms, and/or any signs of labor alongside contractions, call your care provider to discuss.

Prodromal Labor

BRIEFLY EXPLAINED

1 More like prelabor than false labor. Prodromal labor is when contractions start and stop without a pattern. It's sometimes called "false" labor, but it's not for nothing. These early contractions change your cervix (softening, thinning, dilating), prepare your muscles, ligaments and pelvis, and shift the position of your baby for labor.

2 It's not the same as having practice contractions. Practice contractions (sometimes known as Braxton-Hicks contractions) are a tightening of the uterus usually felt at the top of the belly. A change of position or drink of water can make them go away. Prodromal labor contractions are typically more intense, felt lower in the belly and maybe into the back, and don't go away like practice contractions.

3 A good time to keep your normal routine going. You can keep your plans to go out, get dinner, see a movie, etc. It may be tempting to cancel, but a little distraction can be a great thing. When eating, aim for food that's easy to digest. Nutritious foods with carbs and protein will give you energy when labor comes in, too.

4 Invite more "love hormone". Contractions are created by Oxytocin, aka the "love hormone." You produce this hormone more when you're calm, comfortable and confident. So if you want progress, settle in with your loved one(s). Snuggle, cuddle, and savor this stage.

5 Past your due date? About half of birthing parents go into labor on their own by 40 weeks and 5 days (first-time parents) or 40 weeks and 3 days (parents who've given birth before). That means the other half are still pregnant past those dates. Talk to your care provider, but know it's normal and there's often no need to rush your body or your baby's progress.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; Evidence Based Birth; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

Early Labor

BRIEFLY EXPLAINED

1 When contractions become regular and stay regular. Contractions in early labor are continuing to work on your cervix and will increase in intensity and frequency over the hours. Beginning to use breath, visualization, and affirmations in this stage can be helpful.

2 Time to reach out to your birth team (from home). While it may not be time to leave the house, this is a good time to let your team know what's happening. Call your care provider and your doula to let them know what you're feeling. If you do go to a hospital during this stage (or prelabor), and there are no medical concerns, it's fine to go back home.

3 Rest, eat, and stay hydrated. Especially if labor begins at night, sleep as much as possible. If you're hungry, eat lightly (nutrious, easy to digest food). And drink often (water, coconut water, electrolyte drinks, etc.).

4 Find your contraction comfort and rhythm. It can be helpful to ignore contractions for as long as possible. Once you can't ignore them anymore, use each one as an opportunity to figure out what helps you cope. You might find that lower light helps, certain songs or sounds, positions, rhythmic breathing, etc.

5 Keep it intimate. Having fewer people around when you're laboring is often preferrable. Once contractations require focus, distraction isn't helpful and can actually throw off a helpful ritual. If you're concerned about friends or family members understanding these boundaries, consider waiting to tell them about labor until later.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

Active Labor

BRIEFLY EXPLAINED

1 When contractions get even longer, stronger, and closer together. The "5-1-1," "4-1-1," and "3-1-1" rules, when contractions are 3-5 minutes apart, one minute long, for one hour, apply to active labor. At this point, contractions usually require your full focus, you can't talk or walk through them, and you may feel pressure in your bottom increase as baby descends lower into the pelvis.

2 Time to go (if not birthing at home). If you're giving birth at a hospital or birth center, you're not located far away, and nothing abnormal has happened (like sharp pain, heavy bleeding, discolored fluid/discharge, etc.) you're probably going to leave home during this stage, after consulting with your care provider and doula.

3 Comfort measures to the rescue. During a contraction your doula or partner can put pressure on your lower back or sitz bones, or give hip squeezes. In-between contractions they can massage areas that feel good to have massaged. Verbal affirmations are also encouraged, reminding you how strong and close to meeting your baby you are.

4 Movement, sound, and bathroom trips. Wanting to move around, bounce on a ball, get on hands and knees, take several trips to pee, and moan, grunt, hum, etc. are all normal. Listen to your body. Movement, trying new positions, vocalizing, and emptying the bladder can all support labor progress.

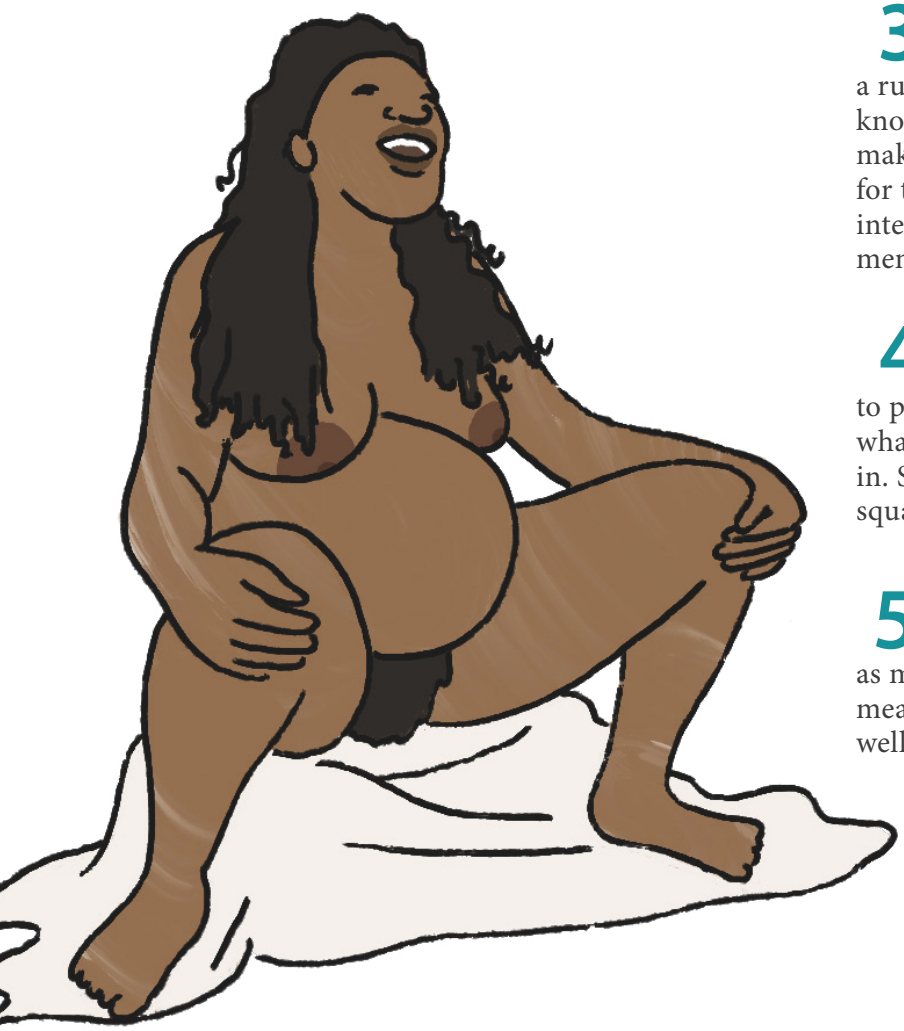
5 "Do I have to poop?" Increased pressure in the pelvis may make you feel like you're going to have a bowel movement during contractions. When this sensation continues between contractions, you're likely moving on to the next stage of labor.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

Transition

BRIEFLY EXPLAINED

1 You are on the mountaintop. Transition is widely considered the most difficult stage of labor, and mercifully, the shortest. Contractions may not be more intense, but will be longer and closer together, alongside increased pelvic pressure. This is when your baby's head passes through the cervix and into the birthing canal.



2 Heightened physical and emotional sensations. As the pressure in the pelvis builds, a birthing person may also feel hot, cold, hot then cold, shivery, or nauseous. With all of these sensation, hormones, and contractions, it's only reasonable that an emotional response may follow. This is when you are most likely to declare, "I can't do this!" and can deeply benefit from reminders that you already are.

3 The adrenaline rush stage. At this height of labor the body releases a rush of the hormone adrenaline, commonly known for "fight or flight." This hormone makes the birthing person alert and focused for the next phase, but can also trigger intense emotional reactions and the shivers mentioned above.

4 A good time to get into pushing position. As the urge to push builds, you may get a sense of what position your body wants to push in. Standing, hands and knees, side-lying, squatted — these are all options.

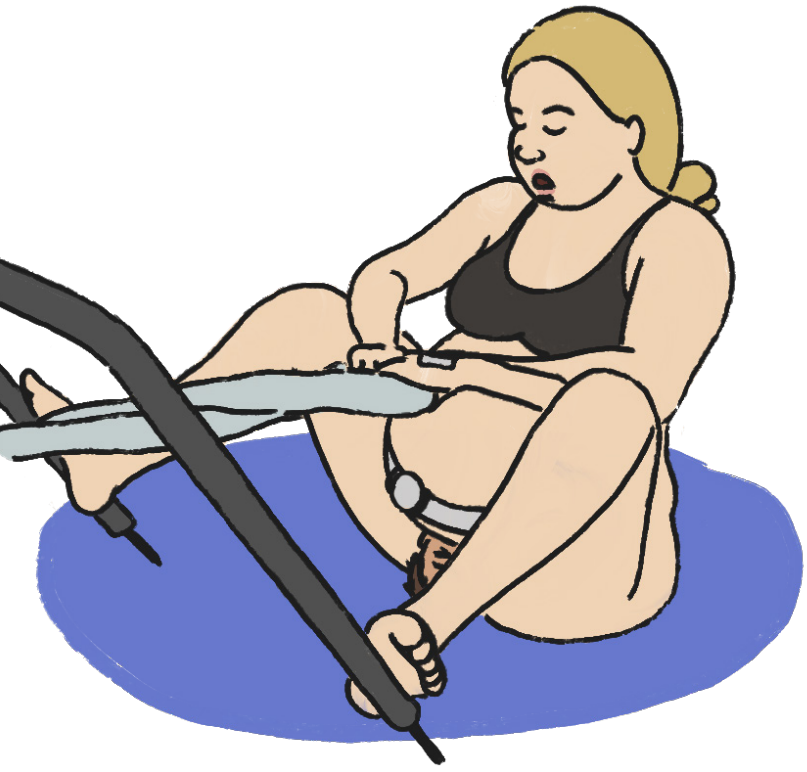
5 Take it one contraction at a time. Relax between contractions as much as possible, and whatever comfort measures you want, bring into this stage as well.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood

Pushing + Birth

BRIEFLY EXPLAINED

1 Complete dilation, less frequent contractions, and the urge to push. On the other side of transition, your cervix is dilated to 10 cm and the baby's head is traveling through the birthing canal. The urge to push is often described as uncontrollable. As you push (voluntarily or otherwise) the baby's head rotates, molds, the labia part and the head becomes more visible.



2 Pushing progress is gradual. As babies descend through the birth canal, it's normal for their head to become more visible during a push (and contraction) and then slip back in-between. This gradual progress is good for the birthing person's perineum and baby's head. It can last for minutes or more than a couple of hours.

3 Grab a mirror to watch the crowning! The intensity of crowning is the stretching sensation created by the baby's head staying in place between contractions. Birthing parents may want a mirror at this point, or to reach down and feel their baby's head to know, it's really there! You're really that close!

4 There are many shades of "I gave birth!" feelings. At birth, high levels of oxytocin and endorphins can create a mental state in the birthing parent that activates the brain's pleasure and reward centers and almost erases previous pain. But not everyone describes the moment of birth as euphoric. Feeling exhaustion, relief, or lingering discomfort does not discredit the power of birth or joy of new child!

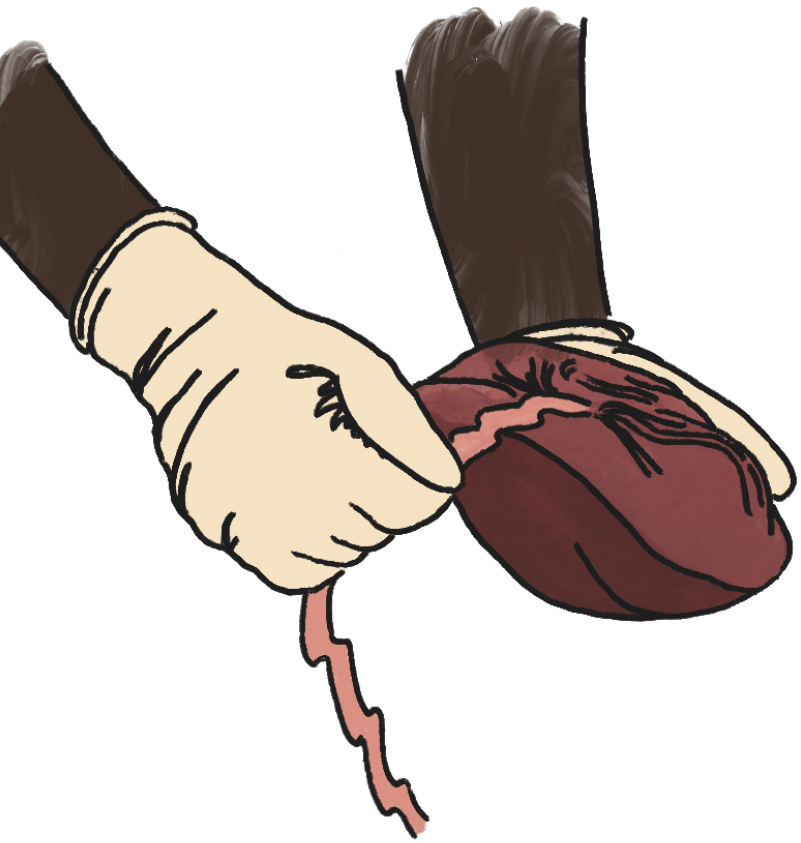
5 Right into your arms for first food. The long awaited moment of skin-to-skin with your baby. If you leave them to their own devices you might see them make their way toward a nipple. A newborn belly is about the size of a cherry, so don't worry if they don't latch long.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; Nurture: A Modern Guide to Pregnancy, Birth + Early Motherhood; Romper

Birth of the Placenta

BRIEFLY EXPLAINED

1 The shortest and least painful stage. After your baby is born, contractions will continue, typically at a slower pace and less intensity. These contractions are meant to help expel your placenta, the organ produced during pregnancy to provide nutrients, oxygen, and hormones to the baby. They may require a few pushes.



2 The fundal (not so much of a) massage. Your care provider may put pressure on your abdomen to check the firmness of the uterus. This is done to ensure that all of the placenta has been removed from the uterus and protects against too much blood loss.

3 Delaying cord clamping. Delaying the clamping and cutting of the umbilical cord for a few minutes or until the cord stops pulsing and is limp has been found to have many benefits for babies, including increased iron levels, improved circulation, better red blood cell levels, and more.

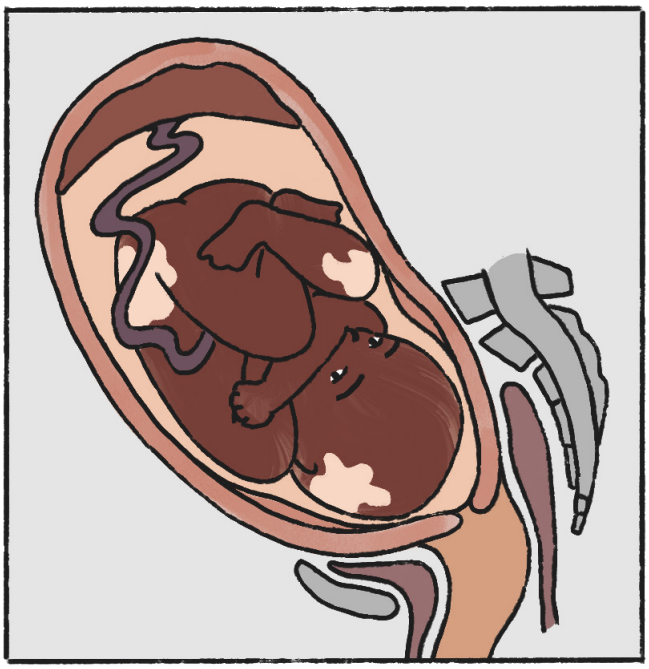
4 Caring for tearing. Some amount of tearing in childbirth is very common, with only 2% of birthing people experiencing a 3rd/4th degree tear (tearing near or to the anus). This is the time when your care provider will assess your tear, if there is one. Most tears can be repaired with numbing to the site and stitches, which dissolve over time.

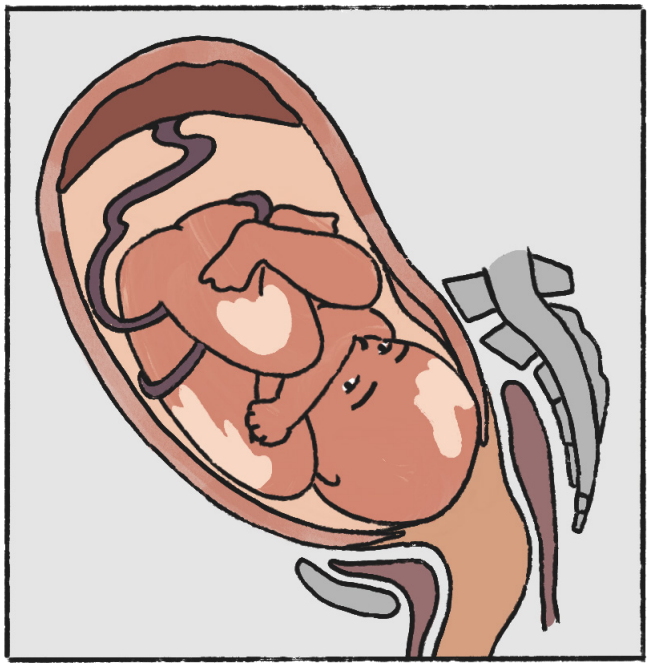
5 Placentas and postpartum. For generations and around the world, cultures have considered the placenta a source of wellness for birthing parents postpartum. Consuming the placenta has been said to reduce bleeding, increase milk supply, decrease chances of postpartum depression and more. Scientific research is sparse, so the greatest body of evidence right now is individual experience.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; ACOG; NICHD; American Urogynecologic Society

The Cardinal Movements of Labor

BRIEFLY EXPLAINED





The cardinal movements of labor are all about how a fetus moves down through the pelvis, through the cervix, and through the birth canal toward birth.

The illustration above shows the starting point for this journey. This is when the baby's head is **floating**, meaning it hasn't lowered into the pelvis yet.

The **fetal station** at this stage is a negative number, -5 through -1.

1 **Engagement** is when the head (or presenting part) of a fetus lowers and settles into the pelvis.

This usually happens in the last few weeks of pregnancy for first-time pregnant people, compared to during labor in later pregnancies. Gravity, the weight of the baby, and contractions all help make it happen. Support from bodywork, movement, and other techniques led by a professional can encourage it as well.

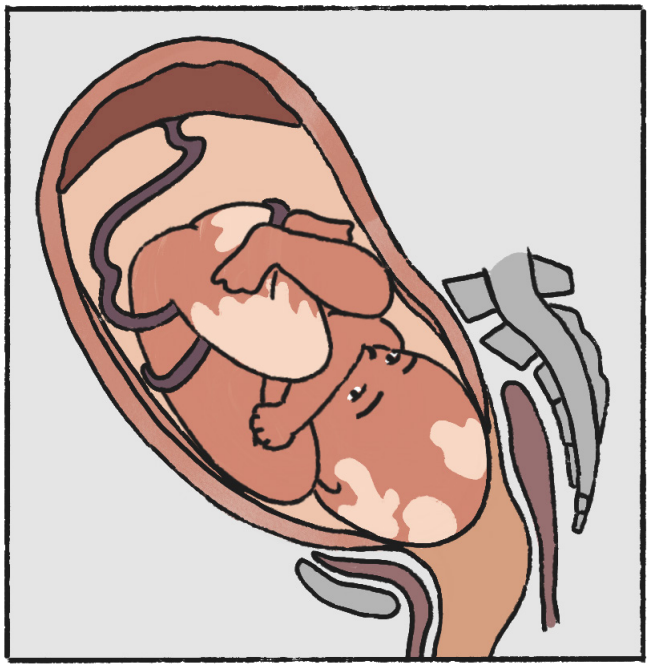
The **fetal station** at this stage is 0.

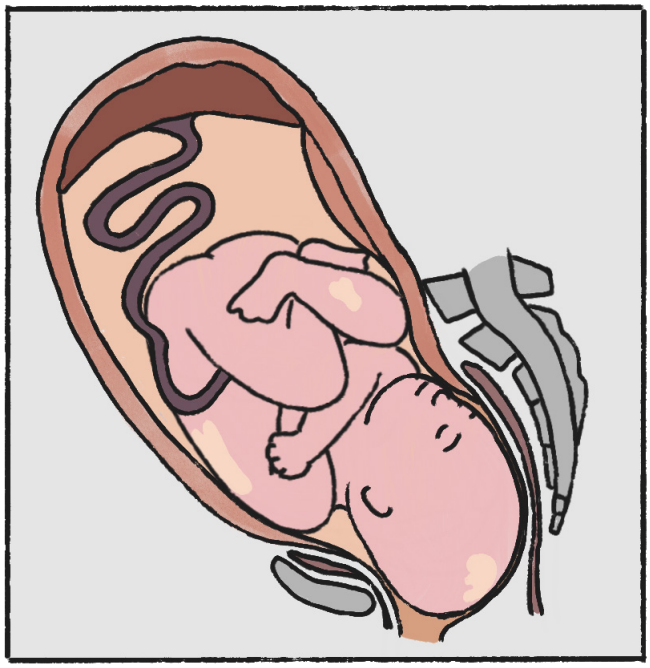
WHAT IF MY BABY ISN'T HEAD DOWN?

Some babies present butt down (breech), feet down (footling), face first, or a combination! Vaginal birth is possible in most situations. You can discuss and weigh the options for turning a baby and/or laboring with a baby who is not head down with your care provider.

The Cardinal Movements of Labor

BRIEFLY EXPLAINED





2 **Descent** is when the head of the fetus moves even lower down into and through the pelvis. Pressure from the cervix and pelvic floor can cause the bones of the fetus's skull to overlap — it's normal and designed to do this! The process is called **molding**, and creates the elongated shape of the head many babies have at birth. The head begins to reshape immediately after birth and will be round after a few days.

The **fetal station** at this stage is a low positive number, +1 or +2.

3 **Flexion** is when the chin of the fetus is brought to its chest. This allows the smallest part of the skull to fit through the smallest part of the pelvis, making it easier to continue moving down.

4 **Internal rotation** refers to the movements the baby makes to continue navigating through the bony pelvis, finding the easiest way through.

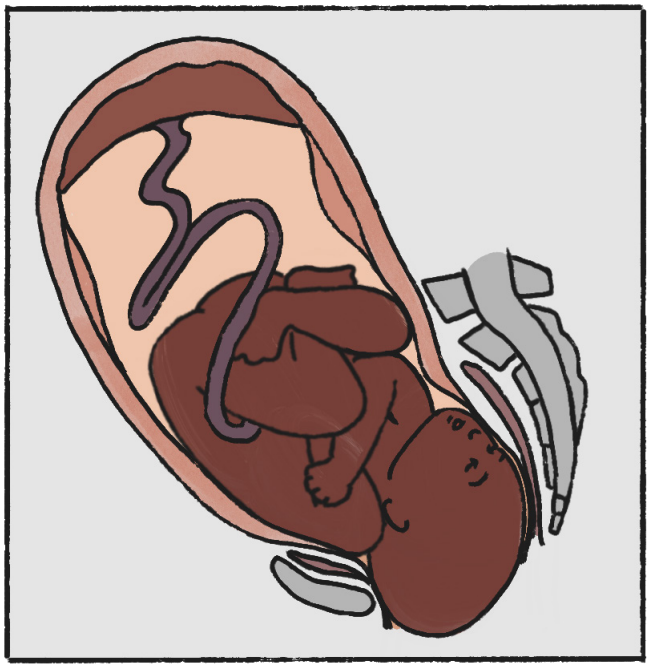
The **fetal station** at this stage is a low positive number, +1 or +2.

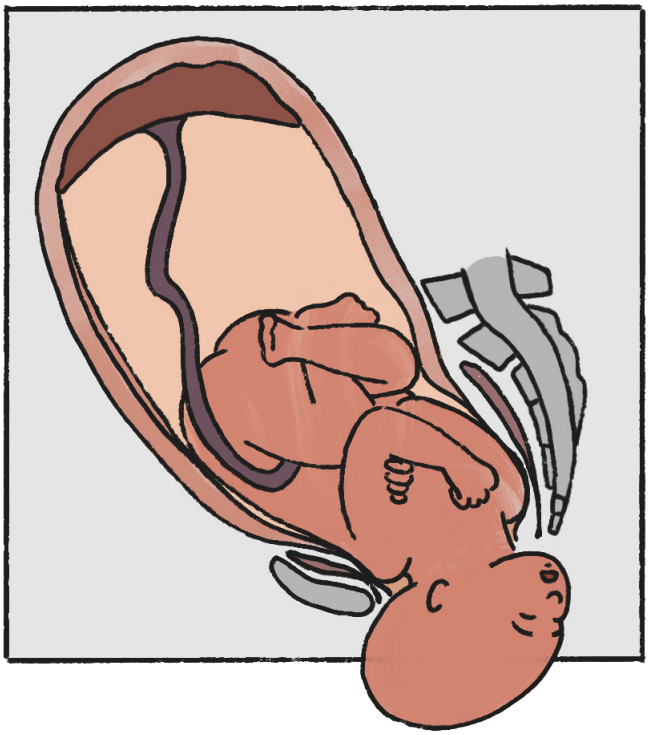
WHAT IF MY BABY IS FACING THE OTHER WAY?

The baby's head will still continue to move down if they're facing the belly ("OP" position) instead of the back ("OA" position). In this case, the birthing person may feel back labor, sensations of discomfort in the lower back because the hard back of the baby's head is pressing against their spine and tailbone (instead of the softer front of the head). Moving and changing positions can help babies to rotate out of OP position.

The Cardinal Movements of Labor

BRIEFLY EXPLAINED





5 **Extension** is how the baby is born! Once the head has moved under the pelvic bone, the chin lifts off of their chest. The head starts to **crown**, meaning it becomes visible, stretching tissues at the opening of the birth canal. The birthing person is often guided through pushing and positioning and a provider may use a warm compress or oils to support the natural stretch of the tissues. The head is soon born.

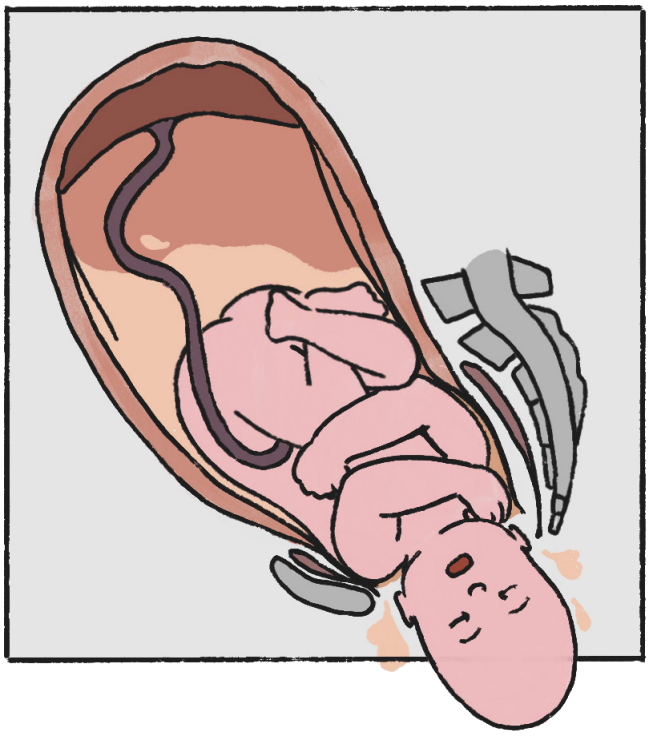
The **fetal station** at this stage is a positive number, +3 when **crowning** begins and +5 just before the birth of the head.

HOW WILL KNOW HOW TO PUSH?

Some people feel an overwhelming urge to push, so that it feels like their body is pushing without any effort (also known as the fetal ejection reflex). Others may put great effort into pushing with each contraction, resting in-between. Still others, (ex. those with an epidural who lack some sensation), may utilize more direction from their birth team during pushing. Talk to your birth team about techniques for pushing, what you'd like to try, and scenarios where different approaches may apply.

The Cardinal Movements of Labor

BRIEFLY EXPLAINED



6 After the head is born, there's typically a pause as the head unwinds, comes into alignment with the rest of the body, and continues to lower. This is called **external rotation.**

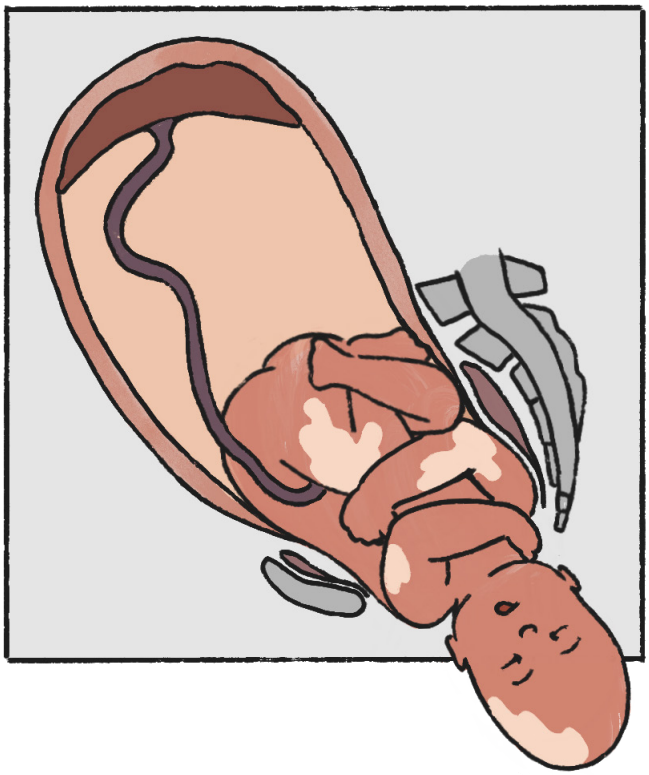
Like all the movements before it, it happens to make the next fit — the baby's shoulders — easier.

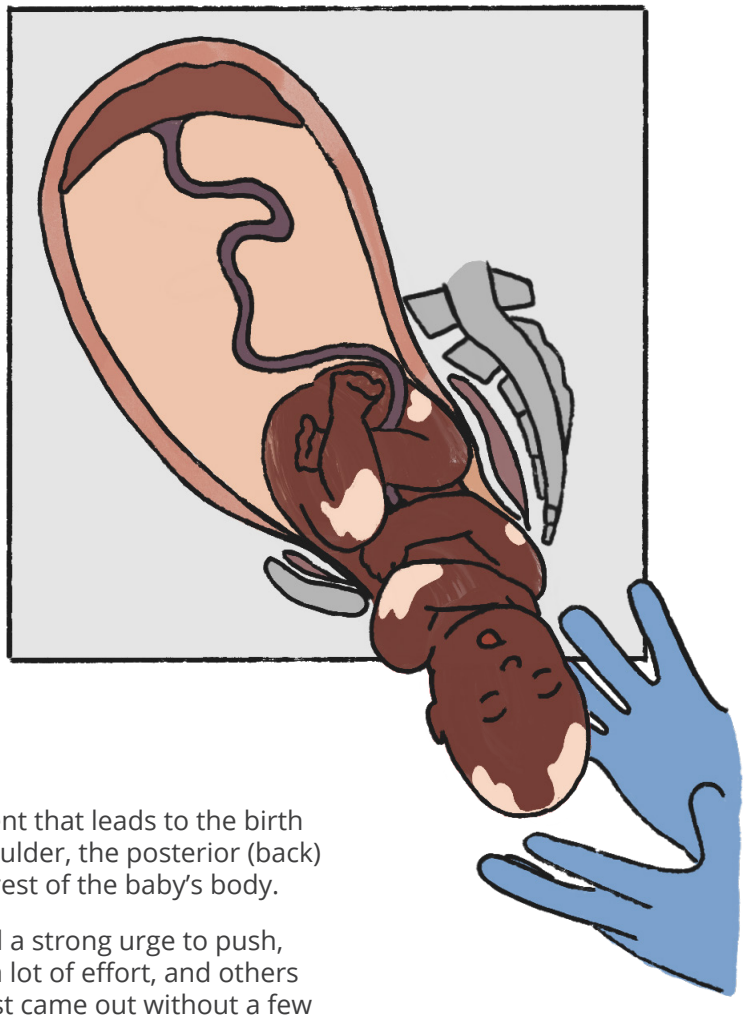
WHAT IS SHOULDER DYSTOCIA AND WHAT DOES IT HAVE TO DO WITH A BABY'S SIZE?

Rarely, a baby's shoulders may be a tight fit behind the pubic bone during birth — that's called shoulder dystocia. According to Evidence Based Birth, only 7 to 15% of babies over 8 lbs., 13 oz. or 9 lbs., 15 oz. (different studies considered different weights) involved difficulty with the birth of their shoulders, and even the majority of those cases are resolved by a care provider with no injuries. Babies of all sizes in pelvises of all sizes are born every day!

The Cardinal Movements of Labor

BRIEFLY EXPLAINED





7 **Explusion** is the movement that leads to the birth of the anterior (front) shoulder, the posterior (back) shoulder, and finally the rest of the baby's body.

Some birthing people feel a strong urge to push, some do not. Some give a lot of effort, and others describe that the baby just came out without a few strong contractions and no pushing — that's known as the **fetal ejection reflex**.

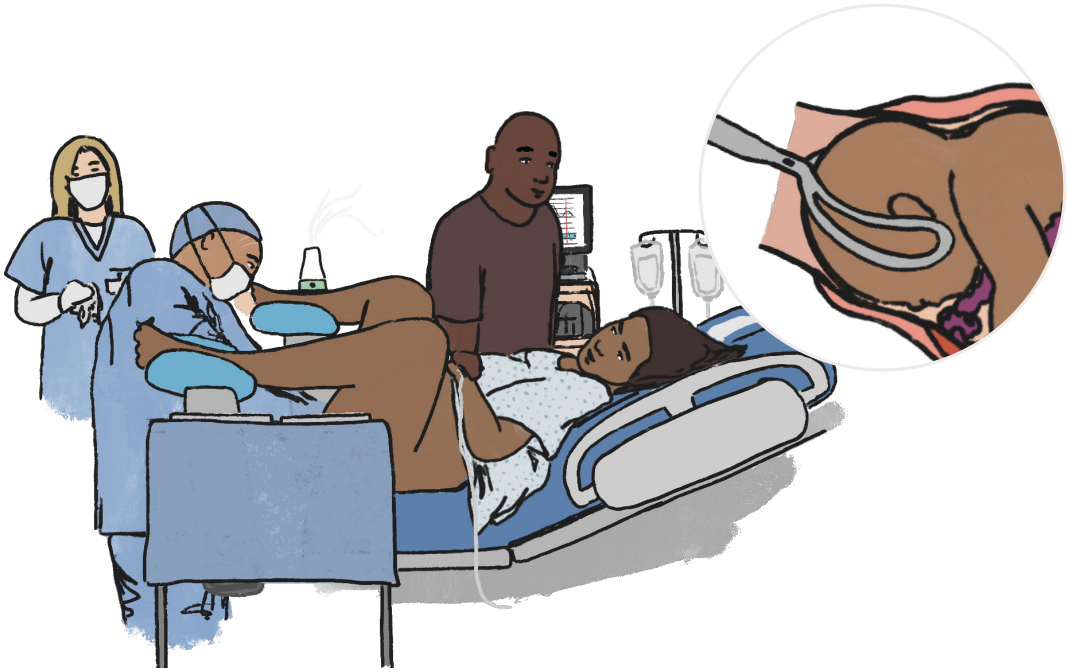
Sources + Recommended Resources: Royal College of Obstetricians and Gynaecologists; Healthline: Parenthood; What to Expect; The American College of Obstetricians and Gynecologists; March of Dimes; University of Michigan Medicine; Cochrane; Spinning Babies; Evidence Based Birth; OBGYN Academy

DO I HAVE TO LIE DOWN ON MY BACK WHEN I GIVE BIRTH?

No, you don't! In fact, according to Evidence Based Birth, upright birthing positions like standing, squatting, kneeling, or sitting can result in a lower likelihood of forceps and vacuum-assisted birth, episiotomy, and abnormal fetal heart rate patterns. The flip side? There can be a higher likelihood of tearing. Every birth is different, so discuss birthing positions with your care provider and set some expectations for what may work for you.

Forceps-Assisted Birth

BRIEFLY EXPLAINED



Forceps look like long, thin, curved metal tongs. They're designed to fit around the head of the fetus firmly.

A care provider might recommend using **forceps** when they have a medical concern that would be helped by speeding up the birth process and the baby may be too high up in the pelvis to use the alternative **vacuum** tool.

Before **forceps** are used, the cervix is fully dilated, the birthing person's water is broken, their bladder is emptied with a catheter and they're numbed (unless they already have an epidural). The **forceps** are inserted into the birth canal and around the fetus's head between contractions and then used during contractions to guide the progress until the head is born.

The risks of **forceps-assisted birth** can include injury to the baby like cuts, bruising, swelling, or nerve damage — as well as to the birthing person, like pain, tearing (or **episiotomy**), difficulty urinating, injury to the bladder, urethra, birth canal or anus, or weakening of muscles in the pelvic floor.

Sources + Recommended Resources: Healthline: Parenthood; What to Expect; The American College of Obstetricians and Gynecologists; Cochrane; Spinning Babies; Evidence Based Birth

THE USE OF FORCEPS IS VERY UNCOMMON.

According to a Centers for Disease Control and Prevention (CDC) report, they were used in less than 1% of live births in 2017. **Discuss the use of forceps with your care provider.** Is this a tool they or other providers in their practice have used before? Would they still use it? In what situations? What alternatives would you want to consider, if any?

Vacuum-Assisted Birth

BRIEFLY EXPLAINED

The **vacuum** tool used to assist birth is a suction cup with a handle and a pump.

A care provider might recommend **vacuum-assisted birth** when they have a medical concern that would be helped by speeding up the birth process and the baby is low enough in the pelvis for it to be useful.

Before a **vacuum** is used, the cervix is fully dilated, the birthing person's water is broken, their bladder is emptied with a catheter and they're numbed (unless they already have an epidural). The suction cup is inserted into the birth canal and attached as much to the back of the fetus's head as possible (avoiding their face) between contractions and then used during contractions to guide the progress down until the head is born.

The risks of **vacuum-assisted birth** can include injury to the baby like swelling, jaundice, **shoulder dystocia**, or fracture (rarely) — as well as to the birthing person, like pain, tearing (or **episiotomy**), difficulty urinating, or loss of bladder control.

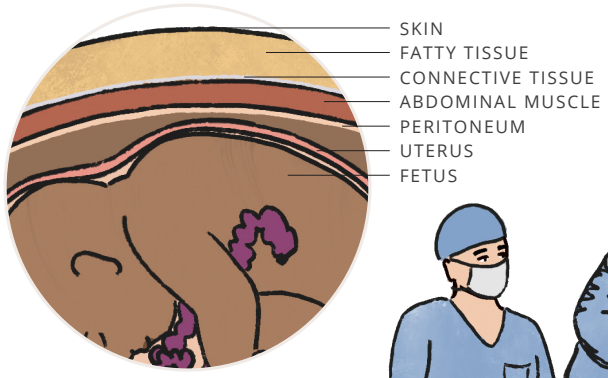
Sources + Recommended Resources: Healthline: Parenthood; What to Expect; The American College of Obstetricians and Gynecologists; Cochrane; Spinning Babies; Evidence Based Birth

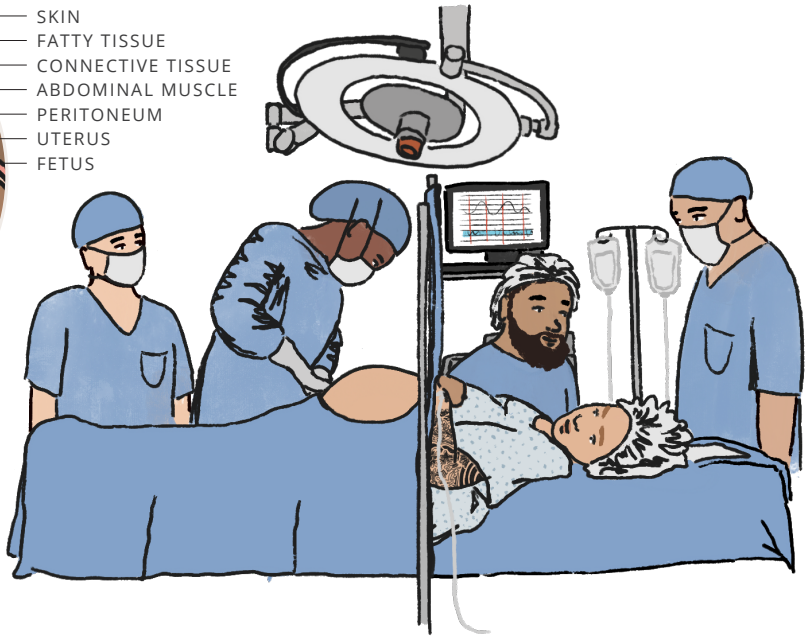
VACUUM-ASSISTED BIRTH IS UNCOMMON.

According to a Centers for Disease Control and Prevention (CDC) report, the vacuum was used in about 2.5% of live births in 2017. **Discuss the use of the vacuum during birth with your care provider.** Is this a tool they or other providers in their practice have used before? Would they still use it? In what situations? What alternatives would you want to consider, if any?

Abdominal Birth

BRIEFLY EXPLAINED





Abdominal birth, also known as **cesarean section** or **c-section**, is the surgical birth of a baby through incisions in the birthing parent's abdomen and uterus.

Before this surgery begins (in a non-emergency situation) a birthing person is given an **IV**, a spinal block or **epidural** anesthetic, and their bladder is drained with a catheter. They're positioned lying flat on a table with their legs secured — hair around the surgical site is shaved, the skin is cleaned, and sterile material is draped all around the belly. Drapes can be clear so they don't block the birthing parent's view.

The first cut, in the skin, can be made vertically (from the belly button to the pubic hairline) or horizontally (from side to side). Horizontal incisions are more common because they heal better, result in less bleeding, and involve less risk for vaginal birth in the future.

Additional incisions go through fatty tissue and connective tissue. Abdominal muscles are separated (not cut), and lastly, incisions are made in the peritoneum and the uterus. Pressure and pulling are often felt as the amniotic sac is opened and the baby is born through this abdominal passage (providers can give much or little assistance).

The **umbilical cord** is clamped and cut (**delayed cord clamping** is still possible if no medical concerns apply), the **placenta** is removed and then the provider closes and sutures the layers back together. Incisions can be closed with staples, stitches, specialized tape, glue, or a combination. Finally, a sterile bandage is applied.

Sources + Recommended Resources: Healthline: Parenthood; What to Expect; The American College of Obstetricians and Gynecologists; Cochrane; Spinning Babies; Evidence Based Birth

CESAREAN BIRTH IS MORE COMMON THAN RECOMMENDED.

According to the Centers for Disease Control and Prevention, about 30% of babies are born abdominally in the U.S. This is high compared to other countries and the World Health Organization's recommendation of 10-15%. **Discuss your preference for and/or the possibility of abdominal birth with your care provider.** Major surgery involves risk, but there are good reasons we have this option, too. It's about what's right for you.

Abdominal Birth Options

BRIEFLY EXPLAINED

Whether planned or unplanned, there are many ways to make an abdominal birth experience fit for you and your family. In a non-emergency situation, there's time to communicate with your care provider and birth team and explore what options are possible in your unique circumstance.

WHO IS WITH YOU

Bringing support people in the OR is often limited due to space and sterility, but once the birthing person is set up for the birth one or two people can often join them.

PHOTO + VIDEO

Some hospitals consider photo/video in the OR a liability, but many are changing prohibitive policies. Talk to your birth team to ensure your right to document your birth.

YOUR BIRTH OPTIONS

During your c-section you may choose to have baby more gently ease through the incision, watch the procedure with a mirror, or have one arm freed of IV, blood pressure cuff, etc. so you have full mobility.

PAIN MED OPTIONS

Pain medications used during cesarean births may make the birthing person feel groggy or out of it. Discuss options for alternative meds with your provider and anesthesiologist.

AN OR SPACE FOR YOU

There are ways to make the OR feel more comfortable to you, from music/sounds, to the type of surgical drape, to asking staff to respectfully focus talk on your procedure.

AFTER BIRTH OPTIONS

After a c-section, assuming the baby's health and stability, many common preferences are still possible in the OR, including delayed cord clamping, having a partner cut the cord, immediate skin-to-skin, and more.

WHAT KINDS OF OPTIONS ARE IN A CESAREAN BIRTH PLAN?

- ☐ Doula presence
- ☐ Partner presence
- ☐ Video + photos
- ☐ Music in the OR
- ☐ Spinal anesthesia
- ☐ Epidural anesthesia
- ☐ Clear/lowered drape
- ☐ Mirror
- ☐ Birth-focused talk in the OR
- ☐ Procedure explained as it's happening
- ☐ Slow birth, similar to vaginal "squeeze"
- ☐ Unstrapped arms
- ☐ Dominant arm + hand free
- ☐ Delayed cord clamping
- ☐ Partner cuts cord
- ☐ See placenta
- ☐ Keep placenta
- ☐ Immediate skin-to-skin
- ☐ Breast/chestfeeding in the OR
- ☐ No/minimal separation
- ☐ IV removed as soon as possible

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; ACOG; NICHD; American Urogynecologic Society; Evidence Based Birth; Verywell Family

Abdominal Birth Considerations

A COLORING PAGE

What is my current thoughts and questions about cesarean birth?

Who on my support team can help me create and then support a cesarean birth plan that works for me?

What kind of comfort measures would I like to use during an abdominal birth?

What kinds of adjustments would I like to have made to the typical cesarean birth experience, if possible?

What do I want to ask/bring up with my care provider about the possibility and/or options for cesarean birth at my next appointment?

How Long Is Labor?

BRIEFLY EXPLAINED

WHAT WE FIND ONLINE

12-19 HRS	4-8 HRS	20 MIN-2 HRS	5-30 MINS
Early Labor	Active Labor	Second Stage: Pushing	Third Stage: Placenta

WHAT WE MAY EXPERIENCE

and many many more variations

If you Google how long labor is — it won't take long to find numbers like these: 12-19 hours for early labor, 4-8 hours for active labor, 20 mins - 2 hours for pushing and 5-30 minutes for the placenta.

These numbers comes from US National Institutes of Health data, based on measurements collected from many labors and many people — but most labors will not match the average.

The length of labor can be impacted by:

- ☑ whether it's someone's first birth
- ☑ fetal position
- ☑ laboring with multiples
- ☑ parental age
- ☑ the pelvis
- ☑ frequency + strength of contractions
- ☑ induction
- ☑ use of comfort measures
- ☑ use of interventions
- ☑ mental + emotional factors
- ☑ more

Instead of setting your expectations for your labor based on other's experiences, it's more helpful to understand that many experiences are possible. Create a supportive team to help you consider what may play a role in your unique circumstances, and develop a plan with you to support your and your baby's health and labor progress.

WHAT IF MY LABOR "FAILS TO PROGRESS"?

Research has found the term "failure to progress" to be vague and based on inaccurate/unhelpful standards. Unless a labor has truly stopped, or real medical concerns arise, evidence supports treating laboring people as progressing normally and giving more time for labor to do its work. Learn more about the variation of normal labor lengths and discuss that with your birth team, as well as methods that may be used to support labor progress if/when it slows.

Labor + Birth Positions

BRIEFLY EXPLAINED

Movement and positioning during labor are evidence-based ways to enhance both comfort and labor progress. The American College of Obstetricians and Gynocologists (ACOG) encourages changing positions frequently during labor — as much as can be done safely. Even with an epidural, position change on a hospital bed is associated with positive experiences and outcomes.

UPRIGHT

In upright laboring and birthing positions, gravity can help bring the baby down. Upright positions also avoid compression on the aorta, which provides blood flow and oxygen to your baby.

RECUMBENT

Positions that involve lying on your back or side provide easier access to the abdomen for fetal monitoring and can be supportive for sleep and rest during labor. They can also help support labor progress in specific circumstances.

SEMI-RECUMBENT

Positions that are partially lying and partially sitting up. They can be particularly helpful when epidural use limits a laboring person's full range of mobility.

WITH A BIRTH BALL

Multiple studies have found that laboring people reported significantly lower pain scores when they used a birth ball during labor.

INVOLVING DANCE

Research on using dance during labor for at least 30 minutes found that these laboring people had lower pain scores and higher birth satisfaction.

IN THE WATER

Water immersion during labor has been found to provide significant pain relief and high birth satisfaction. Water birth, moreover, is associated with lower episiotomy rates and more intact perineums.

WEIGHT OFF SACRUM

When the weight of the body is off the sacrum, the pelvis is able to move and expand more, making it easier for a baby to move down and through. All recumbent positions aren't inflexible — side-lying, for example, is still sacrum-flexible.

WEIGHT ON SACRUM

These positions put weight on the sacrum, limiting its ability to move and expand. Lying on flat on the back, semi-sitting in bed, and lithotomy position are the most inflexible positions for the sacrum.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; ACOG; NICHD; American Urogynecologic Society; Evidence Based Birth

Upright Labor Positions

A COLORING PAGE

Upright labor + birth positions

Gravity can help bring the baby down. Does not compress the aorta, which provides blood flow and oxygen to your baby. Does not put weight on the sacrum, aiding pelvic movement.

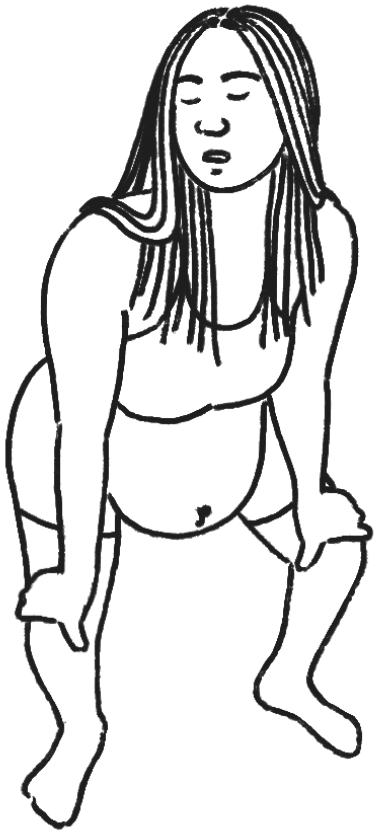
Upright positions I can practice before labor:

_____

_____

_____

_____



Nonupright Labor Positions

A COLORING PAGE

Nonupright labor + birth positions

Supportive for sleep and therapeutic rest during labor. May be helpful to take a break inbetween more active positions. Can also help support labor progress in some circumstances.

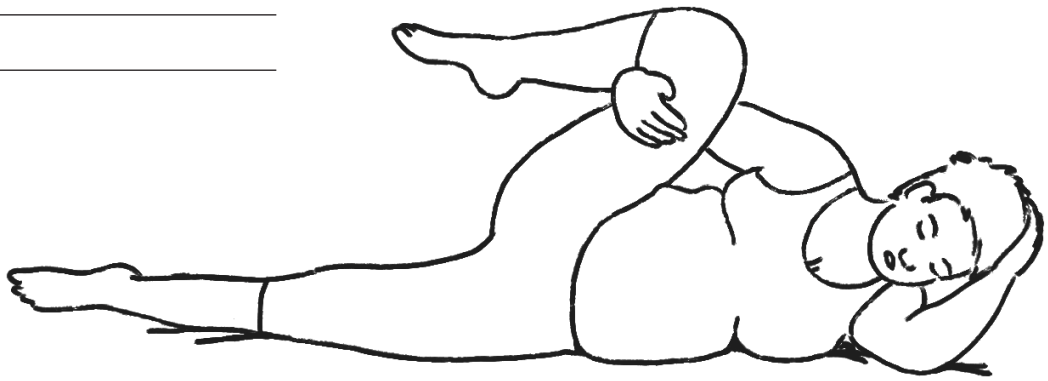
Nonupright positions I can practice before labor:

_____

_____

_____

_____



Birth Ball Labor Positions

A COLORING PAGE

Birth ball labor + birth positions

Helpful to support a variety of labor positions and movements in a comfortable way. The peanut ball can help support an open pelvis in lying down positions.

Birth ball positions I can practice before labor:

_____

_____

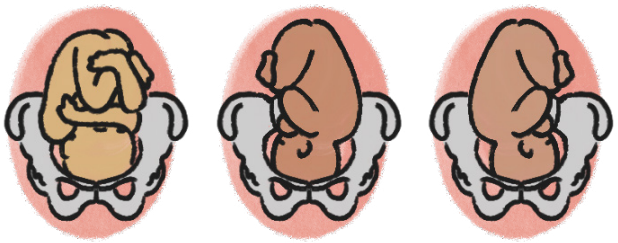
_____

_____

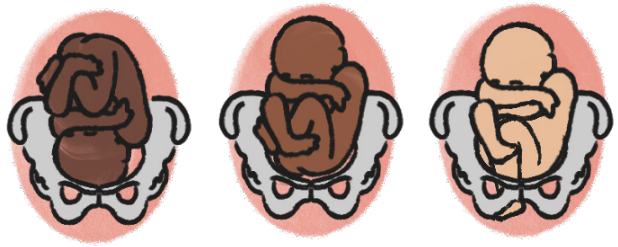
Fetal Positions During Labor

BRIEFLY EXPLAINED

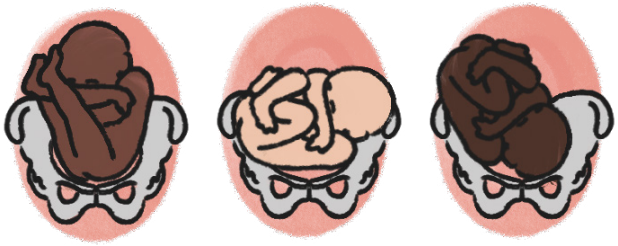
Babies move around, getting in and out of various positions all throughout pregnancy. In the final weeks and days of pregnancy leading up to the start of labor, many babies will settle into a head-down position, chin tucked to their chest, facing the birthing person's back and slightly rotated to their left (a position known as LOA). There are, however, a number of other ways a baby can be positioned before and during labor — and for birth!



Right Occiput Posterior (ROP) | Left Occiput Anterior (LOA) | Right Occiput Anterior (ROA)



Left Occiput Posterior (LOP) | Complete Breech | Footling Breech



Frank Breech | Transverse | Oblique

What does it mean if baby is rotated to the right? A baby who is rotated to the birthing person's right at the start of labor may take some more time to descend and progress.

What does it mean if baby is posterior? A baby who is facing forward, with the back of their head to the back of the birthing person often leads to more back pain during labor and may slow the progress of labor as well.

What does it mean if baby is breech? A baby whose butt is entering the pelvis first. There are different risks associated with breech birth than head-down. Whether vaginal or cesarean birth is planned depends largely on provider expertise, birthing person preference, and an additional assessment of risk/benefit factors.

What does it mean if baby is transverse or oblique? When a baby is lying sideways (transverse) or at a diagonal slant (oblique) in the pelvis, exercises can be done with provider support and/or oversight to help the baby rotate into a different position. In this case if there's no change, cesarean birth is recommended.

Sources + Recommended Resources: Evidence Based Birth; Spinning Babies; Breechpodcast.com; VeryWellFamily; Cleveland Clinic

HOW DO I KNOW WHAT TO DO DURING LABOR?

Your care provider and birth team will guide and support you with your baby's position during labor. Remember that every body is different and babies are born in many positions! And talk to your care provider about their comfort, experience, and skill with supporting birth with various fetal positions.

Fetal Position Considerations

A COLORING PAGE

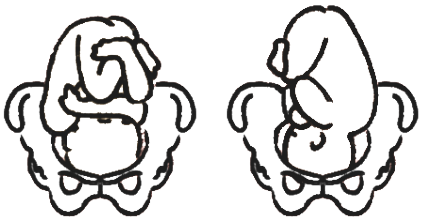
What are some movements I can do during labor that may support my baby's position?

What is my provider's skill, experience, and comfort with supporting labor with various fetal positions?

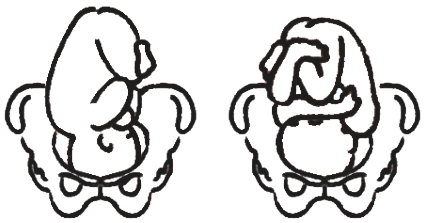
What kinds of comfort measures can help support me in labor with baby in different fetal positions?

What kinds of labor positions can help support me in labor with baby in different fetal positions?

What questions do I have for my care provider and/or doula about fetal position before and/or during labor?



Right Occiput Posterior (ROP) **Left Occiput Anterior (LOA)**



Right Occiput Anterior (ROA) **Left Occiput Posterior (LOP)**

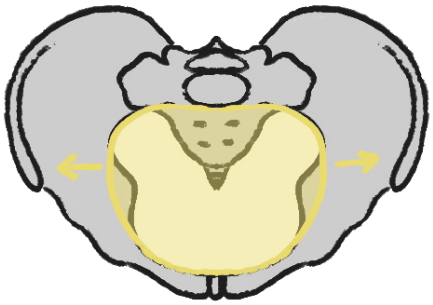
Complete Breech **Frank Breech** **Footling Breech**

Transverse **Oblique**

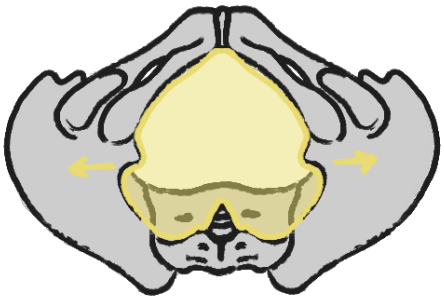
Opening the Pelvic Inlet + Outlet

BRIEFLY EXPLAINED

During labor (and sometimes beginning before), babies descend through the pelvis — entering through the pelvic inlet and leaving through the pelvic outlet. Station is the term for where baby's head (if baby is head down) is in the pelvis — from -5 at the inlet, to 0 at the center of the pelvis, to +5 at the outlet. Different movements through and between contractions can help expand the space for baby to lower through. Discuss how you can use movements like below with your care provider.



OPENING THE PELVIC INLET: In early labor, opening the pelvic inlet helps bring the baby into the pelvis. Positions that place the knees wide apart, the feet together, and tilt the pelvis posteriorly (towards the back) help to open the inlet of the pelvis.



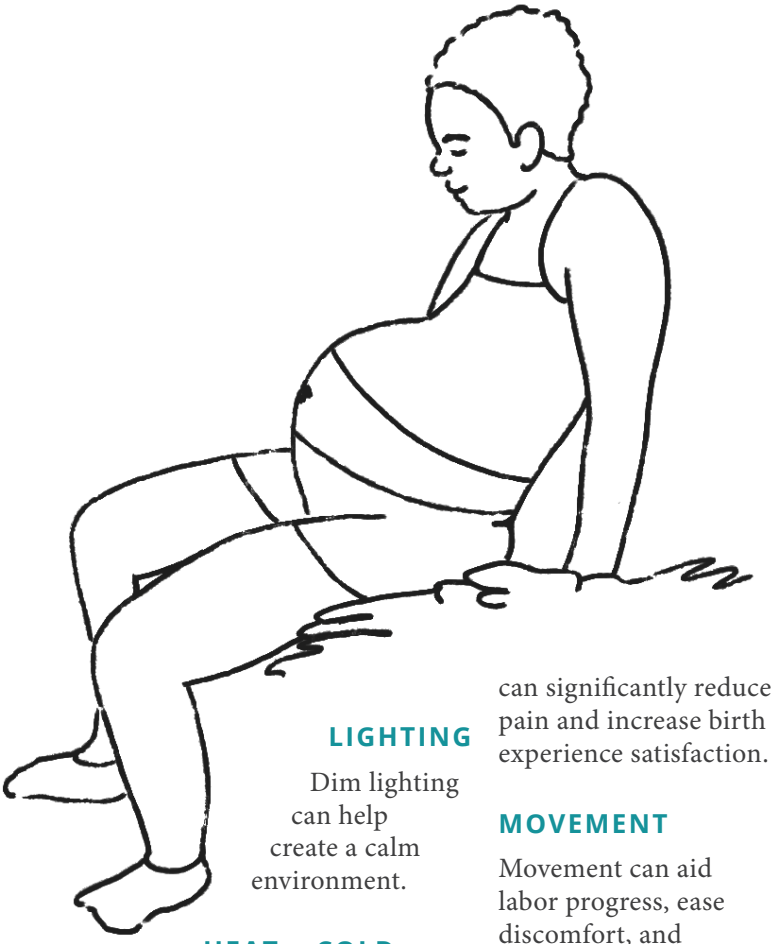
OPENING THE PELVIC OUTLET: In active labor, opening the pelvic outlet creates more room for baby to crown + be born. Positions that place the knees together, the feet wide apart, and tilt the pelvis anteriorly (towards the front) help to open the outlet of the pelvis.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; ACOG; NICHD; American Urogynecologic Society

Comfort Measures

BRIEFLY EXPLAINED

As the body goes through incredible change during labor it's normal for the birthing person to experience intense physical and emotional sensations. There are many options for tools and techniques to ease the intensity and support the positive progress and experience of labor and birth, including, but not limited to:



LIGHTING

Dim lighting can help create a calm environment.

HEAT + COLD

Applying heat with a heat pack or a warm shower, or cold with a cold pack or washcloth from an ice bath can have a soothing effect.

WATER

Water immersion in a bath or under a shower can significantly reduce pain and increase birth experience satisfaction.

MOVEMENT

Movement can aid labor progress, ease discomfort, and increase confidence and satisfaction with the birth experience (even with an epidural). Upright and active positions may help shorten labor and nonupright positions with relaxation. Additional support can be provided by a partner and/or with birth balls.

TOUCH + PRESSURE

Light touch, massage, counterpressure, hip squeezes — physical touch can help ease tension between contractions or decrease intensity during them.

AROMATHERAPY

Aromas from essential oils applied by diffusing, massage, or drops in water can help ease nausea, anxiety, and discomfort and aid relaxation during labor.

MUSIC + SOUND

Soft, calming music and sounds (or whatever type the birthing person prefers) may help reduce pain perception and/or improve birth experience satisfaction by creating a positive distraction.

MENTAL EXERCISES

From the use of positive affirmations, pleasant calming visualizations, to self-hypnosis — positive mental techniques have been found to help manage discomfort.

TENS UNIT

A handheld device that uses electrodes to pulse sensations through the body, the TENS unit can help reduce pain perception.

FOOD + DRINK

Eating and drinking when desired during labor can improve satsifaction with the birth experience, and hydration and calorie consumption can help sustain strength in labor.

BREATHWORK

Used with other comfort measures, slow, deep breathing can help reduce stress and increase relaxation.

CONTINUOUS SUPPORT

Continuous support provided by partners, doulas, and other support people can help laboring people feel informed, empowered, safe, respected, and connected during labor and birth.

Sources + Recommended Resources: Pregnancy, Childbirth and the Newborn; The Mama Natural Guide to Pregnancy + Childbirth; The Birth Partner; ACOG; NICHD; American Urogynecologic Society; Evidence Based Birth

Comfort Measures

DISCUSSION GUIDE

LIGHTING

Write below what kinds of lighting you'd like during labor:

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

HEAT + COLD

Write below how you'd like to use heat + cold during labor:

IMPORTANCE LEVEL

1 2 3 4 5

WATER

Write below how you'd like to use water during labor:

IMPORTANCE LEVEL

1 2 3 4 5

MOVEMENT

Write below how you'd like to move during labor:

IMPORTANCE LEVEL

1 2 3 4 5

Comfort Measures

DISCUSSION GUIDE

TOUCH + PRESSURE

Write below touch + pressure you'd like during labor:

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

AROMATHERAPY

Write below scents you'd like to have available during labor:

IMPORTANCE LEVEL

1 2 3 4 5

MUSIC + SOUND

Write below music + sounds you'd like to hear during labor:

IMPORTANCE LEVEL

1 2 3 4 5

MENTAL EXERCISES

Write below visualizations, affirmations, and other mental exercises you'd like to use during labor:

IMPORTANCE LEVEL

1 2 3 4 5

Comfort Measures

DISCUSSION GUIDE

TENS UNIT

Write below how you'd like to use a tens unit during labor:

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

FOOD + DRINK

Write below food + drink you'd like to have available during labor:

IMPORTANCE LEVEL

1 2 3 4 5

BREATHWORK

Write below breathing techniques you'd like to use during labor:

IMPORTANCE LEVEL

1 2 3 4 5

CONTINUOUS SUPPORT

Write below how you'd like continuous support to be provided during labor:

IMPORTANCE LEVEL

1 2 3 4 5

Comfort Measures

DISCUSSION GUIDE

WRITE-IN:

Write below how this would help provide comfort during labor:

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

WRITE-IN:

Write below how this would help provide comfort during labor:

IMPORTANCE LEVEL

1 2 3 4 5

WRITE-IN:

Write below how this would help provide comfort during labor:

IMPORTANCE LEVEL

1 2 3 4 5

WRITE-IN:

Write below how this would help provide comfort during labor:

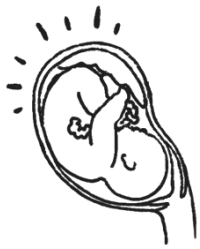
IMPORTANCE LEVEL

1 2 3 4 5

Common Interventions

BRIEFLY EXPLAINED

Any action, treatment, or procedure that's done to start or help progress labor is an intervention. Interventions can be non-medical or medical and utilized minimally or to a great extent. Decisions on whether or not to utilize interventions are often guided by considerations of safety, preference, and satisfaction with the birth experience.

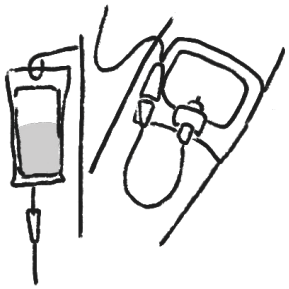


INDUCTION

When labor is started through human intervention. Non-medical methods include sex, massage, nipple stimulation; medical methods include use of foley bulb, membrane sweep, breaking the bag of waters, and medications like Pitocin.

EPIDURAL

An anesthetic injected into the spine. Its numbing effect may relieve pain effectively within 15-20 minutes, without removing all sensation. Requires an IV and continuous monitoring. Pitocin often (but not always) used also.

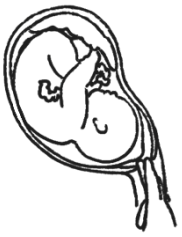


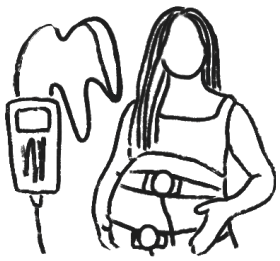
IV/SALINE LOCK

A catheter usually placed in the arm or hand that drips fluids and medication into the bloodstream. Offered for hydration and access in an emergency. When no fluids are running and the catheter is capped off it's a saline lock.

CERVICAL EXAMS

When a care provider uses their fingers to assess effacement (softening and thinning of cervix), dilation (opening of cervix, 0-10 cm), and station and position of the baby.



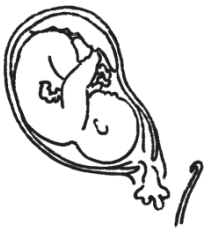


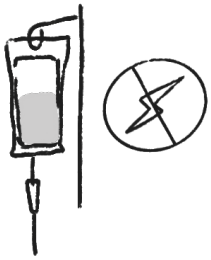
ELECTRONIC FETAL MONITORING

Tracking a baby's heartbeat to keep providers aware of patterns. Some versions of this tool are more/less invasive. Can be used consistently in labor or intermittently (on and off).

ARTIFICIAL RUPTURE OF MEMBRANES (AROM)

When a provider breaks the bag of waters. May support labor progress by allowing baby to descend. May be more effective when the cervix is already soft, and has begun to dilate.



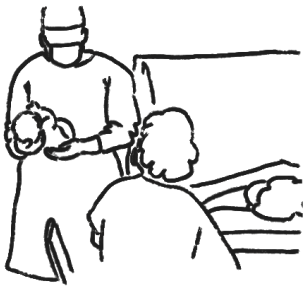


PAIN MEDICATION

Drugs given for pain relief during labor, including Fentanyl, Morphine, Demerol, Stadol, and Nubain — often depending on the hospital. Effects generally last no longer than 4 hours and can have side effects for both parent and baby.

CESAREAN BIRTH

Also known as a c-section, or an abdominal birth, this is the surgical birth of a baby through cuts in the birthing parent's abdomen and uterus.



Why We Do/Don't Use Interventions

BRIEFLY EXPLAINED

Labor is often a mixed bag of hard and wonderful moments and decisions. We don't know in advance what may happen or what decisions we may have to make when labor comes. So when considering interventions to use or not use, questions like these can help guide our way:

- ☑ Is this an emergency?*
- ☑ Will this intervention prevent or reduce a problem? (Ex. treating significant high blood pressure)
- ☑ Will this intervention reduce a potential risk? (Ex. reducing risk of hemorrhage after birth)
- ☑ Can this help my labor progress? How?
- ☑ Will this make me more comfortable?

In some situations you may choose an intervention quickly, in some you may choose an alternative, in some you may choose to do nothing and take your time.

When having these conversations in labor it's critical to have a support and medical team you trust to equip you with information, help outline your options, and support you and your decisions with compassion and respect.

**During a medical emergency, providers will move more quickly and with greater urgency. Even in these cases, informed consent should occur.*

Sources + Recommended Resources: Childbirth Connection; Birthful; MamaNatural.com; Evidence Based Birth; All About Pregnancy & Birth Podcast

Intervention Use

DISCUSSION GUIDE

INDUCTION

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

IV/SALINE LOCK

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

CONTINUOUS ELECTRONIC FETAL MONITORING

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

Intervention Use

DISCUSSION GUIDE

PAIN MEDICATION

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

EPIDURAL

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

PITOCIN

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

Intervention Use

DISCUSSION GUIDE

CESAREAN BIRTH

When could I see myself declining to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

1 being least preferred,
3 being neutral, and
5 being most preferred.

When could I see myself agreeing to use this intervention? Why?

WRITE-IN:

When could I see myself declining to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

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1 2 3 4 5

WRITE-IN:

When could I see myself declining to use this intervention? Why?

When could I see myself agreeing to use this intervention? Why?

IMPORTANCE LEVEL

1 2 3 4 5

Birth Bag Checklist

Not sure what to put in that famous "birth bag"? What you pack in will depend largely on where you plan to give birth and what you feel like you need to be comfortable. Here's a list we created to provide as many ideas as possible — not to say you need every item! Happy packing!

Basics For You

- [ ] In-water labor clothes
- [ ] Out-of-water labor clothes
- [ ] After-birth change of clothes
- [ ] Extra underwear
- [ ] Going-home outfit
- [ ] Nursing-friendly clothes
- [ ] Cozy, non-slip socks
- [ ] Slippers
- [ ] Robe
- [ ] Towel
- [ ] Hairbrush
- [ ] Comb
- [ ] Shampoo
- [ ] Conditioner
- [ ] Body wash
- [ ] Toothbrush + toothpaste
- [ ] Deodorant
- [ ] Lip balm
- [ ] Lotion
- [ ] Hair ties
- [ ] Glasses / Contacts
- [ ] Hand mirror
- [ ] Belly support band

Admin Items

- [ ] Your ID
- [ ] Wallet
- [ ] Insurance card
- [ ] Your birth plan
- [ ] Pediatrician contact info

For Comfort

- [ ] Blanket
- [ ] Pillow(s)
- [ ] Sweater/Hoodie
- [ ] Warm compress(es)
- [ ] Cold pack(s)
- [ ] Eye mask
- [ ] Twinkle lights/electric candles
- [ ] Affirmation cards
- [ ] Other birth space decor
- [ ] Essential oils
- [ ] Entertainment/distractions (if relevant)

Electronics

- [ ] Long cell phone charger
- [ ] Portable power bank
- [ ] Headphones
- [ ] Camera + charger
- [ ] Laptop + charger
- [ ] Memory cards
- [ ] Tripod
- [ ] Portable speaker
- [ ] Portable fan / Mist fan
- [ ] Diffuser

Food + Drink

- [ ] Easy-to eat snacks
- [ ] Popsicles
- [ ] Honey sticks
- [ ] Reusable water bottle
- [ ] Drinks

Infant Feeding

- [ ] Nipple cream
- [ ] Nursing pillow
- [ ] Nursing bra
- [ ] Bottles (if using)
- [ ] Syringes, spoons, etc. (if using)
- [ ] Expressed colostrum (if using)
- [ ] Preferred formula (if using)

For Baby

- [ ] Car seat
- [ ] Going-home outfit
- [ ] Any other outfits
- [ ] Baby blanket(s)
- [ ] Wipes
- [ ] Hand mittens
- [ ] Baby memento book

For Support Person

- [ ] Pillow
- [ ] Blanket / Sleeping bag
- [ ] Toiletries
- [ ] Changes of clothes
- [ ] Snacks + drinks
- [ ] Entertainment

Other

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Birth Preferences

Name: _____ Pronouns: _____

Name: _____ Role: _____ Pronouns: _____

Name: _____ Role: _____ Pronouns: _____

COMFORT MEASURES I PREFER TO USE:

- ☐ Dim light
- ☐ My own clothes
- ☐ Cold washcloths
- ☐ Warm compresses
- ☐ Bath/Shower
- ☐ Movement
- ☐ Touch + massage
- ☐ Birth + peanut ball
- ☐ Music + sounds
- ☐ Aromatherapy
- ☐ Affirmations
- ☐ Visualization
- ☐ Self-hypnosis
- ☐ TENS Unit
- ☐ Eating
- ☐ Drinking
- ☐ Breathwork
- ☐ _____
- ☐ _____
- ☐ _____

INTERVENTIONS I PREFER TO USE:

- ☐ Cervical exams
- ☐ Natural induction
- ☐ Medical induction
- ☐ IV/Saline-lock
- ☐ Water breaking
- ☐ Pitocin
- ☐ Continuous fetal monitoring
- ☐ Standard external fetal monitor
- ☐ Doppler handheld fetal monitor
- ☐ Internal fetal monitor
- ☐ Nitrous oxide
- ☐ Pain medication
- ☐ Epidural
- ☐ Perineal massage
- ☐ Episiotomy
- ☐ Vacuum
- ☐ Forceps
- ☐ Cesarean
- ☐ _____
- ☐ _____
- ☐ _____

INTERVENTIONS I WOULD PREFER TO LIMIT/AVOID:

- ☐ Cervical exams
- ☐ Natural induction
- ☐ Medical induction
- ☐ IV/Saline-lock
- ☐ Water breaking
- ☐ Pitocin
- ☐ Continuous fetal monitoring
- ☐ Standard external fetal monitor
- ☐ Doppler handheld fetal monitor
- ☐ Internal fetal monitor
- ☐ Nitrous oxide
- ☐ Pain medication
- ☐ Epidural
- ☐ Perineal massage
- ☐ Episiotomy
- ☐ Vacuum
- ☐ Forceps
- ☐ Cesarean
- ☐ _____
- ☐ _____
- ☐ _____

PREFERENCES AFTER BABY IS BORN:

- ☐ See placenta
- ☐ Keep placenta
- ☐ Delayed cord clamping
- ☐ Lotus birth
- ☐ Skin-to-skin
- ☐ Suctioning
- ☐ Eye treatment
- ☐ Bath
- ☐ Vitamin K shot
- ☐ Vitamin K orally
- ☐ Circumcision
- ☐ Breast/chestfeeding
- ☐ Bottlefeeding
- ☐ Formula
- ☐ _____
- ☐ _____

Other birth preferences: _____

_____

_____

Primary Care Provider: Initials:

Birth Preferences

Name: Pronouns:

Birth Location
- ☐ Hospital
- ☐ Birth Center
- ☐ Home

Care Provider(s)
- ☐ OBGYN
- ☐ Midwife
- ☐ Family Practitioner

In the birth room...
- ☐ Partner
- ☐ Child(ren)
- ☐ Family/friend(s)
- ☐ Birth Doula
- ☐ Photographer
- ☐ Videographer

My birth is planned as...
- ☐ Vaginal
- ☐ Cesarean
- ☐ Induction

Comfort Measures

Clothes
- ☐ Own clothes
- ☐ Hospital gown

Foods & Fluids
- ☐ Food as desired
- ☐ Liquids - water, juice, etc.
- ☐ Ice chips/Popsicles

Other
- ☐ Music/Sounds
- ☐ Birth ball + peanut ball
- ☐ Warm compress
- ☐ Cold cloths
- ☐ Movement/Mobility
- ☐ Tub/Shower
- ☐ Massage/Pressure
- ☐ Aromatherapy

Interventions

Induction Methods (To Start Labor)
- ☐ None - labor starts on its own
- ☐ Natural (ex. sex, nipple stimulation, walking)
- ☐ Membrane sweep
- ☐ Castor oil
- ☐ Breaking the bag of water (AROM)
- ☐ Medical (Prosteglandins, Misoprostol, Pitocin)
- ☐ Foley bulb

Water Breaking
- ☐ SROM - on its own
- ☐ AROM - as medically needed

Augmentation (Labor Stimulation)
- ☐ None - labor progresses on its own
- ☐ Natural (ex. nipple stimulation)
- ☐ Medical (ex. pitocin)

Cervical Exams
- ☐ As routine ☐ Limited

IV/Saline Lock
- ☐ None - only as medically needed
- ☐ Saline Lock
- ☐ IV

Electronic Fetal Monitoring
- ☐ Doppler/Portable
- ☐ Standard external
- ☐ Internal
- ☐ Continuous ☐ Intermittent

Perineal Care
- ☐ Oil massage
- ☐ NO episiotomy (prefer to tear)

Pain Relief
- ☐ None - will ask if desired
- ☐ Narcotic (ex. Demerol)
- ☐ Epidural
- ☐ Other:

During Pushing
- ☐ Mirror
- ☐ Touch baby's head while crowning
- ☐ Partner catches baby

After Birth

Placenta
- ☐ Birther-led delivery
- ☐ Medically managed delivery
- ☐ Would like to see
- ☐ Plan to keep

Umbilical Cord
- ☐ Delayed cord clamping
- ☐ Clamp after pulsing stops
- ☐ Lotus birth
- ☐ Cord blood banking

Skin to Skin
- ☐ Immediate - as medically possible
- ☐ Evaluation on chest
- ☐ Nursing as soon as possible

Suctioning
- ☐ As routine ☐ Only if needed

Eye Ointment
- ☐ As routine ☐ Only if needed

Vitamin K
- ☐ Shot ☐ Orally
- ☐ Neither

Bath
- ☐ Yes ☐ No

Infant Feeding
- ☐ Breast/chestfeeding
- ☐ Bottlefeeding
- ☐ Formula feeding
- ☐ Bringing expressed colostrum

Primary Care Provider: Initials:

Birth Preferences

Hello! My name is _____ and my pronouns are: _____

Here's who will be with me in my birth space: _____

_____ _____

FOR MY COMFORT DURING LABOR I PLAN TO:

_____

_____

_____

_____

INTERVENTIONS I AM OKAY WITH:

_____

_____

_____

INTERVENTIONS I WOULD PREFER TO LIMIT/AVOID:

_____

_____

_____

AFTER BIRTH, I WOULD LIKE TO:

_____

_____

_____

HERE'S WHAT ELSE I'D LIKE YOU TO KNOW:

_____

_____

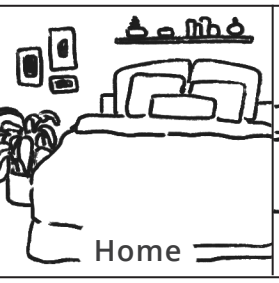
_____

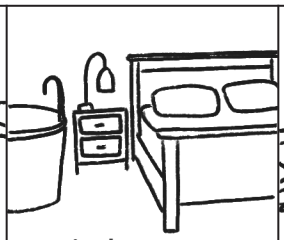
Primary Care Provider: Initials:

Visual Birth Preferences

Hello! My name is _____ and my pronouns are: _____

BIRTH LOCATION


Home


Birth Center


Hospital

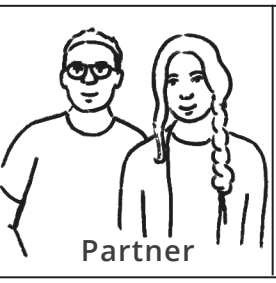
CARE PROVIDER


Midwife


OBGYN

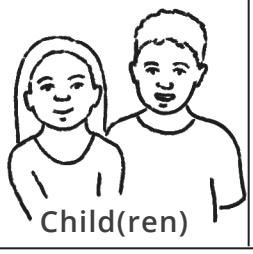

Family Physician

WHO WILL BE WITH ME DURING LABOR


Partner

Doula


Family/Friend


Child(ren)


Photographer

COMFORT MEASURES

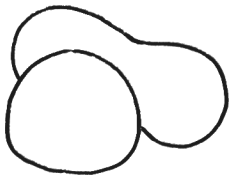

My Clothes


Food


Drink


Ice/Popsicles


Music + Sounds


Birth Balls


Warm Compress

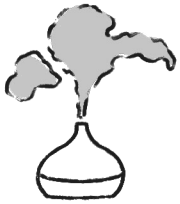

Cold Cloths


Movement

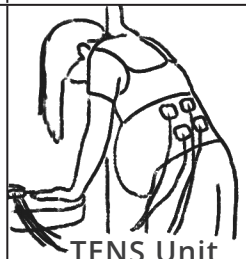

Tub


Shower


Touch + Pressure


Aromatherapy


Dim Light


TENS Unit


Affirmations

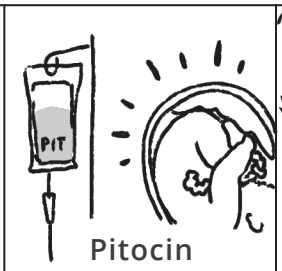
 Primary Care Provider: **Initials:**

Visual Birth Preferences

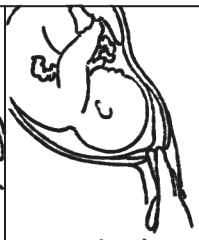
INTERVENTIONS

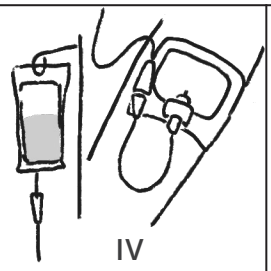

Water Breaking

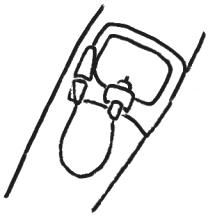

Nipple Stimulation

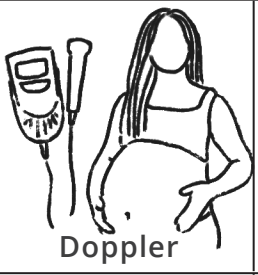


Pitocin


Cervical Exams

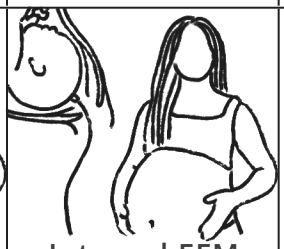

IV

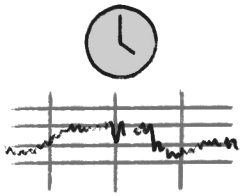

Saline Lock

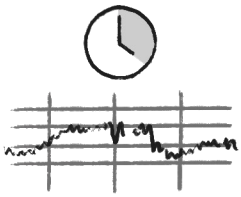

Doppler

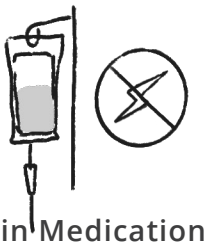

Portable EFM

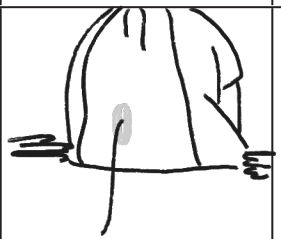

Standard EFM

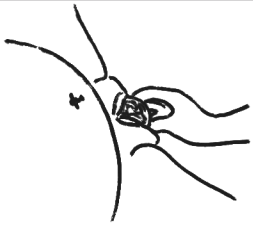

Internal EFM

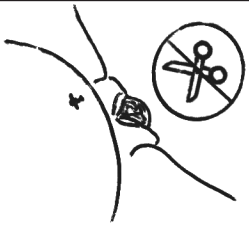

Continuous EFM

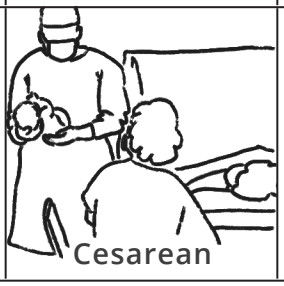

Intermittent EFM


Pain Medication

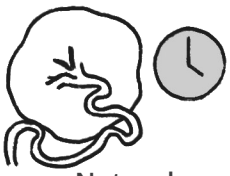

Epidural


Perineal Massage

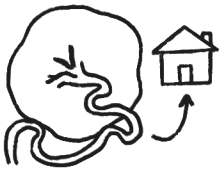

No Episiotomy

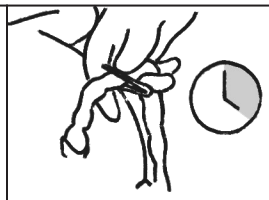

Cesarean

AFTER BIRTH


Natural Placenta Delivery


See Placenta


Keep Placenta


Delayed Cord Clamping


Lotus Birth


Cord Blood Banking


Skin to Skin


Suctioning


Eye Ointment

Vitamin K Shot

Vitamin K Orally


Circumcision


Bath


Breast/Chestfeeding


Bottlefeeding


Formula

 Primary Care Provider: **Initials:**

Cesarean Birth Preferences

Name: **Pronouns:**

During my planned cesarean birth/should a cesarean be necessary — assuming that my baby and I are healthy at the time of delivery and are not experiencing any unforeseen complications — I respectfully request the following:

IN THE OR DURING MY BIRTH:

- ☐ Doula presence
- ☐ Partner presence
- ☐ Video
- ☐ Photos
- ☐ Music/sounds
- ☐ Spinal Anesthesia
- ☐ Epidural Anesthesia
- ☐ Clear/lowered drape
- ☐ Mirror
- ☐ Birth-focused talk
- ☐ Procedure explained as it's happening
- ☐ Slow birth, similar to vaginal "squeeze"
- ☐ Unstrapped arms
- ☐ Dominant arm + hand free
- ☐ No/minimal separation
- ☐ IV removed as soon as possible
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

AFTER BABY IS BORN:

- ☐ See placenta
- ☐ Keep placenta
- ☐ Delayed cord clamping
- ☐ Lotus Birth
- ☐ Skin-to-skin
- ☐ Suctioning
- ☐ Eye treatment
- ☐ Bath
- ☐ Vitamin K shot
- ☐ Vitamin K orally
- ☐ Circumcision
- ☐ Breast/chestfeeding in the OR
- ☐ Bottlefeeding
- ☐ Formula
- ☐ _____
- ☐ _____

Other birth preferences:

_____

_____

_____

_____

_____

Primary Care Provider: **Initials:**